

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Gene McCaskill, Commissioner
T. Scott Beck, Commissioner
Melody L. James, Commissioner

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Appellate Tracking Number : 2012-212972
W.C.C. File No. 0905086

SC Court of Appeals

Alison Morrett,

Employee, Claimant/Appellant.

v.

Capital City Ambulance of GA, Ltd. and
Companion Property and Casualty Group,

Employer, Carrier/Respondents,

**APPENDIX TO
RECORD ON APPEAL**

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December 23, 2013

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Post Trauma Resources

Lawrence H. Bergmann, Ph.D., LPC, LPC/S, CTS
President
Roger W. Deal, M.D.
Medical Director

2 February 2012

Turner Padgett Graham & Laney
PO Box 1473
Columbia, SC 29202
VIA FACSIMILE: 799-3957

Attention: Michael E. Chase

Re: Alison Morrett Addendum

Date of Injury: 11 May 2009

As requested, I reviewed the additional records that predate Ms. Morrett's work-related injury. She began seeing Marjorie Hobbs on 12 August 2004 for her eating difficulties and continues to receive this treatment. The records suggest that she has demonstrated continued problematic behavior, in large part because of lack of motivation to change. She had been hospitalized on six occasions prior to her first meeting with Ms. Hobbs and, at her initial session, reported sleeping approximately two to four hours per night.

Ms. Morrett's symptoms appear to be consistent throughout her counseling with little impact from her work-related injury. The eating behaviors appear to be triggered by her mother both before and after the leg injury but the therapy with Ms. Hobbs seems to have increased Ms. Morrett's motivation to change. In my opinion, it is not that Ms. Morrett was provided with inappropriate treatment in the past or that her behavior has been aggravated by any specific stressor. Rather, her behavior appears to have persisted because, up until this point, she has not had adequate motivation to take advantage of the services that have been offered to her. Because of maturity and the support provided by her counselor, she now appears to be receptive to the needed inpatient treatment. She is an example of how it is not always a case of "the right treatment for the right disorder," but rather "the right treatment for the right disorder at the right time."

In my opinion, Ms. Morrett's psychological condition is more likely than not, with as much certainty reasonable in the field of psychology, no different than before her 11 May 2009 work-related injury.

Respectfully submitted,


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PROVIDENCE HOSPITALS

A Ministry of the Sisters of Charity Health System

2435 Forest Drive • Columbia, SC 29204

OPERATIVE REPORT

PATIENT: MORRETT, ALISON	ACCOUNT: E00113899645
DOCTOR: S Holmes, MD	MR: Z000107343
REFERRING:	SOCIAL SECURITY: XXX-XX-████
PRIMARY CARE: TIMOTHY R WALLACE	AGE: 28 PATIENT TYPE: INO
ADMISSION DATE: 07/23/2010	ROOM: E.2406 A BED:
DISCHARGE DATE: 07/24/2010	NURSING STATION:

DATE OF OPERATION: 07/28/2010

PREOPERATIVE DIAGNOSIS: Hyperextension recurvatum deformity, right knee with varus thrust.

POSTOPERATIVE DIAGNOSIS: Hyperextension recurvatum deformity, right knee with varus thrust.

PROCEDURES PERFORMED:

1. Right high tibial osteotomy.
2. Scar revision, left knee.
3. Hardware removal (tibial interference screw, the screw and washer set).

IMPLANTS: Arthrex contour locked tibial osteotomy, 10-degree with Osteon synthetic bone graft.

SURGEONS: S Holmes, MD

ANESTHESIA: General plus regional.

FLUIDS: Crystalloid.

ESTIMATED BLOOD LOSS: Minimal.

TOURNIQUET TIME: 300 millimeters.

DRAINS: None.

COMPLICATIONS: None.

OPERATIVE REPORT



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DISPOSITION: Postanesthesia care unit and then home.

INDICATION FOR PROCEDURE: The patient is a 28-year-old who has undergone injury to her left knee. She suffered an anterior cruciate ligament tear with reconstruction by Dr. Oliver. I performed a revision anterior cruciate ligament reconstruction and posterior cruciate ligament reconstruction in October 2009. She has had increasingly worsening hyperextension recurvatum deformity with a varus thrust. Her standing mechanical access films are 7 degrees varus compared with the contralateral knee, but 13 degrees varus compared to neutral mechanical varus on her standing films. She was brought to the operating room for high tibial osteotomy and the plane correction is 10 degrees to correct the deformity beyond the contralateral knee, which is her normal.

DESCRIPTION OF PROCEDURE IN DETAIL: After informed consent was obtained, the patient was brought to the operating room and general anesthesia was induced. The left lower extremity was prepped and draped in the usual sterile fashion. The tourniquet was insufflated to 300 millimeters of mercury. A longitudinal incision was made using the previous scar. The previous scar was ellipsed out taking care to excise the entire scar in the underlying dermis so that when the closure was obtained she would have a smoother narrower scar. The skin and subcutaneous tissue were then taken down. Dissection was taken down to the periosteum. The periosteum was elevated to expose the screw and washer used for the posterior cruciate ligament fixation. This was removed with a screwdriver and elevator. The tibial interference screw was removed by identifying the head of the screw using a rongeur to clean out the mouth of the tunnel and then backing the screw out. Subperiosteal dissection was then carried out around the posterior medial corner of the tibia to expose the exposed bone to within 1 centimeter of the joint line distally so that the plate would fit appropriately. A transverse guidewire was placed 1.5 centimeters below the level of the subchondral bone parallel to it to intersect the lateral tibial cortex at 1.5-2 centimeters below the joint line. Then the Arthrex guide was used to do 2 parallel pins in the plane of the cut, which was an oblique cut coursing through the anterior tibial cortex just above the insertion of the patellar tendon, and heading to the same intersection point of the lateral tibial cortex. After these were placed, the cutting

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DISCHARGE DATE:	07/24/2010	ROOM:	E.2406 A
		BED:	
		NURSING STATION:	

block was placed and then this was used to carefully follow the course of the pins with the osteotomy. Retractors were placed posteriorly to carefully protect neurovascular structures. This was then cut with 1-1.5 centimeter of the lateral tibial cortex. I used oscillating saw and osteotomes to try to make sure this was fully cut leaving just a bony hinge laterally. I then weakened the bony hinge by passing a guidewire through the lateral cortex 3 times and then started the process of opening the osteotomy. The Arthrex wedging device was gently tapped into position until a 10-millimeter correction was obtained. I watched on the image intensifier carefully during this entire process to make sure that this was opening correctly and no fractures of the tibia were occurring other than in the desired location.

The plate was placed on the tibia and proximal and distal screws were placed. As I was cinching down 1 of the screws, a crack developed into the lateral tibial plateau going vertically from the osteotomy site. At this point, I recognized the complication, removed the plate, removed the wedging device and the vertical crack in the lateral tibial plateau was now nearly invisible. However, I realized that if I tried to wedge it back open, this would displace that fracture. Then, I used two 3-millimeter guide pins just below the subchondral bone to cross this fracture site. This was done parallel to the joint line and used to provisionally fix that fracture line. I then gradually wedged this open, replaced the plate, and then the proximal 3 screw holes were re-drilled so that they would be parallel to the joint surface and fix the tibial bone all the way to the lateral tibial cortex above the osteotomy site. Two of the screws were Arthrex screws, 1 with a Smith and Nephew 6.5 millimeter cannulated screw to compress across the inadvertent fracture. This did a great job of fixing the plate and that fracture line. Three bicortical screws of appropriate length were placed distally. These were all locking screws as well, so plate was locked into place. Next Osteon wedges were tapped into place to fill the osteotomy site with synthetic bone graft. This nicely filled it and nicely gave structural rigidity to this. At this point, tourniquet was deflated. Multiple images were obtained to verify that this was the osteotomy. The plate and screws were all in appropriate position, but the crack in the lateral tibial plateau was nearly invisible at this point in time, so I felt like this was all well-fixed and should do well. At this point, attention was turned closing the wound. Periosteum was closed with 0 Vicryl, subcutaneous with 2-0 Vicryl, skin with running 4-0

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 COPY for S Holmes MD



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Monocryl and Steri-Strips. Great care was taken to close the wound to minimize scar formation.

After sterile dressings were applied, at this point, the patient was awakened from anesthesia. The patient was discharged to the post anesthesia care unit in stable condition.

DD: Thu Jul 29 14:03:23 2010
DT: Fri Jul 30 01:55:10 2010
23438115 /86119

Signed: _____
S Holmes, MD

CC:

OPERATIVE REPORT

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COPY for S Holmes MD

Operative/Procedure Reports

MORRETT, ALISON RENEE - 0005702675

* Final Report *

Result Type: Operative/Procedure Reports
 Result Date: 23 January 2012 0:00 EST
 Result Status: Auth (Verified)
 Result Title: Operative Note
 Performed By: PIASECKI , DANA PETER MD on 25 January 2012 14:31 EST
 Verified By: PIASECKI , DANA PETER MD on 26 January 2012 9:06 EST
 Encounter info: 1200902538, CMC, IP - Inpatient Admission, 1/23/2012 -

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Operative Note (Verified)

MORRETT, ALISON

5702675

DATE OF SURGERY: 01/23/2012

PREOPERATIVE DIAGNOSES:

1. Right knee multi ligamentous knee injury, status post HTO

POSTOPERATIVE DIAGNOSIS:

1. Right knee multi ligamentous knee injury, status post HTO

PROCEDURE:

1. Right knee arthroscopy, anterior cruciate ligament reconstruction with bone-tendon-bone allograft.
2. PCL reconstruction with Achilles allograft.
3. Posterolateral corner reconstruction with tibialis anterior and Achilles allografts.
4. Posterior capsule repair.
5. Removal of hardware, deep implant.
6. Bone grafting femoral and tibial bone defects.

SURGEON: Piasecki.

ASSISTANT: Hylton, PA-C.

ANESTHESIA: General endotracheal, sciatic and femoral nerve blocks.

CULTURES: None.

DRAINS: One by Hemovac.

SPECIMENS: None.

DISPOSITION: Stable to recovery room.

COMPLICATIONS: None, stable.

Printed by: PIASECKI , DANA PETER MD
 Printed on: 1/26/2012 9:06 EST

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 (Continued)

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INDICATIONS: This is a 29-year-old female who presented to the office status post an index revision high tibial osteotomy to correct her tibial slope in addition to removal of hardware and bone grafting in anticipation of staged revision ACL and PCL reconstructions along with an additional posterolateral corner reconstruction. After demonstration radiographically of appropriate consolidation of her bone grafting and healing of her osteotomy with a discussion of risks and benefits having been performed, the patient consented to moving forward with definitive ligament reconstruction and removal of her prior hardware.

FINDINGS: At The time of surgery in The operating room, The patient demonstrated full range of motion with a clear grade 3 PCL on posterior drawer testing in addition to a 2B Lachman and a grade 2+ pivot shift exam with a stable valgus stress exam at 0 and 30 degrees but with a clearly positive external rotation spin exam along with grade 3 varus instability at 30 of flexion and a dial test which was notably different than the opposite knee at both 90 and 30 of flexion with the majority of external rotation seen at 90. Further diagnostic arthroscopy demonstrated complete disruption of the ACL and PCL as expected. There was mild grade 2 fraying involving the patella and central trochlear groove, but no full thickness chondral defects were noted. The medial femoral condyle demonstrated a grade 2 fraying involving the extension and flexion weightbearing portion of the condyle, but the tibial plateau medially as well as lateral femoral tibial articulation demonstrated no substantial chondral defects. Evaluation of the lateral and medial menisci demonstrated no evidence of substantial tear or instability. There was a clearly positive posterolateral drive thru on evaluation of the lateral compartment with no obvious loose bodies or dramatic synovitis seen in the medial or lateral gutters. Subsequent to open exposure, the patient's prior anteromedial tibial incision and subsequent reaming of the femoral tunnel for the PCL confirmed obstructing hardware. A similar issue was encountered on exposure and initial drilling of the femoral tunnel for the ACL with respect to prior hardware. The ACL screws was replaced with an 8 x 25 cannulated BioComposite screw and then reamed past. The PCL screw was removed without difficulty after reaming the entrance to the bone tunnel. The HTO plate and associated screws also removed in their entirety without difficulty. Removal of these hardware elements, particularly on the femoral side for the PCL and the tibia for the HTO left behind small regions of bone deficiency, which were bone grafted at the end of the case following ACL, PCL, posterolateral corner reconstructions and posterior capsule repair.

DESCRIPTION OF PROCEDURE: Following signing of the correct surgical site and informed consent, the patient was taken to the operating room

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where an uncomplicated general anesthetic was administered in the supine position, the right lower extremity then prepped and draped in the normal sterile fashion after placement of a high thigh tourniquet with a total tourniquet time of 120 minutes. Following prepping and draping in the normal sterile fashion, an exam under anesthesia with the findings as noted in the operative findings section. Initial attention was directed towards hardware removal. As noted, the femoral screw for the PCL tunnel and the femoral screw for the ACL tunnel were both removed using appropriate screwdriver during those portions of those tunnel reamings, the details of which are detailed later in the operative report. With respect to the tibial plate and associated screws, the patient's prior anteromedial arthrotomy was utilized with sharp dissection through skin and underlying subcutaneous tissues to facilitate exposure of the plate. The medial collateral 6.5 cancellous screw and washer were removed anterior to the plate in its entirety with the entrance point of the screw subsequently used for the ACL tunnel. The HTO plate was then removed with the appropriate screwdriver to remove the 6.5's, proximal cancellous screws and distal 4.5 cortical screws along with the plate in its entirety with the small bone void with respect to the wedges of the plate then debrided of fibrous tissue and as noted at the end of the surgery, bone grafting performed of this and the screw site for the PCL.

PCL reconstruction with Achilles allograft: After completion of the above with the knee in 90 degrees of flexion, initial attention was directed towards tibial tunnel preparation for the PCL with an Acuflex tip guide then inserted through a transpatellar tendon portal, the tip of the guide placed at the center of the anterolateral aspect of the footprint for the PCL in the back of the knee with use of an accessory anteromedial portal to remove scar tissue and residual graft substance status post the patient's prior PCL reconstruction with a guidewire inserted through the guide, starting at a point roughly 6 cm below the medial tibial plateau on the proximal medial tibia. The guide seen under direct visualization to enter the appropriate position within the inferolateral footprint. The guide pin position was adjusted slightly with a bullet guide and then a lateral mini C-arm view obtained to demonstrate appropriate center position of the wire within the patient's prior tunnel, which was appropriately located on the tibial side. An 11 reamer was then passed over the wire to ream the tibial tunnel under direct visualization and with care to avoid any plunging of the wire and reamer into the posterolateral aspect of the knee. After completion of the above, the patient's prior distal anteromedial femoral incision was utilized with exposure of the patient's prior femoral tunnel. The same tunnel utilized on the femoral side with use of an outside-in insertion of an 8 followed by a 10 and then an 11 reamer. A 12 impingement rod was then used to gently impact the tunnel to facilitate appropriate sizing with respect to an intended 12

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mm Achilles bone block. As noted previously, the patient's prior PCL interference screw was removed with the appropriate screwdriver after initiating the reaming of the tunnel on the outside of the femoral metaphysis. Upon subsequent tunnel preparation, a non-irradiated Achilles allograft with a 12 mm bone plug and soft tissue portion was shuttled with the assistance of a Magellan suture passer through the femoral tunnel, across the joint space and out the tibial tunnel without difficulty. The cancellous portion of the plug was positioned posteriorly and an 11 x 25 mm cannulated metal interference screw inserted over the posterior plug tunnel interface. Excellent fixation was noted and at the conclusion of the procedure, the outer portion of the tunnel was bone grafted given some mild widening at the outermost portion of the tunnel in this region.

Following subsequent ACL tunnel preparation and graft passage as well as open posterolateral corner exposure and graft passage as well, fixation on the tibial side of the PCL was accomplished with the anterior drawer applied to the knee at 90 degrees of flexion and with tension maintained on the tibial arm of the graft. Care was taken to optimize mismatch issues and graft positioning with respect to the ACL during this portion of the procedure and initial attempts at placing a BioComposite screw over the anterior plug tunnel interface resulted in an anterior cortical rim fracture at the anterior most aspect of the tunnel, communicating with the inferior aspect of the prior HTO. Given concerns for possible extension of this small fracture line, use of this screw was aborted and with tension maintained on the tibial arm of the graft instead, fixation was achieved initially with a 6.5 cancellous screw and spiked WasherLoc washer. Position with tension maintained on the graft with excellent fixation noted. Additional backup fixation was accomplished within the bone tunnel after fashioning of a 25 mm x 8-9 mm bone plug placed into the anterior graft tunnel interface and over top of which a 9 x 20 mm cannulated metal interference screw was inserted with excellent fixation noted accomplishing additional bony compression of the soft tissue arm of the graft in this location. Posterior drawer after completion of the above was normalized with no restriction of motion.

Revision ACL reconstruction with BTB allograft: After completion of The PCL tunnel preparation, an Acuflex tip guide was inserted through the anteromedial portal, the tip of the guide placed at the center of the patient's tibial ACL insertion and the trocar localized over the entrance hole to prior 6.5 cancellous screw on the proximal medial tibia to avoid any overlapping of any more proximal tunnel position with area of some slight bone loss. The guidewire was inserted into the knee, anchored within the roof of the notch then reamed with an 8 followed by a 10 reamer with excellent tunnel integrity appreciated. This was followed by insertion of a 7 mm over-the-top guide, hooked

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around the back wall and externally rotated to facilitate positioning of a flexible guidewire at the center of the femoral insertion on the femoral side, the wire then directed anteriorly out of the distal lateral femur well above the midaxillary line. Initial reaming with an 8 reamer encountered the superior most interference screw from the patient's prior revision reconstruction which was at this point removed and replaced with BioComposite 8 x 25 mm screw, the inferior portion of which was then reamed through with the reamer, The screw then demonstrating and achieving appropriate space filling structural integrity. After completion of the femoral sided reaming to a depth to 10 mm, an acorn reamer was passed over the flexible wire to complete linear orientation of the tunnel, following which the proximal portion of the subsequent posterolateral corner incision was exposed, then utilized to expose the exit point of the femoral tunnel on the distal lateral femur proximal and anterior to the lateral epicondyle. A non-irradiated BTB allograft was then shuttled through the tibial tunnel across the joint space and out of the femoral tunnel through the proximal portion of the posterolateral corner reconstruction, the graft then fixed in position with a 9 x 25 mm cannulated metal interference screw placed over the anterior plug tunnel interface with excellent fixation noted. The graft was slightly recessed out of the femoral tunnel by 2-3 mm to optimize subsequent mismatch on the tibial side. The posterolateral corner grafts having been positioned with care to avoid this proximal ACL fixation region, The knee was cycled and confirmed anatomic positioning of the ACL with no roof impingement or restriction to motion after with the knee in 20 of flexion with tension maintained along the tibial arm of the graft. The anterior plug tunnel interface was dilated and a 9 x 25 mm cannulated metal interference screw inserted into the plug tunnel interface on the tibial side, achieving excellent fixation. Subsequent insertion of the arthroscope confirmed appropriate tensioning of the ACL and overall anatomic position both on the tibial and femoral sides with no inner cruciate impingement. Lachman exam, post-tibial fixation confirmed normalization of the Lachman exam with no roof impingement and no restriction of motion.

Posterolateral corner reconstruction with Achilles allograft and tibialis anterior allograft: After completion of the ACL and PCL tunnel reamings and passage of the PCL tunnel, a roughly 15 cm longitudinal incision was taken over the anterolateral knee from the mid portion of the thigh distally over Gerdy's tubercle distally. Sharp dissection through the skin and underlying subcutaneous tissues facilitated. Subsequent identification and protection of the peroneal nerve around the fibular head and then longitudinal division of the IT band and over windows 2 and 3 to expose the epicondylar layer anteriorly and the LCL and posterolateral capsular layer in the middle window. Notable attenuation was appreciated with respect to the

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capsule and the LCL and given the patient's exam with respect to both rotational and varus instability with a subsequent exposure of the popliteus tendon, confirming minimal, if any, residual popliteus fibers. A popliteal bypass graft was then prepared with a 9 mm bone plug, a 9 mm soft tissue portion which a 7 x 20 mm blind-ended tunnel created at the popliteal attachment and the popliteal sulcus and an anterior to posterior transtibial tunnel created from Gerdy's tubercle to a point roughly 1 fingerbreadth below the lateral tibial plateau edge and medial to the lateral femoral tibia-fibula articulation as palpated digitally through the second IT band window. With the guidewire inserted as noted, a 9 mm reamer was used to prepare the tibial tunnel and the prepared graft as previously noted is placed with the bony portion of the graft press fit within the intended popliteal insertion site on the femur and then fixed with a 7 x 20 mm cannulated metal interference screw, soft tissue portion of the graft then shuttled behind the native LCL around the posterolateral capsule and through the posterior aspect of the tibial tunnel and out the anterior aspect of the tunnel at Gerdy's tubercle. A fibular tunnel was then created at a point 0.2 cm below the tip of the fibular head and 8 mm posterior to the most anterior extent of the fibula directed proximally and medially to the tip of the fibular head and reamed with an 8 reamer to then incorporate the soft tissue portion of an Achilles allograft. Initial attempts were made to utilize a tibialis anterior allograft here, though given the position of The ACL tunnel, it was felt prudent to avoid a transfemoral tunnel at the epicondyle and thus a blind-ended 9 mm tunnel to a depth to 20 mm was created at the epicondyle and seen at the terminus to have reached the ACL but without any transection of the graft or injury to the graft noted. In this location, The 9 x 20 mm bone plug portion of the Achilles allograft was inserted and press fit and then fixed at its inferior extent with a 7 x 20 mm cannulated metal interference screw in the soft tissue portion of the graft then draped over top of the native LCL beneath the IT band fascial layer and then shuttled shoulder anterior to posterior through the fibular tunnel. After fixation of the ACL and PCL, the posterolateral corner reconstruction was tensioned first to tibial bypass graft of the knee in 30 of flexion, gentle internal rotation and valgus load applied with tension maintained on the tibial arm of the graft and a 9 x 30 mm cannulated BioComposite screw inserted over the anterior plug tunnel interface with excellent fixation noted. Very careful subsequent placement of a medium bone staple over the proximal anterolateral tibial metaphysis was then used for backup fixation, the graft tied back upon itself over the proximal tine of a flushly impacted staple with excellent fixation noted and confirmation of no compromise of fixation medially with respect to the ACL and PCL or prior HTO. This was followed by tensioning of the posterior arm of the fibular limb of the LCL graft with placement of the inferior graft tunnel interface of a 7 x 25 mm BioComposite screw affixing the LCL portion of the graft

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with the posterior limb of the graft then shuttled beneath IT band fascial layer and then sewed back over top of the LCL portion of the graft just below the epicondyle. The native LCL was then incorporated with #2 Ethibond sutures into this overall construct and following which a normalization of the varus and external rotation spin exam confirmed.

Posterolateral capsular repair: After completion of the above, the posterolateral capsule just inferior to the ACL tunnel exit point was dissected out the posterolateral femur mobilized with #2 Ethibond sutures and then imbricated with a single 5.5 Lactosorb anchor. The sutures passed using free needles through the capsular tissue and then tensioned with a valgus load applied and with the knee in full extension further normalizing the overall posterolateral corner exam.

Bone grafting tibia and femur: After completion of the above, 40 cc of cancellous allograft chips and 10 cc of demineralized bone matrix were morcellized on the back table and impacted gently with respect to the anteromedial tibia in the region of the prior HTO and the entrance point of both ACL and PCL tibial tunnels along with bone grafting of the femoral PCL tunnel through the anteromedial incision. After completion of the above with all wounds were copiously irrigated, the tourniquet let down with hemostasis achieved with cautery, attention was directed towards closure.

The lateral incision was closed with running 0 Vicryl sutures used for the IT band windows with confirmation of peroneal nerve integrity after completion of the above and subsequent insertion of a Hemovac drain deep to the subcutaneous plane with subsequent closure of the anterior compartment musculature over the anterior leading anterolateral tibial bypass graft incision. Buried 0 Vicryl sutures were used to then close the subcutaneous plane with buried 2-0 Monocryls and staples used for the skin. The anteromedial incision was then closed with buried 0 Vicryl sutures for the deep dermis, buried 2-0 Monocryls and staples used for the skin with a running 0 Vicryl suture closure of the proximal medial femoral incision with a 0 Vicryl suture closure of the VMO split with buried 2-0 Monocryls and staples used for the skin here as well. Interrupted 3-0 nylon sutures were then used for the posteromedial and anterolateral as well as anteromedial portal incisions, the knee then placed in a sterile dressing with an Aquacel dressing applied to the major incisions. The knee then placed in a hinged knee brace locked in extension with the drain hooked to suction and the patient transferred to supine recumbency in a hospital bed and from there to the recovery room without difficulty or complication.

All sponge, needle and instrument counts were correct. I was present during all critical portions of the procedure. There were no

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complications.

Postop rehab protocol will be as per the multi ligamentous knee reconstruction protocol with formal therapy initiated at roughly one week postoperatively with CPM initiated at that time as well.

D: 01/25/2012 02:31PM DANA PETER PIASECKI, MD

T: 01/25/2012 15:55PM NTS

Job # 6357876/Conf # 5244476

cc:

Signature Line

Electronically Signed By: PIASECKI, DANA PETER MD

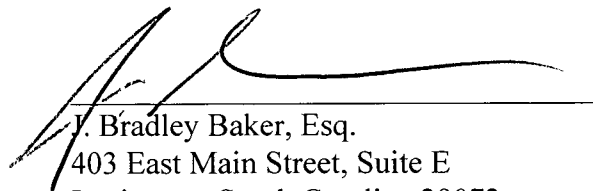
01/26/2012 09:06 AM

Completed Action List:

- * Perform by PIASECKI , DANA PETER MD on 25 January 2012 14:31 EST
- * Transcribe by ESCRIPTION , TRANSCRIPTIONIST on 25 January 2012 15:55 EST
- * Sign by PIASECKI , DANA PETER MD on 26 January 2012 9:06 ESTRequested on 25 January 2012 15:56 EST
- * VERIFY by PIASECKI , DANA PETER MD on 26 January 2012 9:06 EST

Certificate of Counsel

The undersigned hereby certifies that the Appendix to the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



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Attorney for Appellant

December 23, 2013

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