

ORIGINAL

THE STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

· APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

D. GARRISON HILL, Circuit Court Judge

Case No. 2009-CP-23-2535

Archie Eddie Jones..... Respondent

vs.

3M Corporation.....Employer/Appellant

- and -

Old Republic Insurance Company.....Carrier/Appellant

RECORD ON APPEAL

VOLUME I OF II

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JUN 28 2012

SC Court of Appeals

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STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE
IN THE COURT OF COMMON PLEAS

FILED-CLERK OF COURT
GREENVILLE CO. S.C.
PAUL B. WICKENSIMER

JUDGMENT IN A CIVIL CASE

CASE NO: 2009CP2302535

2011 MAY 20 P 3:39

Archie Eddie Jones vs. Three M Corporation

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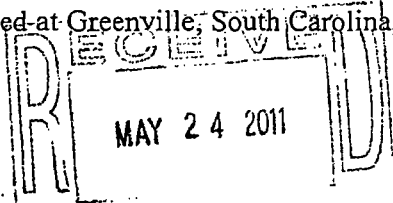
- ☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRPC; ☐ Rule 41(a), SCRPC (Vol. Nonsuit); ☐ Rule 43(k), SCRPC (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j) SCRPC; ☐ Bankruptcy: ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order; ☐ Statement of Judgment by the Court:

Dated at Greenville, South Carolina, this .

Court Reporter:



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JUN 23 2012

SC Court of Appeals

PRESIDING JUDGE -

This judgment was entered on the 20th day of May, 2011, and a copy mailed first class this 20th day of May, 2011, to attorneys of record or to parties (when appearing pro se) as follows:

Kathryn Williams P.O. Box 10693 Greenville, SC 29603

Vernon F. Dunbar Turner Padgett Graham & Laney, PA P.O. Box 1509 Greenville, SC 29602

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Paul B. Wickensimer Greenville County Clerk Of Court
- Clerk of Court

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

FILED-CLERK OF COURT
GREENVILLE CO. S.C.
PAUL B. WICK
THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT
2011 MAY 20 P 3:30

Archie E. Jones, Jr., Employee,
Claimant/Respondent,
vs.
3M Corp., Employer and
Old Republic Insurance Co., Carrier,
Defendants/Appellants.

C.A. Nos. 2009-CP-23-2535

WCC File No. 9708801

ORDER

ENTERED COMPUTER

I. INTRODUCTION / PROCEDURAL BACKGROUND

In this appeal from the Workers Compensation Commission, claimant Archie E. Jones, Jr. (Jones) seeks additional benefits for injury by accident he sustained on June 3, 1997 while working for 3M corp. He specifically contends that as a result of the injury by accident he sustained burns covering his entire body and causing injuries to many body parts, including but not limited to his eyes, arms, legs, feet, toes, urinary tract system, and lungs. He also contends that he suffers from related psychological overlay and has suffered a brain injury and physical brain damage as a result of the accident. Jones seeks lifetime compensation and medical benefits, and he requests a lump-sum payment of his compensation benefits in an amount sufficient to pay his attorney fees and costs in this claim and an allocation of the award to reduce any potential offsets from other disability sources.

Defendants admit Jones sustained injury by accident and sustained compensable injuries, except that they deny that he has brain damage or any injury to his penis/urinary tract.

Defendants further admit Jones is permanently and totally disabled as a result of the accident and is entitled to lifetime related medical benefits, but deny that he is entitled to lifetime compensation benefits. Concerning the alleged brain injury, defendants raise the defense of intervening cause based on strokes Jones had in 1999 and 2005.

By Order dated June 27, 2008, the Hearing Commissioner found that in addition to the admitted injuries, Jones sustained brain injury and physical brain damage and also sustained injuries to his penis and urological system as a result of the accident. The Commissioner awarded lifetime medical and compensation benefits.

Defendants appealed that decision to the Full Commission Panel arguing primarily that the Commissioner erred in finding Jones sustained brain injury and physical brain damage as a result of the accident. However, by Order dated February 25, 2009, the Commission's Appellate Panel affirmed and adopted the Commissioner's Order without change.

Defendants now appeal to this Court.

II. SCOPE OF REVIEW

In Brown v. Greenwood Mills, Inc., the Court of Appeals explained at length the standard of review in workers' compensation cases.

The South Carolina Administrative Procedures Act ("APA") establishes the standard for judicial review of decisions of the workers' compensation commission. A reviewing court may reverse or modify a decision of an agency if the findings, inferences, conclusions, or decisions of that agency are "clearly erroneous in view of the reliable, probative and substantial evidence on the whole record." Under the scope of review established in the APA, this Court may not substitute its judgment for that of the appellate panel as to the weight of the evidence on

questions of fact, but may reverse where the decision is affected by an error of law.

The substantial evidence rule of the APA governs the standard of review in a workers' compensation decision. Pursuant to the APA, this Court's review is limited to deciding whether the appellate panel's decision is unsupported by substantial evidence or is controlled by some error of law. Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence which, considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action.

The appellate panel is the ultimate fact finder in workers' compensation cases and is not bound by the single commissioner's findings of fact. The final determination of witness credibility and the weight to be accorded evidence is reserved to the appellate panel. The possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's findings from being supported by substantial evidence. Where there are conflicts in the evidence over a factual issue, the findings of the appellate panel are conclusive.

The findings of an administrative agency are presumed correct and will be set aside only if unsupported by substantial evidence. It is not within our province to reverse findings of the appellate panel which are supported by substantial evidence.

Brown v. Greenwood Mills, Inc., 366 S.C. 379, 391-93, 622 S.E.2d 546, 553-54

(Ct.App.2005)(citations omitted).

III. LAW/ANALYSIS

Defendants appeal to this Court contending the Commission erred in finding claimant has sustained brain injury and physical brain damage and is entitled to treatment of prostatitis and erectile dysfunction as a result of his admitted injury by accident, erred in failing to hold the record open in order to allow defendants to obtain additional medical examinations prior to the

hearing, and erred in finding claimant is entitled to a partial lump-sum payment of his award for the purposes of paying his attorney fees and costs related to this claim. Because there was no error in the Commission's Order and it is supported by substantial evidence, Commission's Order is affirmed for the reasons that follow.

Decision not to hold record open for defendants' evaluation. Defendants first argue the Commission erred and abused its discretion in not holding the record open and forcing Jones to attend evaluations they had scheduled prior to the hearing. In support of their argument, defendants cite Trotter v. Trane Coil Facility, 384 S.C. 109, 681 S.E.2d 36 (Ct.App.2009). There the Court of Appeals reversed the Commission's decision not to allow a continuance or to hold the record open to receive two depositions. The Court noted that minimum standards of due process requires an opportunity to present favorable witnesses and that great liberality is to be exercised in allowing the introduction of evidence in workers' compensation proceedings, but that "[t]o justify a continuance, the moving party must show not only the absence of some material evidence but also due diligence on his part to obtain it." Trotter v. Trane Coil Facility, 384 S.C. 109, 117, 681 S.E.2d 36, 40 (Ct.App.2009)(quoting Hudson v. Blanton, 282 S.C. 70, 74, 316 S.E.2d 432, 434 (Ct. App. 1984)).

Here, the single Commissioner denied defendants' request because they had known of Jones' contention that he had suffered a brain injury since he initially filed the claim in 1999 and one of the treating physicians had diagnosed a brain injury and requested a neuropsychological evaluation in 1999, but defendants had chosen to do nothing about that contention and had chosen not to investigate the issue or to obtain such evaluation until some eight years later when the time for documentary submissions for the underlying hearing had passed. (Record "K")

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transcript, pp. 853-859) The Commission's Appellate Panel affirmed the Commissioner's decision, and this Court is in agreement with the Commission. Having known of Jones' contention concerning brain injury and having had access to the treating physician's reports for some eight years, defendants clearly did not exercise due diligence in obtaining evidence in this matter. This Court finds no abuse of discretion in the Commission's decision not to hold the record open and allow such evaluations to be conducted after the time for submissions for the hearing had passed based on defendants' conduct in this matter since 1999.

Brain injury and physical brain damage. Defendants next argue the Commission erred in determining claimant suffered physical brain injury as a result of his injury by accident. At issue is that part of § 42-9-10 of the Workers' Compensation Act that provides lifetime compensation benefits for an injured worker determined to be permanently and totally disabled who has suffered "physical brain damage." S.C. Code Ann. § 42-9-10 (1997). The Commission here determined claimant sustained such physical brain damage as a result of hypoxia from his post-accident pulmonary problems. That decision is supported by substantial evidence on the record.

Jones' wife of 45 years, Derrell Jones, testified at length concerning his pre- and post-accident functioning, including the appearance of cognitive difficulties right after his injury by accident and respiratory arrest while in the hospital, such as difficulty remembering things, difficulty with reading and understanding many things, and losing track of his subject when speaking. She admitted that Jones tried to help his niece with a school subject, but he had difficulty and quickly lost all interest in it. Furthermore, the medical records show that Jones sustained an inhalation injury and went into respiratory arrest as a part of a chemical burn to

some 40% to 54% of his body while he was working for employer-defendant. To investigate these problems and increasing confusion, an EEG was performed while Jones was still in the hospital that showed encephalopathy. The discharge summary noted critical respiratory status, including very low oxygen levels and development of E. coli, yeast, and staph infections, which were treated extensively with respirators and antibiotics. Jones' general physician, Dr. June Souviron, recorded Jones' complaints of difficulty with focus and concentration as he attempted to return to work and noted that he had a history of compromised oxygen supply to his brain as a result of his work injury and trauma. Dr. Souviron opined on October 4, 2007 that Jones is permanently and totally disabled because of his work injuries. Pulmonologist Dr. William Walker continued to treat him for body and pulmonary burns, decreased pulmonary function, and incomplete expansion of the lungs. Dr. Gowdhami Mohan treated Jones for respiratory problems, including related chronic obstructive pulmonary disease, bronchiectasis, and obstructive sleep apnea, and he opined that Jones' decreased lung function caused by his work injury contributed to his sleep apnea. Dr. Mohan concurred in the opinion that Jones is unable to work in any capacity due to continued medical and psychological problems. In 1999 and 2000, psychiatrist Dr. Robert Richards diagnosed and treated hypomania, or bipolar disease, ADD due to traumatic brain injury, cognitive disorder due to traumatic brain injury, and delayed onset PTSD. He opined that Jones' problems have never achieved remission, that attempts to expose him to environments with even mild stress usually result in disorganized thinking and racing thoughts, and that his medical condition was aggravating his emotional distress and his emotional distress was aggravating his medical condition. Dr. Richards concluded that Jones has treatment-resistant bipolar disorder due to his traumatic brain injury, that he is not able to

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complete even simple tasks, as stress causes disorganized thinking and intense anxiety, and that he is totally disabled from working.

Jones was evaluated at the Anderson emergency room on June 9, 2001 for an episode in which he bent over and was suddenly unable to speak. Mr. Jones also reported some left-sided facial droop. The evaluating physician noted his work-related injuries, including chronic COPD, and his multiple related medications. The physician also noted that all reported problems had quickly returned to normal, and he opined Jones suffered a transient ischemic attack, or TIA, and he was hospitalized for observation. Following subsequent evaluations, the physicians expressed some doubt whether this episode was in fact a TIA or simply a result of his ongoing psychiatric difficulties and increased recent stress. An MRI scan showed no vascular injury. A similar episode occurred on March 21, 2004 and testing again found no clear new problem. Mrs. Jones testified that these episodes did not permanently worsen her husband's condition at all.

Following review of the medical records and extensive neuropsychological evaluation of Jones, Dr. Robert Moss found deficits in verbal memory, problems in divided attention and processing speed, and problems in phonemic fluency consistent with reported word-finding difficulties. Psychological testing showed marked elevation on somatic scale. Dr. Moss opined that behavioral testing results were consistent with a brain injury and would not be attributable to depression or anxiety, and he diagnosed cognitive disorder and personality change due to brain injury. Dr. Moss opined that the most likely cause was hypoxia related to his post-accident pulmonary problems. He did however posit that the cause could be exposure to the toxic substance in the work injury, though he was not familiar with that chemical. Dr. Moss stated that the normal imaging results found after the TIA events ruled out any possibility that such vascular

events could account for the neuropsychological test results, and he opined that the work injury was in fact the cause of the brain injury.

This evidence constitutes substantial evidence supporting the Commission's findings that Jones has sustained compensable injury to his brain as a result of his injury by accident causing measurable cognitive deficits and physical brain damage and rejecting the subsequent TIA episodes as the cause of his cognitive problems or any re-injury or aggravation of his condition. Given the fact that defendants have not challenged the Commission's determination that claimant is entitled to permanent total disability as a result of the injury by accident, the Commission did not err in awarding lifetime compensation benefits under § 42-9-10.

Remaining contentions. The remainder of defendants' contentions are barely argued in the appellants' brief. Issues that are summarily addressed in a brief are deemed abandoned. Bryson v. Bryson, 378 S.C. 502, 662 S.E.2d 611 (Ct.App.2008); Glasscock v. U.S. Fidelity & Guaranty Co., 348 S.C. 76, 557 S.E.2d 689 (Ct.App.2001); Williams v. Leventis, 290 S.C. 386, 350 S.E.2d 520 (Ct.App.1986). See also Solomon v. City Realty Co., 262 S.C. 198, 203 S.E.2d 435 (1974)(a bald conclusion which leaves unargued the error assigned by the exception is deemed abandoned).

Nevertheless, this Court notes that there is no evidence that the Commission abused its discretion in admitting and relying on the report from Dr. Moss. See Holcombe v. Dan River Mills/Woodside Div., 286 S.C. 223, 333 S.E.2d 338 (Ct.App.1985)(the admission or exclusion of evidence is a matter within the sound discretion of the Hearing Commissioner). There is in fact no evidence on the record to support defendants' contention that Dr. Moss, a psychologist, cannot make a diagnosis of traumatic brain injury, and furthermore, that diagnosis is also made

by Dr. Robert Richards, a psychiatrist and medical doctor. The Commission's finding is well supported in the record, and there is no abuse of discretion in allowing the report of Dr. Moss.

Concerning the issue of treatment for prostatitis and erectile dysfunction, to which defendants devoted a bare three sentences in their brief, there is substantial evidence in the record - including the testimony of Mrs. Jones and the reports from Dr. Hinnant and Dr. Rice - that all of Jones' penile and urological difficulties arose following and as a result of his injury by accident, or the treatment provided for the injury by accident. That decision and the Commission's award of treatment for those conditions are supported by substantial evidence.

And finally, as to the issue of the Commission's award of a lump-sum payment for attorney fees and costs in this matter, the Supreme Court's holding in Glover v. Suitt Constr. Co., 318 S.C. 465, 458 S.E.2d 535 (1995) clearly stated that a partial lump-sum payment may be made to satisfy attorney fees in a lifetime compensation case. Under the Commission's rules, the commuted value of the award must still be determined by the Commission, and the specific amount of the fee and costs must still be agreed on by claimant and approved by the Commission through the Form 61. See S.C. Code Regs. 67-1205, 67-1605. The Order does not state that those separate steps can be or are being bypassed. Defendants' argument on this issue is without merit.

Based on the foregoing, the Commission's Order in this matter is affirmed.

IT IS SO ORDERED.



D. Garrison Hill
Circuit Judge

Dated: May 20, 2011

by Dr. Robert Richards, a psychiatrist and medical doctor. The Commission's finding is well supported in the record, and there is no abuse of discretion in allowing the report of Dr. Moss.

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Based on the foregoing, the Commission's Order in this matter is affirmed.

IT IS SO ORDERED.



D. Garrison Hill
Circuit Judge

Dated: May 20, 2011

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APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 9708801

ARCHIE E. JONES, JR.,

EMPLOYEE,
CLAIMANT/RESPONDENT,

- V -

3M CORPORATION (SFP/SMD),

EMPLOYER,

AND

OLD REPUBLIC INSURANCE CO.,

CARRIER,
DEFENDANTS/APPELLANTS.

Appellate Panel Review held in Columbia,
South Carolina on November 18, 2008 per
notices timely and properly served on all
parties of interest.

Appellate Panel Decision and Order filed

Feb 26, 2009.

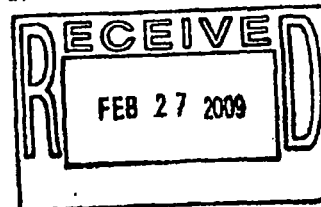
APPEARANCES:

Claimant/Respondent represented by Kathryn
Williams, Esquire, of Greenville, South
Carolina.

 **E-MAILED**

Defendants/Appellants represented by Vernon
F. Dunbar, Esquire, of Greenville, South
Carolina.

*Appeal to Circuit Court due
3/21/1*



STATEMENT OF CASE

The parties were heard by Commissioner J. Alan Bass on November 20, 2007 in Greenville, South Carolina. On June 27, 2008, he issued the following Order:

It is ordered that defendants shall provide the following:

1. All causally related medical treatment and expenses from June 3, 1997 to the present and continuing for claimant's lifetime, including such medical care, treatment, and medications as are needed to maintain his current level of functioning and prevent further deterioration of his condition. Defendants are not responsible for any evaluation or treatment provided to date by Dr. Moss.
2. Permanent total disability compensation in the amount of \$450.62 per week for the remainder of claimant's lifetime, but for no less than 500 weeks. Defendants shall pay directly to claimant's attorney a lump-sum payment of claimant's award sufficient to satisfy his obligation for attorney fees and costs related to this claim.

Within the statutory period, counsel for the Defendants filed an Application for Review in the case setting forth his reasons, copies of which were furnished to all interested parties, prior to oral argument presented before the Appellate Panel on November 18, 2008. All proffered testimony has been taken. Such, together with all documentary evidence, has been delivered by oral argument to the individual members of the Full Commission and has since been under study and consideration.

By appeal, Defendants respectfully submit the following:

1. The hearing commissioner clearly erred in finding as fact and concluding as a matter of law that Claimant sustained a physical traumatic brain injury, the error being that the greater weight of the evidence does not support such a finding.

2. The hearing commissioner erred as a matter of law and abused his discretion in denying Defendants' request to compel Claimant to submit to a medical evaluation with respect to his allegations of a brain injury.

3. The hearing commissioner erred and abused his discretion in failing to exclude the report of Robert Moss, a psychologist, and by relying upon such in adjudicating the Claimant's alleged brain injury claim compensable.

4. The hearing commissioner erred in finding as a fact and concluding as a matter of law that Claimant is entitled to treatment for prostatitis and erectile dysfunction, the error being that such maladies are not related to the compensable work related accident.

5. The hearing commissioner erred as a matter of law in ordering Defendants to directly pay to Claimant's counsel attorneys fees from the Claimant's award.

In an appellate review, the Panel shall, pursuant to S.C. Code Ann. § 42-17-50 (1985), review the Award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner. After careful review in the instant case, the Commission, by unanimous vote, has determined all of the Hearing Commissioner's Findings of Fact and Conclusions of Law are correct as stated. Accordingly, they shall become, and hereby are, the law of the case, and; therefore, the Order is sustained in its entirety.

FINDINGS OF FACT

1. An employee/employer relationship existed between the parties at the time of Claimant's injury. This finding is based on the parties' stipulation.

2. Claimant's average weekly wage is \$675.89 for a corresponding compensation rate of \$450.62. This finding is based on the parties' stipulation.

3. Claimant sustained injury by accident arising out of and in the course of his employment with Employer/Defendant on June 3, 1997 when he was severely burned by a chemical while performing his work duties. This finding is based on Defendants' admission and all the evidence in the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Greenville County EMS, Greenville Memorial Hospital, and the Burn Unit of Medical University of South Carolina.

4. As a result of his injury by accident, Claimant sustained admitted injuries to his skin, eyes, arms, hands, fingers, torso, legs, feet, toes, lungs, and respiratory system. This finding is based on Defendants' admission and all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Greenville Memorial Hospital, the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Walker, and Mr. Mohan.

5. At the Burn Unit of Medical University of South Carolina, Claimant was treated with many debridement and skin graft surgeries for multiple second- and third-degree full-thickness burns covering 40% of his total body surface area and his face, arms, hands, fingers, torso, legs, and feet. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony

of Ms. Jones, and the medical records of the Burn Unit of Medical University of South Carolina.

6. Claimant has continued to have difficulty with skin breakdowns at his burn and graft sites, especially on his feet, and he is in need of continued medical evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Jernigan, Dr. Brown, Dr. Bishop, and Dr. Harvey.

7. At the Burn Unit of Medical University of South Carolina, Claimant was also treated for inhalation injury and burn with a collapsed lung, pulmonary edema, bilateral pleural effusion, and resulting reduced lung volumes and very low oxygen levels. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina.

8. Claimant has continued to have pulmonary and respiratory difficulties as a result of his injury by accident; has been subsequently diagnosed with related chronic obstructive pulmonary disease, bronchiectasis, and obstructive sleep apnea; and is in need of continued medical evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Walker, and Dr. Mohan.

9. Claimant's obstructive sleep apnea is a compensable result of his work-related injuries, as Dr. Mohan opined that the decreased lung function caused by

his work injury contributed to his sleep apnea, and therefore, the treatment provided to Claimant for his condition, including but not limited to his dental appliance, is compensable. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Mohan.

10. Claimant developed compensable psychological distress as a result of his injury by accident, which was diagnosed by the authorized treating physician, Dr. Robert Richards, as treatment-resistant bipolar disorder due to work-related traumatic brain injury and attention deficit disorder due to work-related traumatic brain injury. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

11. As a result of his injury by accident, Claimant has sustained compensable psychological injury or psychological overlay. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

12. Claimant has continued to have related psychological difficulties and is in need of continued evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

13. As a result of treatment provided to Claimant at the Burn Unit of Medical University of South Carolina, including long-term placement of a Foley catheter, Claimant developed urethral erosion and traumatic hypospadias, which Dr. Hinnant treated with surgery and other modalities and which continues to cause difficulties with urination, complete voiding, urinary tract infections, prostatitis syndrome, and erectile

dysfunction. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

14. As a result of his injury by accident, Claimant has sustained compensable injuries to his penis and urological system. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

15. Claimant is in need of continued medical evaluation and treatment for the injuries to his penis and urological system and the related difficulties with urination, complete voiding, urinary tract infections, prostatitis syndrome, and erectile dysfunction. This finding is based on all the evidence in the record, including but not limited to Claimant's testimony, the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

16. Almost immediately after his injury by accident and while still in treatment at the Burn Unit of Medical University of South Carolina, Claimant developed cognitive difficulties, including but not limited to confusion and difficulty with memory, reading and verbal comprehension, and decision-making. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina and Dr. Richards.

17. Dr. Richards noted Claimant's cognitive difficulties, diagnosed cognitive disorder due to traumatic brain injury, and recommended neuropsychological

evaluation; however, the workers' compensation carrier never authorized or provided such neuropsychological evaluation. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Richards.

18. Dr. Robert Moss performed neuropsychological testing on June 29, 2007; found deficits in verbal memory, problems in divided attention and processing speed, and problems in phonemic fluency consistent with reported word-finding difficulties; found behavioral testing results consistent with a brain injury which would not be attributable to depression or anxiety; and diagnosed cognitive disorder due to brain injury and personality change due to brain injury. This finding is based on the medical records of Dr. Moss.

19. Dr. Moss opined the most likely cause of Claimant's cognitive disorder due to brain injury is hypoxia related to his post-accident pulmonary problems. This finding is based on the medical records of Dr. Moss.

20. Dr. Moss opined the normal brain imaging result found after the transient ischemic attack, or TIA, events ruled out any possibility that any such vascular event could account for the neuropsychological test results and that the work accident was in fact the cause of the brain injury. This finding is based on the medical records of Dr. Moss.

21. Claimant has sustained compensable injury to his brain as a result of his injury by accident causing measurable cognitive deficits and physical brain damage. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards and Dr. Moss.

22. Claimant suffered no additional adverse cognitive or other difficulties as a result of the TIA events. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Anderson Area Medical Center, Dr. Souviron, and Dr. Moss.

23. There is no evidence Claimant suffered any re-injury or aggravation of the conditions related to his injury by accident as a result of the TIA events. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Anderson Area Medical Center, Dr. Souviron, and Dr. Moss.

24. Claimant has reached maximum medical improvement from his injuries. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Souviron, Dr. Walker, Dr. Mohan, Dr. Hinnant, and Dr. Richards.

25. Claimant is in need of additional medical and psychological treatment in order to maintain his current level of functioning and prevent further deterioration of his condition. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical record of Dr. Souviron, Dr. Walker, Dr. Mohan, Dr. Hinnant, and Dr. Richards.

26. Claimant attempted to return to work with Employer/Defendant following his injury by accident and medical treatment; however, he was not successful, was eventually restricted from working by Dr. Richards, and has not worked since. This finding is based on all the evidence in the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

27. Doctors Souviron, Mohan, and Richards have all opined that Claimant is unable to work and is permanently and totally disabled because of his work-related injuries. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

28. Claimant has sustained complete loss of earning capacity as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; and his inability to return to work. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

29. Claimant is permanently and totally disabled as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; his traumatic brain injury and resulting cognitive difficulties and physical brain damage; and his inability to return to work and complete loss of earning capacity. This finding is based on Defendants' admission and all the evidence in the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

30. It is in Claimant's best interest that a portion of his award be paid in a commuted lump-sum payment so that he can pay his attorney fees and costs related to this claim. This finding is based on all the evidence on the record.

31. Because of his receipt of Social Security disability benefits, it is in Claimant's best interest that his award of permanent total disability compensation, which is compensation for disability which will affect him for the rest of his life, be allocated

into a theoretical stream of periodic payments extending over his expected lifetime so as to minimize, to the extent allowed by law, any potential offset or reduction he may experience in Social Security disability benefits or other disability benefits. This finding is based on all the evidence on the record, including but not limited to Claimant's testimony; the testimony of Ms. Jones; and the medical records.

CONCLUSIONS OF LAW

1. Under S. C. Code Ann. §§ 42-1-130 to -150, the S. C. Workers' Compensation Commission has jurisdiction over Claimant's claim for benefits.

2. Under S. C. Code Ann. § 42-1-40 and Regulation 67-1603, Claimant's average weekly wage is \$675.89 for a corresponding compensation rate of \$450.62.

3. Under S. C. Code Ann. § 42-1-160, Claimant sustained compensable injury by accident on June 13, 1997 as a result of his work activities with Employer/Defendant causing injury to his skin, brain, eyes, arms, hands, fingers, torso, legs, feet, toes, lungs, respiratory system, penis, urological system, and psyche. Claimant has also sustained compensable traumatic brain injury as a result of his injury by accident with related cognitive difficulties and physical brain damage.

4. Claimant's transient ischemic attacks, or TIAs, did not rise to the level of an independent intervening cause, sufficient to break the chain of causation between Claimant's injury by accident and his related physical, mental, and psychological injuries. See *Whitfield v. Daniel Construction Co.*, 226 S.C. 37, 87 S.E.2d 460 (1954).

5. Claimant has reached maximum medical improvement from his injuries, but is in need of continuing medical and psychological treatment in order to maintain his current level of functioning and prevent further deterioration of his condition. See *Dodge v. Brucoli, Clark, Layman, Inc.*, 334 S.C. 574, 514 S.E.2d 593 (Ct. App. 1999)(maximum medical improvement is plateau at which no further medical care or treatment will lessen the degree of impairment; injured worker is entitled to additional medical treatment to maintain current level of functioning and prevent a worsening of condition despite a finding of maximum medical improvement).

6. Claimant has sustained complete loss of earning capacity as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; and his inability to return to work. *Colvin v. E.I. DuPont de Nemours Co.*, 227 S.C. 465, 88 S.E.2d 581 (1955).

7. Under S. C. Code Ann. § 42-9-10, Claimant is permanently and totally disabled as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; his traumatic brain injury and resulting cognitive difficulties and physical brain damage; and his inability to return to work and complete loss of earning capacity. See also *Wynn v. People's Natural Gas Co.*, 238 S.C. 1, 118 S.E.2d 812 (1961)([i]nability to perform common labor is total disability for one who is not qualified by training or experience for any other employment); *Brown v. Owen Steel Co.*, 316 S. C. 278, 450 S.E.2d 57 (Ct. App. 1994)(when injuries are not confined to a single body part, a claimant is not limited to the scheduled loss statute and is entitled to determination of disability based on loss of earning capacity).

8. Claimant has sustained physical brain damage within the meaning of S. C. Code Ann. § 42-9-10.

9. Under S. C. Code Ann. § 42-9-10, Claimant is entitled to weekly compensation benefits for the remainder of his lifetime, but for no less than 500 weeks, as a result of his permanent total disability and his physical brain damage. *See also Pearson v. JPS Conv. & Indus. Corp.*, 327 S.C. 393, 489 S.E.2d 219 (Ct. App. 1997)(the Act merely requires that a claimant be totally and permanently disabled and suffer from physical brain damage or quadriplegia/paraplegia to be entitled to lifetime compensation benefits).

10. Under S. C. Code Ann. § 42-15-60, Claimant is entitled to and Defendants are responsible for all causally related medical treatment and expenses from June 3, 1997 to the present and continuing for Claimant's lifetime, including such medical care, treatment, and medications as are needed to maintain his current level of functioning and prevent further deterioration of his condition. Defendants are not responsible for any evaluation or treatment provided to date by Dr. Moss. *See also Dodge, supra.*

11. Pursuant to the Supreme Court's holding in *Glover v. Suitt Constr. Co.*, 318 S.C. 465, 458 S.E.2d 535 (1995), Defendants shall pay directly to Claimant's attorney a lump-sum payment of Claimant's award sufficient to satisfy his obligation for attorney fees and costs related to this claim.

12. This award, which is compensation for permanent impairment that will affect Claimant for life, is estimated and allocated into a theoretical stream of periodic payments, as follows: \$101,445.24 for attorney's fees and costs in prosecuting

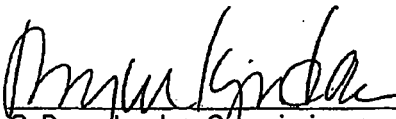
this action and \$187,384.76 for future disability benefits at the rate of \$890.27 per month for 210.48 months (Claimant was born on ~~01/20/1942~~ and has a life expectancy of 17.84 years, or 210.48 months, according to the mortality tables in S. C. Code Ann. § 19-1-150)(the commuted value of Claimant's lifetime compensation benefits is \$288,830.00)(\$187,384.76 divided by 210.48 months equals \$890.27 per month). See *Utica-Mohawk Mills v. Orr*, 277 S.C. 226, 87 S.E.2d 589 (1955); S. C. Code Ann. §§ 42-9-10, 42-9-240 (2005). See also *Sciarotta v. Bowen*, 837 F.2d 135 (3d Cir. 1988), on remand *Sciarotta v. Secretary of H.H.S.*, 735 F.Supp. 148 (D.N.J. 1989); POMS 11501.235(c).

ORDER

IT IS, THEREFORE, ORDERED the Order of the Single Commissioner filed in the above-captioned matter on June 27, 2008 is hereby affirmed by the Panel, and the same shall constitute the Decision and Order of the Appellate Panel.

AND IT IS SO ORDERED.

S. C. WORKERS' COMPENSATION COMMISSION


G. Bryan Lyndon, Commissioner

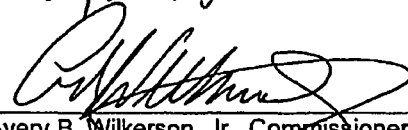
FULL AFFIRMATION

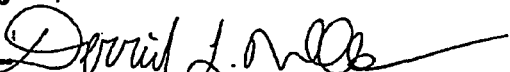
CONCUR:

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 26 day of Feb, 2008
By M. B. [Signature]
Administrative Assistant to the Commissioner


Avery B. Wilkerson, Jr., Commissioner


Derrick L. Williams, Commissioner

(L:19708801.gbl.app.)

KW VFD

ORDER
of the
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
File No.: 9708801

Archie E. Jones, Jr.,

Employee/Claimant,

vs.

3M Corp.,

Employer, and

Old Republic Insurance Co.,

Carrier/Defendants.

Hearing: Held in Greenville, South Carolina on November 20, 2007

Appearances: Kathryn Williams, Esq. of Kathryn Williams, P.A. for claimant
Vernon F. Dunbar, Esq. of Turner, Padgett, Graham & Laney,
P.A. for defendants

Purpose: To determine issues as set forth on the Forms 50 and 51

Decision & Order: J. Alan Bass, Commissioner

Filed:

June 27, 2008



E-MAILED

Appeal due 7/11/08

JUN 30 2008

2431 397

APA SUBMISSIONS

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DEPOSITIONS

- #1 Deposition of claimant, dated 10/30/07, consisting of 39 pages

STIPULATIONS

Counsel for all parties stipulated at the hearing to the following issues:

1. The purpose of the hearing is to determine the issues set forth in the hearing notice, issues pled in the Forms 50 and 51, and other issues timely brought before the Commissioner.
2. Notice of the hearing was timely and properly served upon all parties of interest.
3. Venue, set in Greenville County, is proper.
4. Claimant seeks additional benefits under the South Carolina Workers' Compensation Act based upon an admitted injury by accident which occurred on June 3, 1997 while he was working for employer-defendant, and therefore, the South Carolina Workers' Compensation Commission has jurisdiction of the case.
5. The Commission's file and the Hearing Commissioner's notes are a part of the record of this case, with the exception of any self-serving declarations or unstipulated medical reports.
6. Claimant's average weekly wage is \$675.89, for a corresponding compensation rate of \$450.62.

CLAIMANT'S BIOGRAPHICAL INFORMATION

Age: 64
Education: High School diploma, some college

STATEMENT OF THE CASE

Claimant seeks additional benefits for injury by accident he sustained on June 3, 1997 while working for employer-defendant. He specifically contends that as a result of the injury by accident he

sustained burns covering his entire body and causing injuries to many body parts, including but not limited to his eyes, arms, legs, feet, toes, urinary tract system, and lungs. He also contends that he suffers from related psychological overlay and has suffered a brain injury and physical brain damage as a result of the accident. Claimant seeks lifetime compensation and medical benefits, and he requests a lump-sum payment of his compensation benefits in an amount sufficient to pay his attorney fees and costs in this claim and an allocation of the award to reduce any potential offsets from other disability sources.

Defendants admit claimant sustained injury by accident as alleged and sustained compensable injuries as alleged, except that they deny that he has sustained brain damage or any injury to his penis/urinary tract. Defendants further admit that claimant is permanently and totally disabled as a result of the accident and is entitled to lifetime related medical benefits, but they deny that he is entitled to lifetime compensation benefits. Concerning the alleged brain injury, defendants raise the defense of intervening cause based on strokes claimant sustained in 1999 and 2005.

EVIDENCE OF THE CASE

Claimant's wife, Derrell Jones, testified on his behalf. Ms. Jones stated her husband is 64 years old and that they have been married for 45 years. She testified that prior to his injury at work, he was a vegetarian, a "body builder," and "the picture of health" and that in her opinion his good health is the reason that he was able to survive the accident and his burns.

Ms. Jones testified claimant suffered a burn injury at work in June 1997 and that he was taken to Greenville Memorial Hospital and then flown to MUSC in Charleston, where he stayed for several months. He now has extensive scarring all over his body as a result of the burns, and the scarring

causes infections and other difficulties, especially on his feet where the skin breakdowns limit the time that he can be on his feet and limit his activities. Ms. Jones testified claimant was at that moment dealing with a related bone infection in his foot. He continues to go to a wound care facility for help with those problems. In addition, he has trouble with the parts of his body where the physicians harvested skin for grafting and has to keep lotion on those areas. He also does not have full movement of his hands and fingers.

Ms. Jones testified that claimant went into respiratory arrest while in the hospital following his injury, continues to have trouble with his lungs, and has only about 45% lung capacity. She explained that this greatly diminishes his stamina and he has many days where he simply cannot breathe well and is obviously not feeling well because of it. Claimant has difficulty with his urinary tract due to the fact that he had a catheter in for so long and due to the fact that during his recovery he accidentally stepped on the catheter tube, ripping it from his urethra. He also now has erectile dysfunction.

Ms. Jones testified her husband also has displayed cognitive problems since right after his injury by accident. She explained that before his injury he was very smart and quick and was able to understand and recall most things after reading over it just once. However, after the accident, she noticed right away that he had difficulty remembering things and had a hard time reading and understanding many things, and those problems continue to this day. She stated he now has to go over and over things in order to understand it. Ms. Jones testified claimant loses track of his subject and stammers and rambles when he is talking. He cannot make decisions or commitments anymore and leaves such things to her. She also has to handle their financial matters because he is not able to do so.

Ms. Jones admitted her husband suffered something similar to a stroke on two occasions after his injury at work, once in 2000 and again in 2005; however, she explained that these strokes did not

worsen his condition at all.

Ms. Jones stated that her husband used to be very active and worked out all the time, but now after his injuries, his lowered lung capacity will not allow him to work out and he cannot keep up with her when they walk together. He does go shopping with her on occasion, but again, is limited in the amount that he can walk. His feet get sore from walking on hard surfaces or he will get a sore on his feet from walking, and then he will be in bed for a while or will not be able to walk very well for a couple of weeks. Ms. Jones stated claimant can drive and they recently drove together to Minnesota, but she explained that he drove only part of the way and that they had to stop overnight several times on the trip there and again on the trip back. He is able to keep up with his medications by writing down everything he does and splitting his pills up into daily dispensers, but that is really the only thing that he is able to keep up with. Claimant tried to help his niece with a school subject with which she was having difficulty, but Ms. Jones explained that he obsesses on such things and then will quickly lose all interest. He is much less able to work on things around the house as he used to do, and he frequently injures himself when he tries to do such things and continually has bruises and band-aids on his hands.

Ms. Jones testified claimant attempted to return to work and worked for about eight months, but did not work in his previous job. His employer attempted to train him to use a computer, which he had no prior experience with, and he was not able to absorb it and got very frustrated. In addition, they had him working in a high traffic area, and he was distracted and unable to focus on his work.

She stated he has emotional problems because of his injuries, and he has been seeing psychiatrist Dr. Robert Richards for treatment of those problems for some time. He had no such emotional problems before his injury by accident.

The medical records show that an EMS team reported to employer-defendant's facility on June 3, 1997 and found claimant lying on a backboard covered by a burn sheet. The Fire Chief on the scene reported claimant had been burned by a chemical, Therminol 66, which was described as a super-heated oil that is a skin and respiratory irritant. The EMS attendant noted that claimant stated that his eyes and lungs were burning, and he observed second and third degree burns over approximately 54% of the front of claimant's body, including his face, arms, torso, legs, and feet. Claimant was transported to Greenville Memorial Hospital, but he was then quickly moved by air transport to the Burn Center at the Medical University of South Carolina in Charleston.

While en route to MUSC, claimant experienced respiratory distress and was intubated. At the hospital, he was found to also have an inhalation injury with a collapsed lung, pulmonary edema, bilateral pleural effusion, and resulting reduced lung volumes. By June 7, 1997, this condition was noted to be worsening with developing pneumonia and infections, and the condition continued to wax and wane over the next many weeks. On June 11, 1997, claimant began undergoing multiple, extensive surgeries to debride and treat his burns, many of which were full-thickness burns. Skin grafting procedures were begun on July 2, 1997, beginning with the legs and feet, then face and abdomen. On August 2, 1997, an EEG was performed due to increasing confusion and abnormalities were found consistent with encephalopathy. Further skin grafting was accomplished on August 20, 1997, including the right arm, and claimant's left fifth toe was also amputated.

Claimant was discharged and admitted to the rehabilitation unit on September 25, 1997. His final burn measurement was approximately 40% of his total body surface area. Beyond the multiple skin grafting procedures, the discharge summary was notable for reported critical respiratory status, including very low oxygen levels and development of E. coli, yeast, and staph infections, which was

treated extensively with respirators and antibiotics. Claimant's graft sites were noted to be improving, but there were still continued problems behind his left ear, on his right thigh, and on his abdominal wall. He was continuing to have difficulty with ambulation, contracture of his hands, and with speech and swallowing.

Claimant was discharged from the rehabilitation unit on October 3, 1997, and the discharge summary noted that he was functional in activities of daily living, including ambulation though he could only walk about 1000 feet. His pulmonary situation and his skin was noted to be improving, and his wife was competent with dressing changes. Claimant was provided a home health nurse and was instructed to follow up in the burn clinic.

On October 28, 1997, claimant began treatment for urethral erosion, which was due to long-term catheter placement, and such treatment eventually included surgical repair. At that time, the physician noted that claimant was continuing to struggle with parenchymal disease of his lungs from inhalation. On November 6, 1997, claimant also underwent surgery to correct and close a fistula that remained after removal of his tracheostomy tube. On December 30, 1997, he underwent additional surgery and additional skin grafting on his right foot, with subsequent hydrotherapy. And on August 13, 1998 and again on December 17, 1998, claimant underwent additional surgeries to revise the scarring on his left nose, left upper eyebrow, left ear, neck, trunk, and right arm.

Claimant's general physician, Dr. June Souviron, began following him for his burn and respiratory injuries in October 1997. At that time, she also diagnosed depression due to stress from his burns and prescribed medications. She followed him for chronic chemical pneumonitis, pulmonary fibrosis, acute bronchitis and sinusitis, migraine headaches, and continued psychological distress, including anxiety and depression. Dr. Souviron eventually referred claimant to Dr. William Walker

for his respiratory issues. On February 8, 1999, she recorded claimant's complaints of difficulty with focus and concentration as he attempted to return to work and noted that he had a history of compromised oxygen supply to his brain as a result of his work injury and trauma. Dr. Souviron opined on October 4, 2007 that claimant is permanently and totally disabled because of his work injuries.

Pulmonologist Dr. William Walker began following claimant on March 31, 1998 and noted his work injury including body and pulmonary burns. On examination, he found decreased pulmonary function and incomplete expansion of the lungs and opined that claimant was continuing to struggle with significant lung disease from his burn injury. Dr. Walker recommended continued medications and pulmonary rehabilitation. On June 15, 1998, Dr. Walker stated again that claimant has severe lung disease from his accident, including damage to his pharynx which left him susceptible to aspiration and chronic low-grade bronchitis with obstructive component. He stated claimant is going to have intermittent acute flare-ups of varying degrees of severity and duration, and he opined that he is not able to do strenuous physical activity from a pulmonary standpoint because of his lung disease.

Thereafter, claimant's respiratory problems, including related chronic obstructive pulmonary disease, bronchiectasis, and obstructive sleep apnea, were treated by Dr. Gowdhami Mohan with multiple medications and a dental device for sleeping. He opined that claimant's decreased lung function caused by his work injury contributed to his sleep apnea. Dr. Mohan concurred in the opinion that claimant is unable to work in any capacity due to continued medical and psychological problems.

Urologist Dr. William Hinnant evaluated claimant on June 23, 1998 and diagnosed traumatic hypospadias from the Foley catheter he wore for about three months during his early treatment. Dr. Hinnant recommended and performed corrective surgery on July 9, 1998, and continued to follow claimant thereafter for difficulties with urination, complete voiding, urinary tract infections, prostatitis

syndrome, and erectile dysfunction. Dr. Hinnant performed a urethrotomy procedure in June 2000 to correct a stricture and improve his stream. He ultimately opined that claimant will require a couple of continued visits each year to address stricture and periodic urinalysis.

Psychiatrist Dr. Robert Richards began following claimant on April 20, 1999 for distress related to his injuries. He initially diagnosed hypomania and posttraumatic stress disorder and prescribed medications. Dr. Richards recorded complaints of confusion on April 30 and after further evaluation altered his diagnosis to hypomania or bipolar disease and ADD due to traumatic brain injury. On January 4, 2000, Dr. Richards noted claimant described onset of flashbacks and vivid dreams, in addition to increased arousal, sadness, and hopelessness, and he added the diagnoses of cognitive disorder due to traumatic brain injury and delayed onset PTSD from the work injury. On April 19, 2000, Dr. Richards found reports of continued difficulty with reading and short-term memory, in addition to disorganized thoughts and indecision, and he recommended neuropsychological testing to evaluate cognitive difficulties. In an evaluation on September 10, 2001, Dr. Richards reiterated his earlier diagnoses, including traumatic brain injury and stated that his medication treatment course has been complicated by the need for steroids to treat his respiratory problems. He opined that claimant's problems have never achieved remission, that attempts to expose him to environments with even mild stress usually result in disorganized thinking and racing thoughts, and that his medical condition was aggravating his emotional distress and his emotional distress was aggravating his medical condition. Dr. Richards concluded that claimant has treatment-resistant bipolar disorder due to his traumatic brain injury, that he is not able to complete even simple tasks, as stress causes disorganized thinking and intense anxiety, and that he is totally disabled from working. He opined on February 20, 2003 that claimant had reached maximum medical improvement from his injury-related bipolar disorder and

ADHD, though the steroid treatment necessary for his medical conditions had prevented him from reaching the higher level of functioning usually achieved by patients with those conditions. Dr. Richards continued to follow claimant, adjust his medications, and provide therapy. He opined on October 20, 2007 that claimant is permanently and totally disabled due to his work injuries.

Claimant was evaluated at the Anderson emergency room on June 9, 2001 for an episode in which he bent over and was suddenly unable to speak. Ms. Jones also reported some left-sided facial droop. The evaluating physician noted his work-related injuries, including chronic COPD, and his multiple related medications. The physician also noted that all reported problems had quickly returned to normal, and he opined claimant suffered a transient ischemic attack, or TIA, and he was hospitalized for observation. Following subsequent evaluations, the physicians expressed some doubt whether this episode was in fact a TIA or simply a result of his ongoing psychiatric difficulties and increased recent stress. Of note, an MRI scan of the brain showed some evidence of white matter changes in the right parietal lobe, but this was not felt to be acute. The MRI showed no vascular injury. A similar episode occurred on March 21, 2004 and testing again found no clear new problem.

Dr. Robert Moss performed neuropsychological testing on June 29, 2007. He noted claimant's history of an extensive burn injury at work, including continuing chronic respiratory problems. He also noted Dr. Richards' subsequent diagnoses of bipolar disorder due to traumatic brain injury and cognitive disorder NOS due to traumatic brain injury. Dr. Moss recorded claimant's complaints of memory and concentration problems, changes in reading and receptive language comprehension, changes in spelling and calculation ability, changes in ability to plan and organize, and some word-finding difficulty. Concerning the administered testing, Dr. Moss stated claimant gave good effort and that results were felt to be valid and interpretable. He found deficits in verbal memory, problems in

divided attention and processing speed, and problems in phonemic fluency consistent with reported word-finding difficulties. Psychological testing showed marked elevation on somatic scale, as expected given his continuing physical problems. Dr. Moss stated that behavioral testing results were consistent with a brain injury and would not be attributable to depression or anxiety. Based on these results, Dr. Moss diagnosed cognitive disorder due to brain injury and personality change due to brain injury, and he opined that the most likely cause was hypoxia related to his post-accident pulmonary problems. He did however posit that the cause could be exposure to the toxic substance in the work injury, though he was not familiar with that chemical. Dr. Moss stated that the normal imaging results found after the TIA events ruled out any possibility that such vascular events could account for the neuropsychological test results, and he opined that the work injury was in fact the cause of the brain injury.

FINDINGS OF FACT

1. An employee/employer relationship existed between the parties at the time of claimant's injury. This finding is based on the parties' stipulation.
2. Claimant's average weekly wage is \$675.89, for a corresponding compensation rate of \$450.62. This finding is based on the parties' stipulation.
3. Claimant sustained injury by accident arising out of and in the course of his employment with employer-defendant on June 3, 1997 when he was severely burned by a chemical while performing his work duties. This finding is based on defendant's admission and all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Greenville County EMS, Greenville Memorial Hospital, and the Burn Unit of Medical University of South Carolina.

4. As a result of his injury by accident, claimant sustained admitted injuries to his skin, eyes, arms, hands, fingers, torso, legs, feet, toes, lungs, and respiratory system. This finding is based on defendants' admission and all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Greenville Memorial Hospital, the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Walker, and Dr. Mohan.

5. At the Burn Unit of Medical University of South Carolina, claimant was treated with many debridement and skin graft surgeries for multiple second- and third-degree full-thickness burns covering 40% of his total body surface area and his face, arms, hands, fingers, torso, legs, and feet. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina.

6. Claimant has continued to have difficulty with skin breakdowns at his burn and graft sites, especially on his feet, and he is in need of continued medical evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Jemigan, Dr. Brown, Dr. Bishop, and Dr. Harvey.

7. At the Burn Unit of Medical University of South Carolina, claimant was also treated for inhalation injury and burn with a collapsed lung, pulmonary edema, bilateral pleural effusion, and resulting reduced lung volumes and very low oxygen levels. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina.

8. Claimant has continued to have pulmonary and respiratory difficulties as a result of his injury by accident; has been subsequently diagnosed with related chronic obstructive pulmonary disease, bronchiectasis, and obstructive sleep apnea; and is in need of continued medical evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Souviron, Dr. Walker, and Dr. Mohan.

9. Claimant's obstructive sleep apnea is a compensable result of his work-related injuries, as Dr. Mohan opined that the decreased lung function caused by his work injury contributed to his sleep apnea, and therefore, the treatment provided to claimant for his condition, including but not limited to his dental appliance, is compensable. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Mohan.

10. Claimant developed compensable psychological distress as a result of his injury by accident, which was diagnosed by the authorized treating physician, Dr. Robert Richards, as treatment-resistant bipolar disorder due to work-related traumatic brain injury and attention deficit disorder due to work-related traumatic brain injury. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

11. As a result of his injury by accident, claimant has sustained compensable psychological injury, or psychological overlay. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

12. Claimant has continued to have related psychological difficulties and is in need of continued evaluation and treatment for this problem. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

13. As a result of treatment provided to claimant at the Burn Unit of Medical University of South Carolina, including long-term placement of a Foley catheter, claimant developed urethral erosion and traumatic hypospadias, which Dr. Hinnant treated with surgery and other modalities and which continues to cause difficulties with urination, complete voiding, urinary tract infections, prostatitis syndrome, and erectile dysfunction. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

14. As a result of his injury by accident, claimant has sustained compensable injuries to his penis and urological system. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

15. Claimant is in need of continued medical evaluation and treatment for the injuries to his penis and urological system and the related difficulties with urination, complete voiding, urinary tract infections, prostatitis syndrome, and erectile dysfunction. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina, Dr. Hinnant, and Dr. Rice.

16. Almost immediately after his injury by accident and while still in treatment at the Burn Unit of Medical University of South Carolina, claimant developed cognitive difficulties, including but

not limited to confusion and difficulty with memory, reading and verbal comprehension, and decision-making. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of the Burn Unit of Medical University of South Carolina and Dr. Richards.

17. Dr. Richards noted claimant's cognitive difficulties, diagnosed cognitive disorder due to traumatic brain injury, and recommended neuropsychological evaluation; however, the workers' compensation carrier never authorized or proved such neuropsychological evaluation. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Richards.

18. Dr. Robert Moss performed neuropsychological testing on June 29, 2007; found deficits in verbal memory, problems in divided attention and processing speed, and problems in phonemic fluency consistent with reported word-finding difficulties; found behavioral testing results consistent with a brain injury which would not be attributable to depression or anxiety; and diagnosed cognitive disorder due to brain injury and personality change due to brain injury. This finding is based on the medical records of Dr. Moss.

19. Dr. Moss opined that the most likely cause of claimant's cognitive disorder due to brain injury is hypoxia related to his post-accident pulmonary problems. This finding is based on the medical records of Dr. Moss.

20. Dr. Moss opined that the normal brain imaging results found after the transient ischemic attack, or TIA, events ruled out any possibility that any such vascular event could account for the neuropsychological test results and that the work accident was in fact the cause of the brain injury. This finding is based on the medical records of Dr. Moss.

21. Claimant has sustained compensable injury to his brain as a result of his injury by accident causing measurable cognitive deficits and physical brain damage. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards and Dr. Moss.

22. Claimant suffered no additional adverse cognitive or other difficulties as a result of the TIA events. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Anderson Area Medical Center, Dr. Souviron, and Dr. Moss.

23. There is no evidence that claimant suffered any reinjury or aggravation of the conditions related to his injury by accident as a result of the TIA events. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Anderson Area Medical Center, Dr. Souviron, and Dr. Moss.

24. Claimant has reached maximum medical improvement from his injuries. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Souviron, Dr. Walker, Dr. Mohan, Dr. Hinnant, and Dr. Richards.

25. Claimant is in need of additional medical and psychological treatment in order to maintain his current level of functioning and prevent further deterioration of his condition. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Souviron, Dr. Walker, Dr. Mohan, Dr. Hinnant, and Dr. Richards.

26. Claimant attempted to return to work with employer-defendant following his injury by accident and medical treatment; however, he was not successful, was eventually restricted from

working by Dr. Richards, and has not worked since. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Richards.

27. Doctors Souviron, Mohan, and Richards have all opined that claimant is unable to work and is permanently and totally disabled because of his work-related injuries. This finding is based on all the evidence on the record, including but not limited to the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

28. Claimant has sustained complete loss of earning capacity as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; and his inability to return to work. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

29. Claimant is permanently and totally disabled as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; his traumatic brain injury and resulting cognitive difficulties and physical brain damage; and his inability to return to work and complete loss of earning capacity. This finding is based on defendants' admission and all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records of Dr. Souviron, Dr. Mohan, and Dr. Richards.

30. It is in claimant's best interest that a portion of his award be paid in a commuted lump-sum payment so that he can pay his attorney fees and costs related to this claim. This finding is based on all the evidence on the record.

31. Because of his receipt of Social Security disability benefits, it is in claimant's best interest that his award of permanent total disability compensation, which is compensation for disability which will affect him for the rest of his life, be allocated into a theoretical stream of periodic payments extending over his expected lifetime so as to minimize, to the extent allowed by law, any potential offset or reduction he may experience in Social Security disability benefits or other disability benefits. This finding is based on all the evidence on the record, including but not limited to claimant's testimony; the testimony of Ms. Jones; and the medical records.

RULINGS OF LAW

1. Under S.C. Code Ann. §§ 42-1-130 to -150, the South Carolina Workers' Compensation Commission has jurisdiction over claimant's claim for benefits.

2. Under S.C. Code Ann. § 42-1-40 and S.C. Code Reg. 67-1603, claimant's average weekly wage is \$675.89, for a corresponding compensation rate of \$450.62.

3. Under S.C. Code Ann. § 42-1-160, claimant sustained compensable injury by accident on June 3, 1997 as a result of his work activities with employer-defendant causing injury to his skin, brain, eyes, arms, hands, fingers, torso, legs, feet, toes, lungs, respiratory system, penis, urological system, and psyche. Claimant has also sustained compensable traumatic brain injury as a result of his injury by accident, with related cognitive difficulties and physical brain damage.

4. Claimant's transient ischemic attacks, or TIAs, did not rise to the level of an independent intervening cause, sufficient to break the chain of causation between claimant's injury by accident and his related physical, mental, and psychological injuries. See Whitfield v. Daniel Constr. Co., 226 S.C. 37, 83 S.E.2d 460 (1954).

5. Claimant has reached maximum medical improvement from his injuries, but is in need of continuing medical and psychological treatment in order to maintain his current level of functioning and prevent further deterioration of his condition. See Dodge v. Brucoli, Clark, Layman, Inc., 334 S.C. 574, 514 S.E.2d 593 (Ct.App.1999)(maximum medical improvement is plateau at which no further medical care or treatment will lessen the degree of impairment; injured worker is entitled to additional medical treatment to maintain current level of functioning and prevent a worsening of condition despite a finding of maximum medical improvement).

6. Claimant has sustained complete loss of earning capacity as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; and his inability to return to work. Colvin v. E.I. DuPont de Nemours Co., 227 S.C. 465, 88 S.E.2d 581 (1955).

7. Under S.C. Code Ann. § 42-9-10, claimant is permanently and totally disabled as a result of his injury by accident; the combination of his related physical and psychological injuries, restrictions, and limitations; his traumatic brain injury and resulting cognitive difficulties and physical brain damage; and his inability to return to work and complete loss of earning capacity. See also Wynn v. People's Natural Gas Co., 238 S.C. 1, 118 S.E.2d 812 (1961)("inability to perform common labor is total disability for one who is not qualified by training or experience for any other employment"); Brown v. Owen Steel Co., 316 S.C. 278, 450 S.E.2d 57 (Ct.App.1994)(when injuries are not confined to a single body part, a claimant is not limited to the scheduled loss statute and is entitled to determination of disability based on loss of earning capacity).

8. Claimant has sustained physical brain damage within the meaning of S.C. Code Ann. § 42-9-10.

9. Under S.C. Code Ann. § 42-9-10, claimant is entitled to weekly compensation benefits for the remainder of his lifetime, but for no less than 500 weeks, as a result of his permanent total disability and his physical brain damage. See also Pearson v. JPS Conv. & Indus. Corp., 327 S.C. 393, 489 S.E.2d 219 (Ct.App.1997)(the Act merely requires that a claimant be totally and permanently disabled and suffer from physical brain damage or quadriplegia/paraplegia to be entitled to lifetime compensation benefits).

10. Under S.C. Code Ann. § 42-15-60, claimant is entitled to and defendants are responsible for all causally related medical treatment and expenses from June 3, 1997 to the present and continuing for claimant's lifetime, including such medical care, treatment, and medications as are needed to maintain his current level of functioning and prevent further deterioration of his condition. Defendants are not responsible for any evaluation or treatment provided to date by Dr. Moss. See also Dodge v. Bruccoli, Clark, Layman, Inc., 334 S.C. 574, 514 S.E.2d 593 (Ct.App.1999).

11. Pursuant to the Supreme Court's holding in Glover v. Suitt Constr. Co., 318 S.C. 465, 458 S.E.2d 535 (1995), defendants shall pay directly to claimant's attorney a lump-sum payment of claimant's award sufficient to satisfy his obligation for attorney fees and costs related to this claim.

12. This award, which is compensation for permanent impairment that will affect claimant for life, is estimated and allocated into a theoretical stream of periodic payments, as follows: \$101,445.24 for attorney's fees and costs in prosecuting this action and \$187,384.76 for future disability benefits at the rate of \$890.27 per month for 210.48 months (claimant was born on ~~July 10, 1949~~ and has a life expectancy of 17.84 years, or 210.48 months, according to the mortality tables in S.C. Code Ann. § 19-1-150)(the commuted value of claimant's lifetime compensation benefits is \$288,830.00)(\$187,384.76 divided by 210.48 months equals \$890.27 per month). See Utica-Mohawk

Mills v. Orr, 227 S.C. 226, 87 S.E.2d 589 (1955); S.C. Code Ann. §§ 42-9-10, 42-9-240 (2005). See also Sciarotta v. Bowen, 837 F.2d 135 (3d Cir. 1988), on remand Sciarotta v. Secretary of H.H.S., 735 F.Supp. 148 (D.N.J. 1989); POMS 11501.235(c).

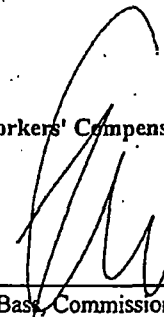
ORDER

It is ordered that defendants shall provide the following:

1. All causally related medical treatment and expenses from June 3, 1997 to the present and continuing for claimant's lifetime, including such medical care, treatment, and medications as are needed to maintain his current level of functioning and prevent further deterioration of his condition. Defendants are not responsible for any evaluation or treatment provided to date by Dr. Moss.

2. Permanent total disability compensation in the amount of \$450.62 per week for the remainder of claimant's lifetime, but for no less than 500 weeks. Defendants shall pay directly to claimant's attorney a lump-sum payment of claimant's award sufficient to satisfy his obligation for attorney fees and costs related to this claim.

S.C. Workers' Compensation Commission


J. Alan Bass, Commissioner

Date: _____

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United States mail addressed to the attorney or attorneys for said parties.

This 27th day of June, 2008.
By Meredith M. McNeil
Administrative Assistant to the Commissioner

23 KW
VFD

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street

Columbia, South Carolina 29202-1715

 CC File # 9708801
 Carrier File # 570-171941
 Carrier Code # 0093
 Employer FEIN _____

 Archie E. Jones
 Claimant's Name _____ SSN _____
 1229 Salem Church Rd., Anderson, SC 29625
 Address _____ City _____ State _____ Zip _____
 (864) 224-2669 (864) 236-2014
 Home Phone # _____ Work Phone # _____

 3M
 Employer's Name _____
 1400 Perimeter Rd., Greenville, SC 29605
 Address _____ City _____ State _____ Zip _____
 Liberty Mutual
 Insurance Carrier
 ()

Preparer's Name _____

Phone # _____

Complete each information blank. To request a hearing, check box 13 b., indicate the kinds of benefits claimed by checking the box(es) at lines 6, 7, 8, and 9, and file this form in duplicate.

A claim for worker's compensation benefits is made based on the following grounds:

- 1 a. The claimant sustained an accidental injury to Entire body (contd. back) on 06/03/97 in Greenville County, State of South Carolina month day year
part of body hurt
- 1 b. Describe briefly how the accident occurred: Burned by 600 degree oil when valve blew out. Oil spray blocked exit door. Vapors filled room.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.
3. The relationship of employer and employee existed at the time of injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on June 3, 1997 in the following manner:
Accident was witnessed; emergency squad called. month day year
- ☒ 6. Due to injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for _____
☒ (b) additional medical examination and treatment for body, feet, skin, lungs, brain (contd. on back)
- ☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: Benefits have been paid.
- ☒ 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
☐ (1) General Disability: ☐ Total ☐ (2) Specific Disability: ☐ Total
☐ Partial ☐ Partial
 Body part(s) affected are: Entire body, feet, skin, lungs, brain, mental, urinary, bronchial (Premature)
- ☒ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of 75% of body is covered with burn scars, graftings, and donor sites for grafts; lost little toe rt. foot; (contd. back)
- 10 a. At the time of injury, the claimant was paid weekly wages of \$756.80 + overtime; and demands accounting of days worked and wages earned as provided by law.
- 10 b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident.
This employer only.
- 11 a. Further grounds of claim: All claims and benefits under the Act.
- 11 b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident: See back.
- 11 c. To the best of your knowledge, did you have any prior permanent disability? No. Division of Claims
 If yes, describe: _____ Claims Administrator
 _____ Workers' Comp. Council
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.
- ☒ 13 a. I am filing a claim. I am not requesting a hearing at this time.
- ☐ 13 b. I am requesting a hearing.

 39-CST-13
Archie E. Jones Jr.
 Signature of Claimant/Representative

RECEIVED

JUN 01 1999

COLUMBIA, SC

Date

5-12-99

Refer to R.67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.

WCC Form # 50. Rev. Date 9/90

50 Employee's Notice of Claim and/or Request for Hearing.

South Carolina Workers' Compensation Commission
P.O. Box 1715 ♦ 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9708801
Carrier File #
Carrier Code #
Employer FEIN

A. Eddie Jones		3M Corporation	
Claimant's Name	SSN	Employer's Name	
1229 Salem Church Road	Anderson, SC 29625	1400 Perimeter Road	Greenville, SC 29605
Address	City State Zip	Address	City State Zip
(864) 224-2669		Old Republic Insurance Co.	
Home Phone #	Work Phone #	Insurance Carrier	
Kathryn Williams	(864) 235-6254		

Preparer's Name

Phone #

Complete each information blank. To request a hearing, check box 13b, indicate the kinds of benefits claimed by checking the box(es) at lines 6, 7, 8, and 9, and file this form in duplicate. A claim for worker's compensation benefits is made based on the following grounds:

- 1a. That Claimant sustained an accidental injury to severe burns over entire body, arms, legs, feet, toes, urinary tract system, lungs, brain injury, whole person and psychiatric on 6/3/97 in Greenville County, State of South Carolina.
- 1b. Describe briefly how the accident occurred Claimant sustained severe burns at work.
2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of the injury.
3. The relationship of employer and employee existed at the time of the injury.
4. At the time of the injury the claimant was performing services arising out of and in the course of employment.
5. Notice of the accidental injury was given to the employer on 6/3/97 in the following manner: Claimant notified his supervisor.
- [X] 6. Due to the injury, the claimant is in need of (check one):
☐ (a) medical examination and treatment for
[X] (b) additional medical examination and treatment for severe burns over entire body, arms, legs, feet, toes, urinary tract system, lungs, brain injury, whole person and psychiatric
- [X] 7. Due to the injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of: Claimant is receiving benefits
- [X] 8. Due to the injury, the claimant has permanent disability of the following nature and extent: (check one)
[X] (1) General Disability [X] Total [X] (2) Specific Disability [X] Total
☐ Partial ☐ Partial
Body part(s) affected are: severe burns over entire body, arms, legs, feet, toes, urinary tract system, lungs, brain injury, whole person and psychiatric
- ☐ 9. Due to the injury, the claimant has a serious bodily disfigurement consisting of whole person.
- 10a. At the time of injury the claimant was paid weekly wages of \$to be supplied; and demands accounting of days worked and wages earned as provided by law.
- 10b. Give names and addresses of all employers for whom the claimant has worked since the date of the accident.
- 11a. Further grounds of claim: See # 12. Claimant makes claim to any and all rights he is entitled to under the Workers' Compensation laws of South Carolina. Claimant requests payment of any award in lump sum with lifetime allocation.
- 11b. List names and addresses of all physicians or other medical specialists who have seen or treated the claimant as a result of the accident. SEE ATTACHED.
- 11c. To the best of your knowledge, did you have any prior permanent disability? Unknown
If yes, describe:
12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers Compensation Commission may direct as just and proper.
- ☐ 13a. I am filing a claim. I am not requesting a hearing at this time.
- [X] 13b. I am requesting a hearing.

Signature of Claimant/Representative

RECEIVED

JUL 17 2007

SEDGWICK CMS
COLUMBIA, SC

Date

7/2/07

Refer to R.67-205, R.67-206, R.67-207, and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department.
WCC FORM #50 Rev.Date 9/90

Employee's Notice of Claim and/or Request for Hearing.

EAP through 3-M

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, SC 29615

Greenville Memorial Hospital
701 Grove Road
Greenville, SC 29605

Medical University of South Carolina
171 Ashley Ave.
Charleston, SC 29425

Anderson Area Medical Center
800 North Fant Street
Anderson, SC 29621

Gowdhami Mohan, M.D.
2000 E. Greenville St.
Anderson, SC 29621

Terry K. Holdredge, M.D.
3031 N. Highway 81
Anderson, SC 29621

William C. Hinnant, Jr., M.D.
112 Essex Drive
Anderson, SC 29621

Dennis W. Whatley, M.D.
2000 E. Greenville St.
Anderson, SC 29621

Ronald E. Tysl, DDS
121 River Street
Belton, SC 29627

Upstate Plastic Surgery
301 The Parkway
Greer, SC 29650

Plastic Surgery Associates of Greenville
24 Memorial Medical Drive
Greenville, SC 29605

Tim R. Brown, M.D.
1011 Frontage Road
Greenville, SC 29615

Dr. W. Clark Jernigan
Piedmont Orthopaedic Associates, PA
35 International Drive
Greenville, SC 29615-4816

Renee H. Altman, DPM
408 Marshall Ave.
Anderson, SC 29621

Michael Hellstrom, M.D.
1655 E. Greenville Street
Anderson, SC 29621

RECEIVED

JUL 17 2007

SEDGWICK CMS
COLUMBIA, SC

South Carolina Workers' Compensation Commission

P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9708801

Carrier File #

Carrier Code #

Employer FEIN

Eddie Jones

Claimant's Name

SSN

1229 Salem Church Rd., Anderson, SC 29625

Address

City

State

Zip

()

Home Phone

Work Phone

3M Company

Employer's Name

1400 Perimeter Rd., Greenville, SC 29605

Address

City

State

Zip

Sedgwick Claims Management Services

Insurance Carrier

William E. Shaughnessy

Preparer's Name

864/552-4602

Phone #

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part.**The employer-insurance carrier in answer to the claim, respectfully shows:**

1. It is admitted that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: Admit burn injury; admit injury to lung; admit transient psychiatric sequelae of injury; deny brain injury
2. It is admitted that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: _____
3. It is admitted that the relationship of employer and employee existed at the time in question. The reasons for denial are: _____
4. It is admitted that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: _____
5. It is admitted that notice of injury was given the employer. The reasons for denial are: _____
6. It is admitted that the employee (needs) (is entitled to additional) medical care as a result of injury. The reasons for denial are: Defendants admit that claimant has suffered total and permanent disability and, pursuant to the SC Workers' Compensation Act, is entitled to medical care for conditions attributable to work injury.
7. It is denied that the employee is entitled to temporary total disability for the period(s) of: _____
Deny that claimant is entitled to additional payments of disability compensation (has received 500 weeks)
8. It is admitted that the employee is permanently disabled. The reasons for denial are: _____
Defendants admit that claimant has suffered total and permanent disability as a result of injury to multiple body parts. It is unknown, in reviewing claimant's Form 50, if claimant is asserting that he is entitled to lifetime compensation benefits and, if so, the defendants deny that claimant is entitled to lifetime compensation benefits.
9. It is admitted that the employee has a serious disfigurement.
10. It is contended that an average weekly wage of \$ previously established applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: _____

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Ms. Kathryn Williams,

Name

Attorney at Law, P. O. Box 10693, Greenville, SC 29603; and Virginia Crocker, SCWCC, P. O. Box 1715, Columbia, SC 29202-1715

Address

on the 26th day of July, 2007 by ☒ first class mail; ☐ personal service; ☐ certified mail.

Preparer's Signature

Title

Attorney

July 26, 2007

Date

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

WCC FORM # 51 REV. DATE 9/90
GRN 15350v3

Employer's Answer to Request for Hearing

South Carolina Workers' Compensation Commission
P.O. Box 1715 + 1612 Marion Street.
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9708801
Carrier File#
Carrier Code#
Employer FEIN

A. Eddy Jones		3-M
Claimant's Name	SSN	Employer's Name
1229 Salem Church Road,	Anderson, SC 29625	Donaldson Center,
Address	City State Zip	Address
		Sedgwick CMS/Old Republic Ins. Co.
Home Phone #	Work Phone #	Insurance Carrier
Kathryn Williams P.O. Box 10693, Greenville, SC 29603 (864) 235-6254		

Preparer's Name	Address	Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

☒ Injury by Accident ☐ Occupational Disease ☐ Both Injury by Accident and Disease ☐ Other

1. Date of accident: 6/3/97
2. AWW: \$675.89 Comp. Rate: \$450.62
3. Type of injury and body part(s): Claimant sustained severe burns at work severe burns over entire body, arms, legs, feet, toes, urinary tract system, lungs, brain injury, whole person, psychiatric.
4. Facts in controversy: a) lifetime benefits; b) continued medical treatment; c) reimbursement for out of pocket expenses with Dr. Souviron; d) lump sum and lifetime allocation of benefits.
5. Legal issues involved: a) 42-1-120 and 42-9-10 (compensation for temporary total disability and general disability); b) 42-15-60 (payment of medical treatment); c) See No. 4.
6. Unusual problems:
7. Witnesses (designate if expert)*: A. Eddy Jones, Derrell Jones
8. Exhibits: Personnel and employment records.
9. Medical evidence: (indicate report pursuant to R.67-612; deposition or appearance) Under the Administrative Procedures Act, the following medical evidence was submitted: Greenville EMS, Greenville Hospital System, MUSC, June Souviron, M.D.; Anderson Area Medical Center; William W. Walker, M.D.; C. William Hinnant, Jr., M.D.; Robert W. Richards, M.D.; L. James Cochrane, M.D.; W. Clark Jernigan, M.D.; Healthsouth Surgery Center; Gowdhami Mohan, M.D.; Timothy R. Brown, M.D.; John D. Ware, M.D.; J. Barry Bishop, M.D.; Tracy S. Harvey, M.D.; Ronald E. Tysl, M.D.; Scott W. Beman, M.D.; David Wortham, M.D.; Anderson Radiology; Boris A. Ilg, M.D.; Douglas A. Reeves, M.D.; Kirk Hensarling, M.D.; James E. Lovett, M.D.; John R. Hunt, M.D.; Samuel W. Capra, Jr., M.D.; Robert A. Moss, Ph.D.; J. David Rice, M.D.
10. Name, address, and specialty, if any, of the treating physician: Dr. Richards, psychiatrist, Greenville, South Carolina; Dr. Souviron, general practitioner, Anderson, South Carolina; Dr. Mohan, pulmonologist, Anderson, South Carolina
11. Impairment rating(s); body part(s); physician and date of opinion: Dr. Richards, Claimant is totally and permanently disabled as a result of the physical, psychological and physical brain injury suffered in his work injury, 10/30/07; Dr. Souviron, Claimant is totally and permanently disabled as a result of his work injuries, 10/4/07; Dr. Moss, Claimant's work injury resulted in a brain injury, 6/29/07.

SIGNATURE [Signature]
DATE OF HEARING: November 20, 2007
On behalf of ☒ Claimant ☐ Employer

TIME OF HEARING: 8:30 a.m.

File this form and proof of service on the opposing party according to
*Commissioners reserve the right to admit expert witnesses at hearings.

and R.67-212. Do not send medical reports.

PRE-HEARING BRIEF

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9708801
Carrier File # WC555248098
Carrier Code #
Employer FEIN

A. Eddie Jones (Archie) ~~250-703-3321~~
Claimant's Name SSN
1229 Salem Church Road Anderson SC 29625
Address City State Zip
864.224.2669
Home Phone Work Phone

3 M Corporation
Employer's Name
1400 Perimeter Road Greenville SC 29605
Address City State Zip
Sedgwick CMS
Insurance Carrier

Vernon F. Dunbar P. O. Box 1509 Greenville, SC 29602 864-552-4601
Preparer's Name Address Phone #

Provide the information requested in the space provided. Use an additional sheet, if necessary. Type or print all information.

- Injury by Accident Occupational Disease Both Injury by Accident and Disease Other
- No1. Date of accident 06/03/1997 2. AWW: \$ MAX Comp. Rate: \$ 450.62
3. Type of injury and body part(s) brain and penis
4. Facts in controversy: Whether claimant suffered an compensable physical head/brain injury. Whether claimant's erectile dysfunction compensable. Payment of various medical bills.
5. Legal issues involved:
6. Unusual problems: Hold the record open for the reports of Dr. Maria Recio and Dr. David Price Ph.D.
7. Witnesses (designate if expert)* Claimant, Claimant's supervisor, and Jo Ann Knobel. Defendants reserve the right to call additional witnesses at the hearing.
8. Exhibits:
9. Medical evidence: (Indicate report pursuant to R.67-612; deposition or appearance) Please refer to APA
10. Name, address, and specialty, if any, of the treating physician: Dr. Robert Richards, Greenville SC
11. Impairment rating(s); body part(s); physician and date of opinion:
- SIGNATURE Vernon F. Dunbar Date: 11/09/2007
- DATE OF HEARING: 11/20/2007 TIME OF HEARING: 8:30
- On behalf of Claimant • Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

ORDER
of the
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
File No.: 9708801

Archie E. Jones, Jr.,

Employee/Claimant,

vs.

3M Corp.,

Employer, and

Old Republic Insurance Co.,

Carrier/Defendants.

Hearing: Held in Greenville, South Carolina on November 20, 2007

Appearances: Kathryn Williams, Esq. of Kathryn Williams, P.A. for claimant
Vernon F. Dunbar, Esq. of Turner, Padgett, Graham & Laney,
P.A. for defendants

Purpose: To determine issues as set forth on the Forms 50 and 51

Decision & Order: J. Alan Bass, Commissioner

Filed:

June 27, 2008

 **E-MAILED**

JUN 30 2008

2431 397

Appeal due 7/11/08

South Carolina Workers' Compensation Commission
1612 Marion St.
P.O. BOX 1715
Columbia, SC 29202-1715
803) 737-5723



WCC File #: 9708801

Carrier File #: WC555248098

Carrier Code #:

Employer FEIN #:

Claimant's Name: Ardie E. Jones, Jr. SSN: 250-205-588 Employer's Name: 3 M Corporation
Address: 1229 Salem Church Road Address: 1400 Perimeter Road
City: Anderson State: SC Zip: 29625 City: Greenville State: SC Zip: 29605
Home Phone: 864-224-2669 Work Phone: Insurance Carrier: Sedgwick Claims Management Services
Preparer's Name: Vernon F. Dunbar, Esq. Law Firm: Turner Padgett Graham & Laney P.A. Preparer's Phone #: (864) 552-4601

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ claimant ☒ employer (check one) Date of injury: 06/03/1997
The undersigned makes application for review of the findings of the Commissioner in the above-captioned case. The request for review is based on the following grounds: (State the grounds of your appeal in the form of questions presented. Each question presented must contain a concise statement of one proposition of law or fact. Refer to evidence by title and exhibit number. Use additional pages if necessary).

1. The Hearing Commissioner erred as a matter of law and abused his discretion in denying the defendant's motion to engage in additional discovery and to obtain a neuropsychological assessment and/or to depose Dr. Moss.
2. The Hearing Commissioner erred as a matter of law and abused his discretion in denying the defendant's request to leave the record open to obtain additional discovery in view of the fact that the employee/claimant would not have been prejudiced by the request to engage in additional discovery.
3. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant sustained a physical traumatic brain injury, the error being that the greater weight of the evidence does not support a finding of a traumatic brain injury.
4. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant has pulmonary respiratory difficulties resulting from the admitted accident, the error being that the greater weight of the evidence does not support such a finding.

Check one) Oral argument ☒ is ☐ is not requested. Appellant's request for oral argument is waived if not indicated on this form.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Kathryn Williams, Esquire

Name

Attorney for Claimant, Post Office Box 10693, Greenville, SC 29603

Address

SCWCC

on this the 11th day of July, 2008 by ☒ first class mail ☐ personal service ☐ certified mail.

JUL 14 2008

Preparer's Signature

Attorney
Title

July 14 2008
Date JUDICIAL

Check this box if you are not represented by an attorney. ☐

If the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

WCC Form # 30
Rev. 3/97

REQUEST FOR COMMISSION REVIEW

5. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant suffers from psychological distress, namely bipolar disorder, and is in need of lifetime medical treatment, the error being that the greater weight of the evidence does not support such a finding.

6. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant is in need of medical evaluation and treatment for a prostatitis syndrome and erectile dysfunction, the error being that such maladies are unrelated to the claimant's admitted work related accident.

7. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant immediately developed cognitive difficulties and had trouble with his memory, reading and verbal comprehension as a consequence of the accident, the error being that such a finding is contrary to the evidence when in fact the claimant had returned to work for a substantial period of time.

8. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that Dr. Moss correctly diagnosed a brain injury, the error being that Dr. Robert Moss is a neuropsychologist and cannot medically diagnose the occurrence of a brain injury.

9. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant suffered a traumatic brain injury; and he abused his discretion in relying upon the report of Dr. Robert Moss, the error being that Dr. Moss is not qualified to diagnose a physical brain injury.

10. The Hearing Commissioner erred in finding as a fact and concluding as a matter of law that the claimant is entitled to a partial lump sum payment and the inclusion of Utica Mohawk language.

11. The Hearing Commissioner erred as a matter of law in ordering the defendants to pay directly to claimant's attorney a lump sum payment of the claimant's award, the error being that only the claimant is qualified to consent to attorney's fees and not the defendants.

12. The defendants reserve the right to add additional errors.

the claimant appeals and is representing himself or herself, the Judicial Department will prepare the additional copies of this form and serve this form on the opposing party. R.67-701B. Otherwise, file the original and four copies of this form with the Judicial Department. The appeal must be postmarked no later than 14 days from the date of service of the Hearing Commissioner's decision. R.67-701 and R.67-205. Attach the filing fee to this form. Attach a Form 32 if you are unable to pay the filing fee. Refer to R.67-701 through R.67-711 for additional information.

JCC Form # 30
rev. 3/97

REQUEST FOR COMMISSION REVIEW

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF GREENVILLE

Archie Eddie Jones)
Plaintiff,)

versus)

3M Corporation, et al.,)
Defendants.)

09-CP-23-2535

TRANSCRIPT OF RECORD

April 13, 2011
Greenville, South Carolina

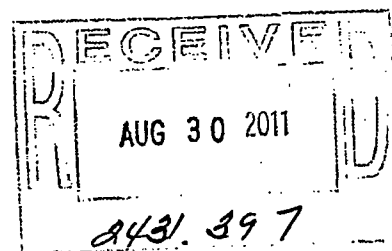
B E F O R E:

The Honorable D. Garrison Hill

A P P E A R A N C E S:

Kathryn Williams, Esquire
Attorney for the Plaintiff

Vernon F. Dunbar, Esquire
Attorney for Defendant



HOLLIE M. JENKINS
COURT REPORTER

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Worker's Compensation Appeal	3

INDEX TO EXHIBITS

<u>NO.</u>	<u>DESCRIPTION</u>	<u>ID.</u>	<u>EV.</u>

(No exhibits were entered into evidence during this hearing)

Archie Eddie Jones v. 3M Corporation, et al.

1 The Court: This is an appeal from the Workers' Compensation
2 Commission, 2009-CP-23-2535, Jones v. 3M Corporation.

3 Mr. Dunbar: Good morning, Your Honor.

4 The Court: How are you doing, Mr. Dunbar?

5 Mr. Dunbar: I'm doing quite well, sir.

6 The Court: Good to see you. I saw Ms. Williams, Monday, I
7 believe it was.

8 Ms. Williams: You did. We have to quit meeting like this.

9 Did you get -- There were some -- There was a brief filed
10 before the record was filed, and then after Vernon filed the
11 record, we just changed it to add, you know, the correct
12 citations to the record. But I don't know if you've gotten any
13 briefs from us or not.

14 The Court: I do. I have a -- I've got---

15 Ms. Williams: I'm not going to load you down with paper,
16 you know, the arguments are the -- I mean, I didn't change the
17 substance of the brief when we changed it.

18 The Court: Yeah, okay. No problem.

19 Ms. Williams: It was just the page numbers.

20 The Court: Is it your appeal or...

21 Mr. Dunbar: It's my appeal, Your Honor.

22 Ms. Williams: Yes, sir.

23 The Court: Okay. Go ahead, sir.

24 Mr. Dunbar: Thank you very much, Your Honor. I represent
25 3M in this particular Workers' Compensation appeal. The

Archie Eddie Jones v. 3M Corporation, et al.

1 Claimant's name is Archie Eddie Jones. Mr. Jones had worked for
2 3M since 1983, and on June 3rd, 1997, he was involved in a
3 chemical burn in which he suffered burns over 40 percent of his
4 body, chemical burns. As a consequence, he was first taken to
5 Greenville Hospital System, and then he was later transported to
6 the Medical University of South Carolina to their Burn Center,
7 when they had one in operation during that point in time. He was
8 hospitalized for about three months, later released. He
9 attempted to go back to work, and he worked for about eight
10 months. After that he decided that he could not work and he
11 would deemed permanently and totally disabled. So my client paid
12 the 500 weeks of Workers' Compensation benefits based upon the
13 burns that he had suffered, third degree burns to 40 percent of
14 his body. They affected his feet, pulmonary system because of the
15 burns, the trunk, the legs.

16 After that, in July 2007, Mr. Eddie files -- I'm sorry, Mr.
17 Jones files a Form 50 alleging erectile dysfunction, prostatitis
18 as well as a brain injury and bipolar disorder. My clients
19 denied the compensability of the prostate problems, the erectile
20 dysfunction and also a physical brain injury. We took the
21 position that 500 weeks had been paid and there were no other
22 benefits to be paid to Mr. Jones.

23 He alleges that as a consequence of his work-related
24 accident some ten years before that he had suffered a physical
25 brain injury. And a brain injury entitles one to lifetime

1 compensation benefits because it is deemed a catastrophic injury.
2 It's along with paraplegia and quadriplegia. It's severe brain
3 injury. So in this day and age, when we look at Gabby Giffords
4 and football players, we know what a brain injury is.

5 Well, in this particular case, after he was released from
6 the hospital at MUSC he was complaining of not having quite the
7 mental alertness that he had had prior to the burn. He also
8 complained of fatigue. As a consequence, an MRI was performed on
9 the brain. ~~It came back normal.~~ The doctors, in essence, said,
10 well, your mental alertness may be due to sleep apnea and the
11 medications that you are taking -- Neurontin, and, I believe,
12 Advil -- not Advil but Adavil (phonetic) and other prescription
13 medications that may have had a side effect on his mental
14 alertness.

15 Well, as we go forward, in 2007, he files a Form 50. And if
16 you look at that Form 50, particularly 11(b) notes that when you
17 file a 50 you're supposed to list all the medical priors.
18 Because this is a lifetime case, my clients had access to all the
19 reports of all the treating physicians. However, there is one
20 report that we did not have access to and we did not -- we
21 weren't even aware of its existence until the Form 50 had been
22 filed -- well, actually right before the hearing when the
23 pretrial brief is served 15 days before the hearing, and that's
24 of Dr. Robert Moss.

25 Dr. Moss had performed a neuropsychological evaluation. He

Archie Eddie Jones v. 3M Corporation, et al.

1 performed that neuropsychological evaluation in June -- well,
2 even before June. His report is dated June 2007. Yet, when you
3 look at the Form 50, that was not disclosed. So my clients are
4 looking at this thinking maybe perhaps the only issue that we're
5 going to go forward on is not a permanent physical brain injury,
6 because he's had not only one MRI in 1999 but he suffered
7 intervening strokes which are not related to the accident at all.
8 I think there is no dispute about that. But he suffers three
9 intervening strokes: the first one in 2001; another one in 2005
10 -- or maybe 2000, 2001 and 2005. And after each of those strokes
11 he is administered neurological tests and he undergoes MRIs. The
12 MRIs show some changes, white matter in the brain consistent with
13 the aging process and poor circulation but nothing suggestive of
14 a traumatic brain -- physical brain injury resulting from either
15 a chemical burn or anything of that nature. So we do have those
16 reports.

17 The only evidence in the file of a physical brain injury
18 comes from a psychologist -- a neuropsychologist -- a
19 neuropsychologist who is not endowed and not empowered and not
20 authorized to read any x-rays, CT scans or MRIs. And I looked at
21 the section that governs psychologists, which is 40 -- if memory
22 serves me correct, section 40-45-20 and 50. So he doesn't have a
23 medical license to do any of those things; yet he opines that
24 some ten years after this work-related accident that he has a
25 physical brain injury.

Archie Eddie Jones v. 3M Corporation, et al.

1 Well, at the hearing -- Commissioner Bass was the
2 commissioner who was in charge of this case -- I asked that the
3 record remain open because at the point in time I had scheduled a
4 neurologist to take a look at it, to do more studies, if
5 necessary, to determine whether he has a physical brain injury
6 first and foremost, secondly, whether they could ascertain by
7 comparing all of the MRIs and the CT scans and other diagnostic
8 tests whether it was as a result of the '97 incident, the 2001
9 stroke, the 2005 stroke or any other stroke.

10 That appointment was scheduled. Ms. Williams objected to it
11 because she said the report wouldn't come in time before we had
12 the scheduled hearing, which was scheduled for November 20th, I
13 believe, Dr. Rico (phonetic), her evaluation with Mr. Jones was
14 sometime on November 15th, 2007.

15 I also wanted to have a neuropsychological evaluation only
16 dealing with the brain injury with a Dr. Price, and I believe
17 that was scheduled for November of 2007. I made a motion before
18 Commissioner Bass to leave the record open. He declined. He
19 denied it. And my basis for asking to leave the record open is
20 because based upon an admitted case and all the evidence that was
21 listed and everything up for the Form 50 there was absolutely no
22 evidence of a physical brain injury aside from Dr. Moss's report.
23 So in the interest of due process and protecting my client's
24 rights, I thought that I was entitled to have an evaluation. As
25 a matter of fact, Section 42-15-80 under the South Carolina

Archie Eddie Jones v. 3M Corporation, et al.

1 Workers' Compensation laws says as long as someone is claiming
2 compensation -- he's already a lifetime medical recipient, but
3 he's also claiming additional compensation -- my clients have the
4 right to a medical evaluation. Commissioner Bass ruled that
5 because we had known about an allegation of a brain injury as far
6 back as '99, when he said he was not mentally alert, we were on
7 notice for brain injury; therefore, he was denying my request for
8 a motion.

9 We took the position, well, when he made those complaints in
10 1999, an MRI was given and it came out normal. And because of
11 the other intervening strokes and all the other diagnostic tests
12 that really didn't show anything, we thought there was no basis
13 of a physical brain injury. After all, the burden of proof is on
14 the plaintiff. So once we get this I think we have every right
15 to investigate and to see and at least employ other persons to
16 take a look at it who are medically trained, and we were looking
17 at a neurologist primarily in this case. That was denied. And
18 that's the crux of my appeal, that my client was denied due
19 process pursuant to 42-15-80, also because there is a continuing
20 obligation to update, provide all the medical providers that have
21 treated the claimant. Again, if you look at page number 804,
22 11(b), it says "List all medical providers or specialists who
23 have seen him." If you look at the attached page, Dr. Robert
24 Moss's name is not there despite the fact that he had already
25 evaluated, examined the plaintiff and even issued or promulgated

1 a report, till we get to a hearing some four or five months
2 later. It's objected to. We can't go forward. It takes until
3 June 2008 before this order is even promulgated by Commissioner
4 Bass. So certainly by then we would have our reports, probably
5 ever deposition known to man. We would have been in a better
6 position to either resolve it or accept it. But at this point in
7 time, we are here before this court seeking redress on that
8 issue.

9 The second issue that we argue about is that we were ordered
10 to pay for erectile dysfunction, prostatitis and the treating
11 neurologist, Dr. William Hennett (phonetic) indicated that when
12 this gentlemen was hospitalized in Charleston, he was on a
13 catheter for a long time. And as a result of being on the
14 catheter he experienced some urethral deterioration. So Dr.
15 Hennett says, periodically he will have to undergo some type of
16 treatment for that. We have never denied that. However, with
17 respect to erectile dysfunction, we deny that. As a matter of
18 fact, Dr. Hennett and other urologists do not make any connection
19 between the prostatitis and erectile dysfunction with respect to
20 the burn injury. However, the plaintiff does and the Commission
21 ordered that.

22 We also objected to the compensability of this case on the
23 basis of Dr. Moss's report being the primary basis for that. He
24 is s a neuropsychologist. Now, I admit that Dr. Robert Richards,
25 who is a psychiatrist, completed a medical questionnaire that

Archie Eddie Jones v. 3M Corporation, et al.

1 says that his brain injury is related. But Dr. Richards was
2 retained by my client for one purpose, that was to treat this
3 gentleman for his depression. During the course of treating him
4 for his depression, it was discovered that he has bipolar
5 disorder. We all understand that bipolar disorder is a chemical
6 imbalance of the brain. Yet we're treating him -- or we're
7 paying for those things as well.

8 So we think that Dr. Richards' opinion on brain injury is
9 probably best left to a neurologist or someone who can certainly
10 study the brain in terms of recent tests. Dr. Richards didn't
11 have any of those tests. Dr. Moss, the neuropsychologist, relied
12 -- looked at all the other MRIs, which I don't think he is
13 capable or authorized to do, and indicated that everything comes
14 from -- all the cognitive problems result from the 1997 incident.
15 That's ten years ago, and there are a lot of things that
16 transpired in between. And when you look at the last MRI,
17 there's really no evidence of any brain injury.

18 So we take the position that Dr. Moss' report should have
19 been excluded, shouldn't have been given any weight, and we think
20 that was an abuse of discretion as it was not to allow us to have
21 a neuropsychological exam or a neurological examination. So we
22 think it's an error of law as well as an abuse of discretion.

23 In terms of a physical brain injury, it was interesting, if
24 you look at the lay evidence, Mr. Jones testified that he takes
25 his medications, he drives, he drove to Minnesota, he and his

1 wife, to help a friend move. For someone with a brain injury, a
2 driver's license or driving license privileges hadn't been
3 revoked. He was working around his house. He helped his
4 granddaughter, tutored her, I believe, in science, physical
5 science.

6 So these things from a lay standpoint, just lay evidence,
7 refute a physical brain injury case, particularly as we think
8 about brain injury cases in the context of NFL players, Gabby
9 Giffords. We just don't see it in this particular case. So we
10 don't think that there is the substantial evidence that the
11 Commission had relied upon in order to find this case
12 compensable. We think that the -- It's just a mere scintilla at
13 best, and that's Dr. Moss's report and nothing else, because this
14 gentleman's behavior, his activities over the years, certainly
15 defy the notion of a physical brain injury in terms of a
16 catastrophic injury as we know it. I don't believe a guardian
17 has even been appointed for him in this case. I may be
18 incorrect, and I'm certain Kathryn will correct me if I'm wrong
19 on that. But this certainly is not the case, and we would ask
20 that this case first be remanded so that my clients could
21 certainly exercise its due process rights afforded under the
22 constitution, but more importantly under our statute, 42-15-80,
23 in terms of getting this medical evaluation and
24 neuropsychological evaluation that was not disclosed. And if
25 not, certainly we would ask for it to be reversed in that there

Archie Eddie Jones v. 3M Corporation, et al.

1 were legal errors committed, abuse of discretion, and that there
2 was not substantial evidence to support the Commissioner's award.
3 Thank you, sir.

4 **The Court:** Thank you very much, Mr. Dunbar.

5 **Ms. Williams:** May it please the court.

6 **The Court:** Yes, ma'am, Ms. Williams.

7 **Ms. Williams:** I've been in this business so long that it's
8 almost like I've come from another era, but I haven't been in it
9 so long that I don't get upset when cases are handled less than
10 forthrightly, and what the carrier's done in this -- and that
11 continues from the inception of this case, I believe, up through
12 this argument today. This is a carrier that almost got away with
13 it. If it's not fraud, it creeps up all over it.

14 The claimant in this case is 65 years old. He was a
15 longtime employee of 3M, as you've heard. He was burnt to a
16 crisp in a chemical fire. He got trapped in a room and the only
17 way to get -- his only hope of getting out of it was to run
18 through it, and so he did. He was burned -- and I'm talking
19 about from the top of his head to the bottoms of his feet, and
20 it's amazing that he survived it. He had internal burns. He had
21 thermal burns in his lungs and his throat. He survived it, but
22 from head to toe he is one big mass of scar tissue. It's
23 difficult to look at him.

24 The authorized treating physician in this case, a
25 psychiatrist named Robert Richards, who's been treating him from

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1 way back, diagnosed, back in 1999, a traumatic brain injury.
2 Okay? He made that diagnosis in 1999. They knew about it. This
3 fellow was not represented. But at that time Dr. Richards asked
4 the carrier to provide a neuropsychological evaluation. He talks
5 about how Dr. Moss is a neuropsychologist, isn't qualified to do
6 the things he did. But the facts are that psychiatrists rely on
7 these experts all the time for diagnosing brain injury. But the
8 carrier refused to send him to a neuropsychologist. As I said,
9 the Claimant was not represented at that time. And what the --
10 They knew about this diagnosis back in 1999 of a traumatic brain
11 injury. What they hoped is that this client would never find out
12 about it, that his 500 weeks would run, they'd pay him out, and
13 then they'd be off the hook for the weekly benefits.

14 I would note that the defendants in this case retained
15 counsel in 2004. Okay? Three years before this fellow ever
16 comes to me to see a lawyer. They play possum. They don't
17 notify him that they are involved. Nobody knows that they are
18 involved. They all keep quiet too. And that's disturbing to me
19 too. I would think that, you know, there were two law firms.
20 McAngus, Goudelock and Courie had it first, and then it was
21 transferred to Turner Padgett. But there are a number of fine
22 lawyers at that law firm that let this adjuster get away with
23 misleading this guy as to what the law is in South Carolina.

24 He came to me in 2007 when his 500 weeks were about to run.
25 And as you know, if you are totally and permanently disabled, you

1 get 500 weeks. If you have a brain injury, though, that's caused
2 by the accident, then you're entitled to lifetime weekly
3 benefits. Okay? He comes to me and he says, you know, the
4 adjuster tells me that my 500 weeks are about to run out, and I
5 understand all that, and I don't have a problem with that. But I
6 want to be sure that they're going to be on the hook for my --
7 that they're going to continue to pay for the ongoing medical
8 treatment that I need as a result of this burn injury. Is there
9 anything I need to do to make that happen, to be sure that that
10 happens? And in the course of the interview -- He has difficulty
11 remember things, and it frustrates both of us. -- and finally he
12 blurts out, I'm sorry but I had oxygen deprivation when I
13 arrested on the way to the hospital and ever since then I haven't
14 been able to remember anything. And I'm -- so, you know, ding,
15 ding, ding. I get his medical records. Sure enough, I find that
16 way back then, you know, ten years ago, these doctors have
17 diagnosed a traumatic brain injury that these folks just ignore.
18 Okay? The doctor wants to send him for treatment for it; they
19 just flat ignore it, hoping that he'll never find out about it
20 and it will go away.

21 Now -- And so here they are today thinking that they deserve
22 to get an IME, and what happened with that is about -- Well,
23 after the APAs -- We had to submit our evidence 15 days in
24 advance. After we submitted our evidence then they decide to
25 schedule and IME when they have known about this brain injury for

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1 nine years and counsel has been involved for four years, and the
2 Commissioner just said, You weren't surprised by this. You knew
3 that they were alleging a brain injury. You knew that somebody
4 had diagnosed a brain injury. If you had wanted an IME, you've
5 had nine years to do it. You don't get to come here the day
6 before trial and ask for an IME with -- By the way, Dr. Price,
7 who is a neuropsychologist who's got the same deficiency that
8 they claim Dr. Moss has -- he's not a doctor -- and is, you know,
9 pardon me, but the mother of all streetwalkers when it comes to
10 neuropsychological evaluations. So, you know, if this isn't --
11 if it's not carrier fraud, it's about a half a step away.

12 But let's talk about the medical evidence that supports the
13 traumatic brain injury, and I'm going to hand up just a few
14 records because you've got a record on appeal that's that thick.
15 These are pulled from that, but I just want to keep you from
16 having to dig for it.

17 If you go in -- And he talks about how he wasn't having
18 these cognitive problems until after his release from MUSC, and
19 he talks about the lack of testing that -- or physical testing
20 that shows a brain injury. Not true. The first thing you see in
21 this chart -- this was when he was still in the hospital at MUSC
22 being treated for the burn injury -- on August the 2nd of 1997,
23 they do an EEG, an objective test, it is consistent with
24 encephalopathy. Encephalopathy is brain damages. Okay? I mean,
25 that's what that is. So we get that right in his first visit.

1 Then you go to the next thing that I've given you. It's
2 marked as page 1, just kind of for ease of reference. January
3 the 24th of 1999, and this is a report from Dr. Richards, who is
4 the authorized treating psychiatrist, a medical doctor. 11/24/99
5 diagnosed bipolar mixed due to TBI, traumatic brain injury.
6 Cognitive disorder NOS, not otherwise specified, due to traumatic
7 brain injury.

8 Look at the top. You'll see a file number. That's the
9 carrier's file number. You look at the bottom and you'll see,
10 "Received December 15th, 1999." So they received this in their
11 file back in 1999.

12 You look at page 2, that's July 27th, '99, even earlier. He
13 says, "Bipolar mixed due to TBI. Attention deficit disorder due
14 to TBI." That was received by the carrier September 17th of '99.

15 September 2nd of 1999, on page 3, "Bipolar mixed due to TBI."
16 That's received by the carrier in September.

17 A report on page 4, June 22nd, 1999, "Bipolar, depressed due
18 to traumatic brain injury." That's received by the carrier.

19 Then you see an evaluation that was done in '98 by a speech
20 pathologist, and he says on page 6 -- and this was received by
21 the carrier on August 11th of 1999 -- "Mr. Jones exhibits moderate
22 to severe short and immediate memory deficits. He is very
23 troubled by these deficits and feels they have significantly
24 impaired his ability to function independently." And he
25 diagnoses moderate to severe memory deficits.

1 Then you go back to page 7, that's Greenville Psychiatry in
2 2000. That's when you see Dr. -- the authorized treating
3 psychiatrist says, "I want him to have a neuropsych test." Okay?
4 He says that on page 7. And he never gets it. Okay? The
5 carrier denies it.

6 Then you go to 2001 and that is a typewritten report, you
7 know, assuming that they might say, "Oh, well, we couldn't read
8 -- these are handwritten notes. We can't read it. He does a
9 nice little typewritten report for them. This is dated September
10 10th, 2001. He says he doesn't have any significant past
11 psychiatric history until this accident happened. At page 9, he
12 says he's impressed by his long work history and his work ethic.
13 He attempted to return to work part-time, and in fact he did. He
14 tried to go back to work after this injury, but -- and he says he
15 decided he wasn't able to work. That wasn't it at all. He got
16 there and cognitively could not function at work, and so the
17 doctors took him back out.

18 Page 10. He diagnoses clear black and white, it's
19 typewritten, "Bipolar not otherwise specified due to traumatic
20 brain injury. Cognitive disorder not otherwise specified due to
21 traumatic brain injury. Status, post-severe burns with traumatic
22 brain injury." And then he says he is totally disabled at this
23 time. He is resistant to treatment probably due to the traumatic
24 brain injury.

25 And then at page 11, July 6th, 2007 -- and again, the

1 defendants had -- I mean, they were keeping up with these
2 records. They had this all along. I wasn't even involved in
3 this case. July 6th, he says, "My working diagnosis remains
4 bipolar not otherwise specified due to traumatic brain injury.

5 Then on page -- what's marked as page 12, back in October of
6 '07, he signs a statement to me that says he is permanently and
7 totally disabled due to his physical brain injury.

8 Then he provides a statement of disability at page 13. "He
9 has permanent cognitive impairment due to brain injury."

10 Now, then they want to say, well, in a few years after this
11 he had a stroke. Well, we don't know if that's what it was or
12 not. But he goes to the hospital. He has some sort of incident.
13 He goes to the hospital. They do an MRI and this is -- I'm
14 trying to find the date for you -- 2001. "No evidence of acute
15 infarct." Okay? So no evidence of a stroke on that MRI.

16 Then there is another incident after that in '04, and he
17 goes back to the hospital, and it says, "Normal CT to the head.
18 No lesion noted." Okay? So there was no evidence of acute
19 infarct then. So those strokes had absolutely nothing to do with
20 the problem he's having now. And in fact subsequently the
21 doctors even questioned whether he had had a stroke or not or
22 whether these sort of incidents that he had were the result of
23 anxiety and stress and the psychiatric problems that he's having
24 as a result of the injury. So it's not even clear that he had a
25 stroke.

1 I sent him to Dr. Moss, who is a neuropsychologist, and I
2 did that when I got involved. And this was, you know -- that's
3 what Dr. Richards had wanted from the beginning. Dr. Moss tested
4 him, and he notes that Dr. Richards had made the diagnosis of TBI
5 back in 1999. He notes the chemical fire. He said, page 18 --
6 And he spent, by the way, the claimant went to Dr. Moss's office
7 at 7:25 in the morning and stayed with him until 3:05 in the
8 afternoon. He did a very extensive battery of neuropsychological
9 testing that is typically done in these brain injury cases to
10 determine if somebody has sustained cognitive deficits as the
11 result of a brain injury. He notes that he gave a valid effort
12 on the testing. And then he winds up at page 21 diagnosing
13 consistent with what the authorized treating doctor already had:
14 "Cognitive disorder due to brain injury, personality change due
15 to brain injury. And he says that he believes that it's the
16 result of the burn injury that he had in 1999 and that he rules
17 out the stroke having any -- those supposed strokes having
18 anything to do with this.

19 So the evidence is absolutely clear in this case and
20 overwhelming, and has been since 1999, that this guy had a
21 traumatic brain injury. For them to show up at a hearing ten
22 years later and say, "Gosh, we're surprised by that," and now at
23 the last minute we want an IME to get somebody to say something
24 different is just preposterous.

25 The Court: What's the standard of review on whether or not

1 to grant an IME? I mean, is that just discretionary?

2 Ms. Williams: Discretionary, just like it is with a trial
3 judge. It's discretionary with the Commissioner.

4 The Court: Okay.

5 Ms. Williams: You have to show abuse of that discretion.

6 With regard to the urinary and the penile problems, this
7 fellow, when he was in the hospital, they had a catheter tube in
8 him, and trying to get around his hospital room he was unstable.
9 The bottoms of his feet were severely burned. He was unstable on
10 his feet. Even today he has problems with that. He stepped on
11 the catheter tube and ripped it out. Okay? He did a whole lot
12 of damage to his penis and his urethra in that accident, and he's
13 been treated regularly by a urologist since that time, and that
14 treatment is clearly related to this injury, and the Commission
15 should be affirmed. In fact, he had -- to repair it, he was
16 uncircumcised before this happened. He circumcised him and used
17 that skin to go in and try to repair the damage. He's got a
18 world of problems as a result of that. And for them to say today
19 that that's not related to that incident is, again, just against
20 the weight of the evidence.

21 Now, the -- I didn't hear you. I had requested a partial
22 lump sum for my attorney fee. You don't object to that at this
23 point?

24 Mr. Dunbar: Well, I would rely on what's in my brief in
25 terms of I don't think Form 61 has ever been approved in that.

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1 Ms. Williams: Well, what the Commission ordered -- Form 61
2 has not been approved and I haven't -- The form 61 is the form
3 you file at the Commission that outlines what your fee is and
4 what your costs are, and they have to approve it before you can
5 charge it. But the Commission said, and it's order is, "We find
6 she is entitled to her fee. She's going to have to file a Form
7 61 and will have to prove exactly what that is." Okay. We're
8 going to still have to approve it, but she's entitled to it. And
9 the *Glover v. Suitt* case specifically addresses that.

10 I believe the order should be affirmed in its entirety.
11 Thank you.

12 The Court: Thank you, Ms. Williams.

13 Mr. Dunbar: Your Honor, if I may respond. You asked the
14 question what was the standard of review.

15 The Court: Right.

16 Mr. Dunbar: Commissioner Bass was basically corrected by
17 our Court of Appeals in the case of *Charter v. Trane Coil*
18 *Facility* as cited in our brief on page 9 -- that's 681 S.E.2d 36
19 (2009) -- for not permitting the record to remain open so a
20 defendant could take a deposition and arrange for an independent
21 medical evaluation in that particular case similar to the case of
22 mine.

23 Now, Ms. Williams indicated that we were -- we shouldn't
24 have been taken surprise. Well, let me just tell you why. Dr.
25 Richards says traumatic brain injury, but that's just based upon

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1 his conversation -- as with all psychiatrists, his consultation
2 with his client. There is no independent medical test or a
3 battery of tests to support a traumatic brain injury, from 1999
4 up until we see something from Dr. Moss.

5 The reason why I say that is because there are two doctors
6 -- On May 18th, 1999, Dr. Terrence Clark, a neurologist issued a
7 report, an MRI of the brain was done. Dr. Clark noted that the
8 MRI was within normal limits. Now, there was some scattered deep
9 matter signals, but in essence he said there's nothing there. So
10 even though Dr. Richards is saying traumatic brain injury, a
11 report after that from a neurologist that's unrefuted says there
12 is nothing there based upon an MRI.

13 Later Dr. John Pilch, P-i-l-c-h, just a couple months later
14 in 1999, a neurologist, said that there is nothing showing up on
15 the brain, and, in essence, said that the problem with
16 Respondent's, or Mr. Jones's fatigue and decreased alertness
17 resulted from sleep apnea because he's having trouble breathing,
18 and when you can't breathe you don't sleep, and when you don't
19 sleep you become lethargic and tired, and you're not as mentally
20 alert. And he also says, interesting, that the prescriptive
21 medications Neurontin and Aderdax (phonetic) were also the cause
22 of his decreased mental alertness.

23 So at this point in time my clients have a normal MRI and an
24 opinion from two neurologists basically stating, sleep apnea,
25 consumption of medications is why he is not alert but not from a

1 brain injury. Only Dr. Richards is saying that and he has
2 nothing to back it up. Also, Dr. Pilch noted that this
3 gentlemen, or Mr. Jones, was alert and appropriate in complex
4 conversations. He goes on, he's driving, he's doing plumbing
5 repairs, he's working on automobiles around his house after this
6 accident.

7 On June 1st he has -- I'm sorry -- June 9th he goes to
8 Anderson Area Medical Center for a stroke. According to my
9 review of the file, again, we have a neurologist who says he's
10 had a stroke. We also have a Dr. Bruce LaForest (phonetic) who
11 said that the burn injury did not result in increased factors for
12 a stroke and that there was no association between the stroke and
13 brain injury. So he clearly had a stroke in 2001.

14 2004, Dr. Frank Oliver, another neurologist, with Anderson
15 Neurological Associates treated him for a second stroke and
16 prescribed him Plavix and aspirin. So clearly he's having
17 strokes, because he's given medications to treat patients, or Mr.
18 Jones, for a stroke.

19 2005, he apparently has another incident where he undergoes
20 an MRI of the brain and is treated for vertigo and a stroke.
21 Again, we have at least four neurologists that haven't found
22 anything up until this point until Dr. Moss comes into play.

23 He was not burned to a crisp. If you saw him, you wouldn't
24 realize he was burned. This is not a burn of someone running
25 through fire. This was a chemical burn. Yes, he did sustain

1 horrific burns, but it was from his trunk down. Basically it's
2 the legs and trunk. In terms of disfigurement, I don't think
3 that's even in the record. But to the best of my recollection,
4 there is certainly no visible disfigurement. He was paid 500
5 weeks of benefits.

6 Now, I must address the aspect of fraud because my clients
7 did not defraud this gentleman in any way, shape or form. The
8 doctors all saw normal MRIs. Nothing suggested traumatic brain
9 injury. Should they have probably referred him to a
10 neuropsychologist? Under the attendant circumstances, I can see
11 why the adjuster didn't. She's getting MRIs. She's getting
12 reports from neurologists after this incident that's really
13 showing nothing. She knows that Dr. Richards is only there to
14 treat him for his depression and psychological problems, hadn't
15 conducted one single diagnostic test for his problem. Also,
16 you've got the sleep apnea problem that's going to interfere with
17 his mental alertness.

18 So we take the position that we didn't ignore it. No one
19 ignored it. But there was simply no evidence for us to do
20 anything at that point in time.

21 And with respect to Dr. Price and Dr. Moss, Ms. Williams and
22 I, we've gone down this road before. There is a case that I
23 probably need to give you -- it's *Crisp v. Southco* -- in terms of
24 the importance of the neurological examination.

25 Now, in this case Ms. Williams has petitioned for cert and

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1 it's pending before the Supreme Court, so I'm not certain how the
2 court will treat it, but I think it's very insightful on what the
3 court is looking at in terms of diagnosing these traumatic --
4 alleged traumatic physical brain injuries. A neurological exam
5 is important. A neuropsychological exam is just one tool that
6 doctors use, but not the definitive tool.

7 If I may approach, I would like to hand this up. In the
8 case of *Crisp v. Southco*, Dr. Moss was a little bit quicker on
9 the switch. I think it was 18 months after the incident before
10 he diagnosed a permanent physical brain injury as opposed to ten
11 years. So we take the position that ten years down the road is
12 remote. It has to be based upon a lot of speculation, conjecture
13 and surmise, given the fact that this gentleman had three
14 intervening strokes in between the time that he suffered this
15 work-related accident and when Commissioner Bass adjudicated him
16 permanently and totally disabled. Thank you.

17 **The Court:** All right. Thank you very much.

18 Mr. Dunbar, while you make a compelling argument, I believe
19 the order of the Workers' Compensation Commission should be
20 affirmed. I don't believe there was an abuse of discretion based
21 on the circumstances and the conduct from 1997 forward. While a
22 different commissioner or judge might have allowed the IME, I
23 don't believe it was an abuse of Commissioner's Bass's discretion
24 to not allow one based on the medical records that are part of
25 the record in this case, and there is substantial evidence

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1 supporting the other findings. So, thank you very much.

2 Ms. Williams, if you will just submit a proposed order and
3 give a copy to Mr. Dunbar.

4 Ms. Williams: Yes, sir. I sure will.

5 The Court: Thank you. All right.

6 -----End of requested transcript of record-----

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CERTIFICATE

I, THE UNDERSIGNED, DAWN V. KOFFSKEY, DO HEREBY
CERTIFY THAT THE FOREGOING IS A TRUE, ACCURATE AND
COMPLETE TRANSCRIPTION OF THE RECORD AS TAKEN BY HOLLIE
M. JENKINS, OFFICIAL COURT REPORTER FOR THE 13TH
JUDICIAL CIRCUIT OF THE STATE OF SOUTH CAROLINA,
INCLUDING ALL THE PROCEEDINGS HAD AND EVIDENCE
INTRODUCED IN THE TRIAL OF THE CAPTIONED CASE, RELATIVE
TO APPEAL, IN THE CIRCUIT COURT FOR PICKENS COUNTY,
SOUTH CAROLINA, ON THE 13th DAY OF APRIL 2011.

I DO FURTHER CERTIFY THAT I AM NEITHER OF KIN,
COUNSEL, NOR INTEREST TO ANY PARTY HERETO.

August 25, 2011



DAWN V. KOFFSKEY
COURT REPORTER

BEFORE THE SOUTH CAROLINA
WORKER'S COMPENSATION COMMISSION
W.C.C. FILE NUMBER 9708801

COPY

A. Eddie Jones (Archie),)

Employee,)

Claimant,)

~~VS~~)

3M Corporation,)

Employer,)

and)

Sedgwick CMS,)

Carrier,)

Defendants.)

DEPOSITION OF A. EDDIE JONES

Pursuant to notice and/or agreement of the parties,
the deposition of A. Eddie Jones was taken commencing at
10:43 a.m. on the 30th day of October, 2007, at the
offices of Kathryn Williams, PA, 619 North Main Street,
Greenville, South Carolina, 29601.

REPORTED BY: Lisa M. Nowell

CANNON COURT REPORTING
112 Manly Street
Greenville, South Carolina 29601
(864) 232-9517

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DEPOSITION OF A. EDDIE JONES

APPEARANCES:

Kathryn Williams, Esquire
Kathryn Williams, PA
619 North Main Street
Greenville, South Carolina 29601

.... On Behalf of the Claimant

Vernon F. Dunbar, Esquire
Turner, Padgett, Graham & Laney, PA
200 East Broad Street
Greenville, South Carolina 29602

.... On Behalf of the Defendants

ALSO PRESENT: Derrell Jones

STIPULATIONS:

This deposition is being taken pursuant to South Carolina Rules of Civil Procedure. The deponent waives the right to read and sign the transcript of the deposition.

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INDEX TO EXHIBITS

No exhibits were introduced

DEPOSITION OF A. EDDIE JONES

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1 A. Eddie Jones, having been first duly sworn, was
2 examined and deposed as follows:

3 EXAMINATION BY MR. DUNBAR:

4 Q. Mr. Jones, you and I just introduced ourselves. I'm
5 Vernon Dunbar. I represent 3M. I'm going to ask
6 you a series of questions about your current health
7 status. If I ask you a question you don't
8 understand or you need for me to repeat, ask me and
9 I'll gladly do so. If at any time you need to take
10 a break, let us know. We can gladly take any breaks
11 to accommodate you. Before we begin, are you under
12 the influence of any drugs, medications, or anything
13 that could influence or affect your ability to
14 answer any questions?

15 A. I have vertigo real bad right now, and it's from an
16 antibiotic I'm taking for my foot. And I have
17 gotten sick the last two days about a couple of
18 hours after I took the medication, and this is the
19 couple of hours after I took it. So, I don't know
20 whether I'm going to be sick or not.

21 Q. I understand. From a mental standpoint, you're
22 mentally astute, aware, and you understand
23 everything I'm asking?

24 A. Pretty much.

25 Q. All right, sir. Please state your full name of the

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DEPOSITION OF A. EDDIE JONES

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1 record.

2 A. It's Archie E. Jones, Junior.

3 Q. And what is your age?

4 A. Sixty-four.

5 Q. What is your date of birth?

6 A. ~~1/30/43~~.

7 Q. Who is your primary treating physician as we sit
8 here today?

9 A. June Souviron.

10 Q. How do you spell --

11 A. S-O-U-V-I-R-O-N.

12 Q. And where is Dr. Souviron located?

13 A. She's on Main Street in Anderson.

14 Q. How often do you see her in the course of a month or
15 every six months?

16 A. It's hard to say. Sometimes I just call her, and
17 she knows my situation. So, I have --

18 MS. WILLIAMS:

19 He just needs to know approximate, Eddie.

20 WITNESS:

21 A. Okay. I can't remember. I saw her -- matter of
22 fact, she called me yesterday. I'll say every
23 couple of months. Sometimes I see her three or four
24 times in a month:

25 EXAMINATION RESUMED BY MR. DUNBAR:

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DEPOSITION OF A. EDDIE JONES

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1 Q. What maladies does she treat you for? What type of
2 illnesses?

3 A. My feet.

4 Q. Your feet?

5 A. My feet and wounds to my feet. The graphs break
6 down. And right now, I'm going to Wound Care ~~instead~~
7 instead of going to her. She sent me to Wound Care
8 at AnMed Hospital, and she sent me to a surgeon.
9 Twice in the last three months, I've had to have
10 surgery on my feet. One was for tissue that was
11 dead. One was they had to remove some bone so the
12 skin could grow over because the bone was protruding
13 out my two joint, big toe joint. And I went to Dr.
14 Frassinelli for that, but she sent me to him. So,
15 that's one of the reasons I went to her.

16 Q. When you've had these surgeries for treatment of
17 your wounds or your feet, has it been outpatient, or
18 have you had to do it inpatient?

19 A. One of them was inpatient, the leg. And the foot,
20 he did in the office.

21 Q. And what type of anesthesia did they use in terms of
22 numbness?

23 A. None.

24 Q. No anesthesia? Even when you were inpatient?

25 A. I don't have any feeling. Matter of fact, I have.

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DEPOSITION OF A. EDDIE JONES

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1 trouble driving because I can't tell whether I've
2 got my foot on the brake pedal or the accelerator.
3 Sometimes I have it on both. And I can't figure out
4 why the car won't speed up, and I've got my foot on
5 the brake and the accelerator. But my feet are
6 pretty numb.

7 Q. And is that numbness constant?

8 A. Yeah. Right now, I'm having trouble -- because of
9 the vertigo, I have trouble compensating. If I
10 close my eyes, I fall because my feet don't have any
11 -- see, I can't really tell by my feet how I'm
12 balancing myself. So, if I close my eyes -- it's
13 hard to take a shower. It's hard to wash my face
14 and close my eyes to keep from getting soap in it.
15 I fall over.

16 Q. Now, do you utilize any type of cane, or crutch, or
17 anything to walk?

18 A. No, I don't. I don't really need that.

19 Q. Tell me a little bit about your educational
20 background.

21 A. I went to Boy's High School, then I went to Anderson
22 College. I've been to a technical school.

23 Q. How did you perform in school? "A" student? "B"
24 student?

25 A. I did well. When I went back to college, though, I

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DEPOSITION OF A. EDDIE JONES

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1 was working twelve hours a day and going at night,
2 going to school at night, and it was a load. So,
3 Derrell helped me some.
4 Q. And that's your wife?
5 A. That's my wife.
6 Q. So, you said you attended a boy's high school.
7 What's the name of it again?
8 A. Boy's High.
9 Q. Boy's High?
10 A. Yeah.
11 Q. And where is that located?
12 A. It was in Anderson. Now it's T.L. Hanna. She went
13 to Girl's High.
14 Q. So, they had a Boy's High and a --
15 A. Boy's High and Girl's High, yeah. And it was that
16 way from 1923 to 1961.
17 Q. Okay. I've never heard of that, but I've heard of
18 T.L. Hanna. You had an admitted unfortunate burn at
19 work on June 3rd, 1997; is that correct?
20 A. That's right.
21 Q. And I think, as a consequence of that, you had
22 severe burns to your entire body for the most part,
23 and it affected your arms, your legs, your feet,
24 urinary system. What other parts of your body --
25 A. It burned my lungs.

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1 Q. It burned your lungs. Okay.

2 A. Yeah, that was a -- to begin with, that was the
3 worst part. It took six years to get my lungs to
4 even settle down. I had bronchial infections and
5 pneumonia continuously. I took antibiotics for two
6 and a half years, three different kind of
7 antibiotics. And I still have problems. Matter of
8 fact, I'm having problems right now getting one of
9 my inhalers. Reba McFarland's not -- not dealing
10 with us real good.

11 Q. So, your lungs became your primary problem after
12 they got burned?

13 A. Yeah. Now, it's somewhat settled down. My feet are
14 the real problem right now, and my concentration is
15 not real good. I can't read or concentrate. I can
16 read a paragraph. But if I go past that, I can't --
17 I don't know what I've read. I have no earthly
18 idea. And Dr. Richards said I had developed ADD,
19 and it showed up in that psychological evaluation.

20 Q. Had you ever been diagnosed with ADD or ADHD before?

21 A. No. I had almost a photographic memory, and now I
22 don't have -- I have almost no recollection of
23 things that happen now. I can remember pretty good
24 things that happened a long time ago, but I have --
25 my memory is not very good. My concentration's not

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1 very good.

2 Q. Any family history of ADD or ADHD?

3 A. No. I got nine brothers and sisters, and they all -

4 - I don't know of any problems they have.

5 Q. How about any of your children? Do they have

6 problems with it?

7 A. I don't know about that. One of my sons died. The

8 other one -- does he have --

9 MS. JONES:

10 He has ADD.

11 WITNESS:

12 A. He has ADD. I didn't -- I didn't know what he was

13 diagnosed with.

14 EXAMINATION RESUMED BY MR. DUNBAR:

15 Q. And how old is your son that has ADD?

16 A. He's forty-four.

17 MS. WILLIAMS:

18 She can't help you, remember.

19 EXAMINATION RESUMED BY MR. DUNBAR:

20 Q. Do you recall whether your son - and this may be a

21 tough question - how long he's been diagnosed with

22 the problem? Or did you have to help him through

23 school, or was he a pretty decent student and you

24 didn't have to help him?

25 A. He started taking Ritalin, and he went from C's and

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1 D's to A's and B's.

2 Q. He's now about forty-four?

3 A. Uh-huh (affirmative).

4 Q. And what is your son's name?

5 A. Brett, B-R-E-T-T.

6 Q. Brett Jones?

7 A. Uh-huh (affirmative).

8 Q. Not to be confused with the quarterback?

9 A. Uh-uh (negative). No, not him. You have an

10 interesting way of writing.

11 Q. I know. Don't I? Sideways, or some people say it's

12 upside down.

13 A. Well, I know why. Because when you're left-handed,

14 you're writing, you're covering up what you're

15 writing and you can't see it. So, I know why you're

16 doing that.

17 Q. Yeah, get it all over your wrist. So, none of your

18 brothers or sisters had ADD, but you do have a son

19 that has been diagnosed with it?

20 A. I don't have anybody in my family that has it that I

21 know of. Well, I know they don't, matter of fact.

22 Q. Now, you say you have problems concentrating. Any

23 other problems?

24 A. The urinary is another problem. I finally got some

25 -- I finally got some medication that helps. And

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1 what happened was I had a Foley catheter in for
2 three and a half months, and it thickened my bladder
3 and it wouldn't expand to hold water. So, I'd have
4 to -- I'd have to get up three or four times at
5 night, sometimes five or six times, to use the
6 bathroom. Well, that catheter tore my urethra back
7 about this far (indicating) underneath. It just
8 tore it, and it had to be repaired. And while --
9 they had to put a catheter in while it healed up.
10 They circumcised me and used that skin to fix the
11 opening. And because my feet are so -- I'm so
12 uncertain on my feet, I was going to empty the bag
13 and stepped on the tube and jerked the catheter
14 through my prostate. And it was painful and bled.
15 And anyway, ever since then, I've had this problem
16 with frequency or urgency. And it took several years
17 to find out -- to figure out what was going on. I
18 had to go to the doctor over here, doctors. And I
19 saw two doctors in Anderson, and they pretty much
20 ignored me. I won't go into the details.

21 Q. Okay. Now, I know there have been some medications
22 that you've asked 3M to pay for dealing with the, I
23 guess, urinary tract system and erectile
24 dysfunction.

25 A. Uh-huh (affirmative).

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1 Q. Does that all come from the problems you were having
2 with your urinary tract as a consequence of the
3 burn?

4 A. It came from the catheterization being in there for
5 three and a half months. You see, they had to go --
6 it went right through the prostate. So, and the
7 prostate is giving -- gave me a lot of problems from
8 that.

9 Q. Now, who's treating you for the prostate or urinary
10 problems that you're having?

11 A. Dr. Rice.

12 Q. Dr. Rice?

13 A. Rice here in Greenville.

14 Q. And he's prescribed a series of medications for you
15 and pills; has he not?

16 A. Yeah. He just -- he gave me one medication, and it
17 worked.

18 Q. Do you recall the name of that medicine?

19 A. Sanctura.

20 Q. And what is it for? Is it for erectile dysfunction?

21 A. It's to expand my bladder. I don't have -- he gave
22 me a prescription for -- I don't even know what it
23 is, injections. And I can't use that because it
24 burns too bad.

25 Q. There are a number of bills that have not been paid

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1 that are outstanding.

2 A. Uh-huh (affirmative).

3 Q. Can you tell me, out of the bills that you can
4 recall that haven't been paid, whether they're
5 related to your accident or not?

6 A. Which ones? Do you know?

7 Q. Well, it's a lot of them. And I want you to tell me
8 the ones that you can think of why you think 3M
9 should pay it under workers' comp as opposed to
10 anything else.

11 A. Well, the biggest one right now is the dental
12 appliance I have to wear because my throat was
13 burned, and I strangled on secretions at night. So,
14 they made me a dental appliance like you use for
15 sleep apnea, and I use that to keep my tongue -- it
16 pushes my jaw forward and holds it while I sleep so
17 that my tongue won't relax down and strangle me to
18 death. It's similar to sleep apnea. And that's one
19 of the -- that's the biggest bill that's
20 outstanding. Now, the rest, I don't know of any --
21 I don't know of any other.

22 Q. So, the dental appliance is one of the main ones
23 that you can recall?

24 A. Yes. Yes, it is. There's one that they turned down
25 that's called Promogran, and it's the medication

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1 they want to put on this place on my foot that's
2 broken down. And it's been three weeks, and they
3 didn't -- they won't approve it. And that's -- it
4 was prescribed by both Wound Care and by the doctor,
5 and they -- I'm not getting it. Also one of my
6 inhalers, I'm not getting that. They didn't approve
7 it, and I don't know what's going on.

8 Q. And how long have you been taking this particular
9 medication, the inhaler?

10 A. The inhaler?

11 Q. Yes, sir. Approximately.

12 A. Eight years.

13 Q. Eight years?

14 A. Maybe more. I don't remember. At first, I didn't
15 know that I had a -- I didn't know that I had a
16 breathing problem. You know, I'd been under all
17 those medications that I was coming down off of.
18 And being on Morphine, and Demerol, and Versed for
19 so long, I thought I could just jump back right into
20 things. But I found out right quick forty-six
21 percent lung capacity doesn't work too good. So, I
22 -- anything physical, I'm short of breath, and I
23 have passed out.

24 Q. Now, you're on a -- well, at one point, you were on
25 a host of medications back in 2006. I have about

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1 thirty-three listed, at a minimum. Let me show this
2 to Ms. Williams first.

3 MS. WILLIAMS:

4 This is a list of medications?

5 MR. DUNBAR:

6 Yeah.

7 WITNESS:

8 A. Let me see if any of those --

9 EXAMINATION RESUMED BY MR. DUNBAR:

10 Q. If you'll let me know if any of those --

11 A. Some of them -- those have just been all -- this is
12 what I do, is keep track of this. That's the only
13 thing I can really concentrate on because it's a
14 full-time everyday thing. Albuterol, Atrovent,
15 Combivent. I don't use Combivent anymore. That's
16 number three. Lopamax, Atrovent, Pulmicort,
17 Serevent, Singulair. Humibid has been changed to
18 Mucinex, that's been changed to this right here
19 (indicating).

20 Q. You can just tell me the number.

21 A. It's number fourteen.

22 Q. Okay.

23 A. I only take that once a day now instead of taking --
24 instead of taking 1,120 milligrams twice a day, I
25 take it once a day. They said it was going to cause

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1 me to have some heart problems. And number ten, I
2 don't take that anymore. They took me off that and
3 cut this down so I wouldn't have heart trouble.
4 Resperidol is .25 and one -- that's number
5 seventeen, .25 -- what does that say right there
6 (indicating)?

7 Q. It looks like it increased to .50.

8 A. Okay. I'm actually on -- I think it's one at night
9 and .50 in the morning. Depakote, I'm down to 250
10 milligrams. That's number eighteen. They're trying
11 to drop that down to see if it can help with my
12 concentration. And Dexedrine, nineteen, I don't
13 take any -- I don't take that right now. It was
14 causing increased heart rate. It was really, really
15 getting out of hand. Dexedrine. I'm taking a
16 hundred -- on number twenty, I'm taking 150
17 milligrams of Zoloft rather than 100. Number
18 twenty-one, I have on here that I stopped taking the
19 Actonel. My bones were -- my bones were -- I was
20 into osteopenia. Prednisone was bleeding my bones
21 out, and I got down to -- it started burning my
22 stomach so bad along with Prednisone and the other
23 medications that I take. They're really not good
24 for your stomach. My stomach got to burning so bad,
25 they had to take me off that. And she said that --

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1 I had a bone scan, and it was -- seemed to be okay.
2 Lamisil. I don't know what Lamisil is. Do you?
3 Q. I do not.
4 A. This was a long -- this was awhile back. I have to
5 take Colase stool softener. Prevacid, I have to
6 take that to keep my stomach from burning.
7 Celebrex, I have to take that for foot pain. And I
8 still have to use Lidoderm patches on my feet so I
9 can walk. It's a lidocaine patch. And if I didn't
10 have that, I couldn't even walk. I don't have them
11 on right now, and I'm about to die. Then all these
12 bandages are just for my feet. And this AmLactin
13 lotion, I put on my back where they took all my skin
14 off my back for a donor site. That (indicating) is
15 increase blood pressure. That (indicating) is to go
16 on my knee, where my knee was burned. And the rest
17 of that is -- there's some -- I thought that was
18 vitamins, but it's not. Flomax, I take for the
19 urinary problem. Plavix. That's pretty much it.
20 Q. Okay. You had testified that number eighteen, they
21 cut it down to 250 to help you with your
22 concentration.
23 A. Uh-huh (affirmative).
24 Q. Is that correct?
25 A. Yeah.

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1 Q. Have you noticed any appreciable difference since
2 you cut down on your dosage?

3 A. Not -- not -- it's hard for me to say. I can't --
4 unless I have something really challenging to
5 concentrate on, I don't -- I haven't had anything.
6 I've been sick with this vertigo, so all I've been
7 doing is laying around. With that and my foot, too,
8 all I've been doing is laying around, watching T.V.,
9 and eating and sleeping for the last, I guess, three
10 months.

11 Q. Do you notice any ability in your concentration?
12 Has it gotten better or has it gotten worse over the
13 past three months, or stayed the same?

14 A. Not really. Not really.

15 Q. Hasn't gotten any better or worse? About the same?

16 A. It hadn't gotten worse, but I don't think it's
17 gotten any better. I really -- like I say, I really
18 haven't had any reason to concentrate. And what I
19 do, if I have something that I have to choose or
20 make a decision on, that's something I've lost. I
21 cannot make decisions. Like I can't even -- I can't
22 even choose the clothes I wear. If I got more than
23 one shirt, I can't decide which one I'm going to
24 wear. And so, my wife does most of that. She does
25 -- any situation where I have to concentrate that I

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1 would really use concentration, I let -- I let her
2 do it. And matter of fact, I got my benefits form
3 from 3M, a yearly thing that has to be -- you pick
4 your benefits and the package you want and all that.
5 I read that thing three times, and I didn't know
6 what I'd read. So, Derrell -- Derrell had to take
7 over.

8 Q. Had you ever had that problem in the past?

9 A. Before the accident?

10 Q. Yes.

11 A. No.

12 Q. When did you first start noticing problems in terms
13 of concentration or an inability to concentrate?

14 A. Well, I noticed it before I got out of the hospital
15 down there at the burn unit that I couldn't -- I
16 can't watch T.V. Everything just -- my mind races
17 faster than what I'm concentrating. And I couldn't
18 -- I couldn't -- I could watch the T.V., but I
19 couldn't tell you what I was watching when I was in
20 the -- when I was in the burn unit. I was only in
21 there, off medication, for two weeks, and then I
22 came home. And I really had a lot of problems.
23 When you can't watch T.V., that's pretty bad.

24 Q. So, while you were in the burn unit, you notice an
25 inability to concentrate and watch T.V.?

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1 A. Well, I didn't -- I didn't -- they kept me on
2 Versed. Versed keeps you from thinking. And if you
3 don't think about it, you don't know it. And if you
4 don't know it, it didn't happen. So, they kept me
5 on that for three and a half months. I didn't even
6 -- other than when the IV would run out, I didn't
7 even know I was in the world. I knew I was alive,
8 but I didn't know I was in the world.

9 Q. Now, after you were released from the hospital, did
10 you have any -- well, did you notice anything
11 different about your ability or lack of ability to
12 concentrate once they took you off the Versed and --

13 A. Yeah. It was considerably worsened. I couldn't --
14 I couldn't -- well, my wife is my memory because my
15 memory is bad, too. But since I can't ask her, it's
16 hard for me to tell.

17 Q. Did you complain to her about it during this time?

18 A. Oh, yeah. She knew it. She knew it. That and --
19 there's a lot of the medications, especially
20 Prednisone, make you really, really belligerent.
21 And I was almost violent because of Prednisone, and
22 that's the reason I take Risperidol. It keeps me
23 from killing people.

24 Q. When did they change you or take you off the
25 Prednisone?

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1 A. I'll be taking it the rest of my life.

2 Q. Oh, so you're still on it?

3 A. (Affirmative nod).

4 Q. Did they just lower your dosage?

5 A. Well, I -- I am kind of -- she gives me what I need,
6 and I always have a little reserve. And she -- the
7 doctor allows me to up it and decrease it as I need
8 it if my lungs get -- if my bronchial tubes start
9 getting inflamed, I can up the dose and it'll go
10 away. Sometimes I have to go real -- take a lot. I
11 haven't recently, real recently. But I take -- I
12 have taken 60 milligrams a day. And right now, I'm
13 taking 20.

14 Q. So, after you're released from the burn center,
15 you're having trouble concentrating?

16 A. Oh, yeah.

17 Q. What are some of the things that your wife had to do
18 for you or maybe still do for you because of these
19 problems? You told me about an inability to dress
20 yourself.

21 A. Well, financial stuff, making choices on just about
22 anything. I just -- I just cannot -- I just cannot
23 make choices. That's something I've lost, and I
24 don't -- I try, but it -- the more I try, the worse
25 confused I get. I just -- if I go -- I'll tell you

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1 the thing I told Kathryn. If I go to the store to
2 get a jar of peanut butter and there's more than one
3 on the shelf, I just -- I'll come back without it.
4 I just can't -- I just can't -- I get -- it just
5 confuses me. I just go blank.

6 Q. And you've never had these problems before?

7 A. Oh, no. No, not really. Can't think of any. I
8 can't think of any time I've ever had a problem like
9 that.

10 Q. What are some of the things your wife helps you
11 with? I know the finances, reading, correspondence
12 from 3M. Anything else?

13 A. She deals with all the -- with all my medical
14 problems that require stuff like that, like forms
15 and things like that. I just cannot concentrate
16 enough to get to do what needs to be done. If it's
17 a serious decision, she has to do it.

18 Q. Your present address, is it 1229 Salem Church Road?

19 A. That's right.

20 Q. And how many years have you lived there,
21 approximately?

22 A. Over thirty.

23 Q. And is that in the city limits of Anderson?

24 A. No, it's on the edge. We're right out of the city
25 limits.

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1 Q. Is there anything that you do around the house from
2 a physical standpoint? I know that your wife takes
3 care of all the financial matters.

4 A. I cut the grass with a riding mower. I try to
5 weedeat, but my feet -- I just -- it just hurts so
6 bad. I can walk as long as I'm on a flat surface
7 like this. But walking on uneven surfaces, if my
8 shoe shifts to the side and my foot slides, oh, I'm
9 in so much pain. But I do -- I try to do things. I
10 try to do anything that I can, but if my lungs
11 aren't -- if my lungs aren't giving me the problem,
12 my feet are. And when my lungs are good, my feet
13 aren't. If my feet are good, my lungs aren't. So,
14 I can't do any kind of exercise, and the Prednisone
15 makes you hold fluids and gain weight. And I wish
16 that I could exercise, but I can't. And I've tried,
17 and I don't have the wind -- I don't have the breath
18 for it. I don't know whether I -- I don't know
19 whether I could build it up or not, but I'm on a --
20 I'm not doing well right now as far as that goes.

21 Q. You said that you work in your yard and you use a
22 riding lawnmower and a weedeater. Any other type of
23 tools you --

24 A. I have a lot of old cars. I fool with old cars, but
25 I can't do that either because that takes a lot --

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1 ever since I came home from that burn unit, if I try
2 to get under anything and look up, I get deathly
3 ill, just like vertigo, and it lasts for anywhere
4 from thirty -- thirty minutes to an hour. I'm so
5 ill, I can't even get out from under the car. So, I
6 -- now, my son -- my son is there. He helped -- he
7 helped me fix a part of my car this week because he
8 could get underneath. I can't get under. I tried.
9 I thought I could slide up under there and just look
10 at the situation. Whew, I was sick for about thirty
11 minutes.

12 Q. When was the last time you tried to work on one of
13 your old cars? And I say you trying meaning going
14 up under a car and looking up or working on
15 something over top of the hood. When was the last
16 time you did anything?

17 A. This week.

18 Q. This week?

19 A. Uh-huh (affirmative).

20 Q. How did you feel when you tried it?

21 A. I -- it's hard to -- it's hard to come -- I've been
22 a mechanic all my life. I started when I was real
23 young. And that, I don't have to -- I don't have to
24 concentrate on that because it's something I've just
25 always done. So, it felt good to get out there and

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1 fool with the car. But it was the car I was
2 driving, so I had to fix it. And I can't afford to
3 have somebody fix it for me, so I -- I got my son --
4 my son just sold his house and moved in with us.
5 So, he's there now.

6 Q. How long has your son been there with you?

7 A. A couple of weeks. It helps me because he can do
8 things that I can't do.

9 Q. Did anybody else move in other than just your son?

10 A. (Negative response).

11 Q. When was the last time you did some yard work;
12 weedeating, ride the lawnmower?

13 A. About two weeks ago.

14 Q. And how did you fare when you --

15 A. I actually have centipede. I've only cut my grass
16 twice this year.

17 Q. Lack of rain?

18 A. It's doesn't grow up. You know, centipede creeps.

19 So, I only -- where the weeds have blown in from
20 other places, that's all I had to cut was out on the
21 roads, and that's all we cut. Brett did the
22 pushing, and I just kind of supervised.

23 Q. How long does it usually take you, at the height of
24 the growing season, to take care of your yard?

25 A. It takes a couple of hours to cut the yard on a

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- 1 riding mower.
- 2 Q. Now, I take it you do drive a little?
- 3 A. Yeah. I drive.
- 4 Q. What's the farthest distance you've driven in the
- 5 past year or so?
- 6 A. Farthest I've driven. Chisholm, Minnesota.
- 7 Q. And how long of a drive is that?
- 8 A. It's twenty-four hours.
- 9 Q. I'm assuming you did stop and --
- 10 A. We stopped twice.
- 11 Q. Out of that twenty-four hour drive, how many hours
- 12 would you say you drove?
- 13 A. Let's see. We left, went to Lafayette, Indiana and
- 14 spent the night, then went on to Minneapolis. We
- 15 crossed the bridge that caved in, too.
- 16 Q. Oh, really?
- 17 A. Yeah. That bridge that caved in and killed all
- 18 those people, we went across that bridge twice.
- 19 It's scary.
- 20 Q. Yeah.
- 21 A. I would say probably eight hours. I mean, we
- 22 stopped and ate and stuff like that. But probably
- 23 might have been eight hours or less.
- 24 Q. Now, you drove and who else? Who else drove? You
- 25 and your wife?

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- 1 A. Uh-huh (affirmative).
- 2 Q. Just the two of you?
- 3 A. Well, we were going up to move our friend back down
4 here from -- to take care of her dad. She was
5 along, too.
- 6 Q. Did she drive any?
- 7 A. No, she didn't drive any.
- 8 Q. Any problems on that trip driving for you?
- 9 A. Other than the fact I almost ran into a van, no.
10 Got yelled at for about ten miles.
- 11 Q. It happens like that when we drive.
- 12 A. Yeah. I just happened to take my eyes off the road
13 for one second. A girl had just skidded down into
14 the mud. And when I looked back, the van was right
15 there, and I was running seventy miles per hour. It
16 was scary. It scared them, it didn't scare me.
- 17 Q. Now, your concentration problems, do you think you
18 have them under control or not?
- 19 A. The medications are -- I'm in the middle -- Dr.
20 Richards is trying to adjust my medication. He's a
21 pharmacologist psychiatrist, and he -- he's trying
22 to adjust the medications for both for mood and
23 energy. And I was taking Dexedrine for a stimulant,
24 and I'd get up in the morning and take that and I
25 was good to go for the whole day. Well, when they

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1 took me off that, now I'm lucky if I can even
2 pretend to start anything before noon. And I get up
3 -- I get up -- I got up at 6:00 for years. And to
4 even get dressed, it takes that -- I just can't get
5 things going. I just can't get -- it's a -- I don't
6 know what the diagnosis or what's wrong, but
7 probably Dr. Richards can tell you.

8 Q. Now, did you have any type of stroke or anything
9 after your burn?

10 A. I had a TIA afterwards.

11 Q. After you had your TIA, did you notice anything
12 different about your ability to concentrate, your
13 ability to think or reason?

14 A. No, it never changed. The only thing -- I just went
15 on the Plavix, which is a medication to make your
16 red blood cells slippery so that you don't get a
17 clot. And there was -- I had an MRI, another one,
18 but there was no damage from the stroke. It was the
19 same as the one that Dr. Richards did earlier to
20 find out if I had brain damage. And he's been
21 telling me all this time that I had some brain
22 damage, and I just couldn't see how that could be.
23 And then I got -- I got to concentrating on that a
24 little bit, trying to think of what -- and things
25 were not right. But it took a long time for me to -

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DEPOSITION OF A. EDDIE JONES

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1 - for me to accept that -- when I first came home, I
2 was so messed up, I didn't even know which end was
3 up. I couldn't -- I had post-traumatic stress and
4 panic attacks, and I just -- I couldn't -- I
5 couldn't control them. And it was -- I'd never been
6 in any situation like that. I didn't -- let me
7 think about this a minute. I've always thought that
8 anybody that had mental problems or psychological
9 problems, all they had to do was say, "Get over it.
10 Go to work. Do something." And then I got them,
11 and I found out that it's not that way, that you
12 have no control over your brain function when you're
13 like that. When brain chemicals are messed up, you
14 can't do anything. You -- these medications right
15 here are the reason I can function right now. If
16 you take them away, I go right back to post-
17 traumatic stress, and have panic attacks, and all
18 that stuff.

19 Q. Do you recall when Dr. Richards may have first told
20 you about his suspicion of brain damage?

21 A. A long time ago. It was about six years ago or
22 more. I was having so -- I was having such a hard
23 problem with breathing. If you don't get
24 oxygenated, it messes everything up. I mean, it
25 messes -- if you don't get enough blood to your

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DEPOSITION OF A. EDDIE JONES

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1 brain, you don't get -- or enough oxygen to your
2 brain or you don't get enough oxygen to your organs,
3 it messes everything up. So, that's what he told
4 me. And it's been five or six years, but it kind of
5 slowly -- I'm searching for words. I mean, it just
6 -- it dawned on him that there was something wrong.
7 So, I had the MRI, and it did show some white matter
8 damage on the MRI.

9 Q. Did Dr. Richards or did any other doctor tell you
10 that your brain problems at that point in time came
11 from your work related accident, or your brain
12 injury?

13 A. Dr. Richards told me that, actually. And let's see.
14 I'm getting really confused about times, and
15 situations, and things like that. But Dr. Richards
16 told me. I didn't -- I didn't have any idea, you
17 know. I said, "I don't think I have brain damage,"
18 but he assured me I did.

19 Q. Now, you also said that you had some post-traumatic
20 stress disorder and anxiety, or panic attacks. Do
21 you still suffer with those maladies or problems, or
22 have they subsided?

23 A. They haven't subsided, but I don't have them near as
24 much as I used to. And that's part -- that's part
25 of the reason I can't get started in the morning or

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DEPOSITION OF A. EDDIE JONES

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1 can't get anything done. If I have to go to the
2 doctor or some something at 1:00, if I start when I
3 get up at 6:00 or 7:00, I just barely make it to
4 what I'm going to. I just can't organize my
5 thoughts enough to do it.

6 Q. Does it get better as the day proceeds?

7 A. Yeah. It gets better toward the -- toward the
8 afternoon, it gets better.

9 Q. What time do you go to bed at night?

10 A. I go to bed about 11:00.

11 Q. And what time do you typically wake up? Not
12 necessarily get up, but what time do you wake up?

13 A. In the last three or four months -- for, I'd say,
14 eight years, I woke up and got up at 6:00. But in
15 the last -- in the last three or four months, I
16 can't get enough sleep. I sleep all afternoon. I
17 sleep to the middle of the afternoon if I don't have
18 a reason to get up, and sometimes -- sometimes I do
19 if I have a reason to get up. And that's just come
20 on recently. That's not -- that's not the norm.

21 Q. Any changes in your diet?

22 A. Not really. No, I have a good diet. I eat mostly
23 for my body. Not as much for taste as I do for my
24 body. So, before I had -- before this accident
25 happened, I spent about six years getting ready for

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DEPOSITION OF A. EDDIE JONES

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1 this, for that accident. I worked out five or six
2 days a week. I ate -- I didn't eat meat. I didn't
3 eat any meat for almost nine years, and I ate turkey
4 and chicken, poultry. On up to about fifteen years
5 back, I ate that from -- but for almost nine years,
6 I didn't eat any meat whatsoever, not a bite, and
7 worked out six days a week. Took amino acids and
8 vitamins and did everything healthy, and then this
9 accident happened. And because my organs and my
10 heart were in such good shape is the only reason I'm
11 alive, that and the good Lord.

12 Q. Now, it's my understanding, after your accident, you
13 did go back to work for a period of time.

14 A. About eight months.

15 Q. About eight months. What was your job,
16 specifically? What did they have you do when you
17 went back?

18 A. They put me on a -- actually, it was some form of
19 drafting. It was AutoCad, and I had no training in
20 it. I had no computer experience, zero, and I had
21 that concentration and memory problem. And it took
22 my -- it took that eight months just to figure out
23 what I was supposed to be doing, and then Dr.
24 Richards said I didn't need to be going there. It
25 was causing me a lot of problems. I was having to

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DEPOSITION OF A. EDDIE JONES

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1 drive -- I couldn't drive on the interstate. I
2 couldn't drive over there because I felt
3 claustrophobic when I'd get between vehicles, and I
4 just -- I had this weird sensation of movement, and
5 it just -- I was in bad shape.

6 Q. So, you worked there for about eight months. Have
7 you worked anywhere since you last worked at 3M?

8 A. No.

9 Q. Are you receiving Social Security disability
10 benefits?

11 A. (Affirmative nod).

12 Q. How long have you been receiving those?

13 A. A long time. I don't know. I actually do not know
14 when it started or -- I remember going down and
15 talking to them about it, but I don't remember how
16 long ago that is. I have no idea about dates, or
17 times, or periods, or anything like that.

18 Q. I think you testified earlier you had attended
19 Anderson Technical College. Did you attend any
20 other college other than Anderson Technical College?

21 A. Just Tri-County Tech, technical college. It was a
22 tech school then. That was just the second year --
23 second year they've had it, and they were pretty
24 much organizing things. The staff, and the programs,
25 and the curriculum, they just -- they were trying to

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DEPOSITION OF A. EDDIE JONES

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1 get everything organized. And it wasn't -- it
2 wasn't probably the best training I could have
3 gotten at the time. It's a very good school now.

4 Q. So, you went to both Anderson Tech and Tri-County
5 Technical College?

6 A. Anderson College and Tri-County.

7 Q. Okay.

8 A. Well, it's Anderson University now.

9 Q. Have you ever served any time in the military?

10 A. No.

11 Q. Have you ever been hospitalized before for, prior to
12 your accident of June '97, for any depression or
13 psychological problems?

14 A. No.

15 Q. So, you were the picture of health before this
16 incident?

17 A. (Affirmative nod). Yeah. Wish I could do that
18 again, but I have to have the protein for my skin
19 because they told me I had to eat meat. That's the
20 only reason I started back eating meat.

21 Q. Now, are you scheduled to undergo any surgeries in
22 the future?

23 A. Nothing I know of. There was one that Dr. Harvey,
24 the burn surgeon down there at the burn unit,
25 suggested, and that was -- my toes are getting

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DEPOSITION OF A. EDDIE JONES

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1 webbed on my left foot. And he suggested that those
2 should be separated, and that's a good bit of pain.
3 And that's the only thing I can think of that's even
4 been mentioned that hasn't been done. I don't know
5 of any other surgeries.

6 Q. Your sleep apnea, have you recovered from that, or
7 are you still being treated for it?

8 A. Sleep --

9 Q. Sleep apnea.

10 A. The breathing thing -- I mean, the strangling -- I
11 have a swallowing problem right now, and I aspirate
12 food at least once a day because I got no feeling in
13 the back of my throat. I don't have a gag reflex.
14 I don't have -- so, food can get into my airway
15 without me knowing it. And that's to keep the
16 secretions out of my lungs. That's the reason I use
17 that dental appliance.

18 Q. Have you seen any doctor for your concentration
19 problems other than Dr. Richards?

20 A. No.

21 Q. Are you scheduled to see any doctors for your memory
22 problems, concentration problems, or thinking?

23 A. No. I don't -- I see Dr. Richards regularly, once a
24 month. I've been seeing him pretty much once a
25 month. Sometimes, if I'm not having problems and he

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DEPOSITION OF A. EDDIE JONES

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1 didn't adjust the medication and need to know if
2 it's working, I'll see him every couple of months.
3 But no more than -- I never go any longer than that
4 without seeing him. And he can -- he is sharp. He
5 is really, really -- he can listen to me talk like
6 I'm talking to you right now and tell me what's
7 wrong with me. He is good. He could tell by the
8 tone of your voice, by how fast you respond, how
9 good you use your words, and that kind of stuff, how
10 that medication that he's prescribing works.

11 MR. DUNBAR:

12 Why don't we go off the record one moment.

13 (OFF THE RECORD)

14 EXAMINATION RESUMED BY MR. DUNBAR:

15 Q. When you had your TIA, where were you hospitalized?

16 A. Anderson Memorial.

17 Q. Anderson Memorial?

18 A. AnMed. It's the main hospital, not the campus.

19 Q. And do you recall the name of the doctor who treated
20 you for that?

21 A. Dr. Oliver.

22 Q. Dr. Oliver?

23 A. I think it's Robert. Frank. Is it --

24 Q. It's either Frank or Robert?

25 A. Frank or Robert Oliver.

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DEPOSITION OF A. EDDIE JONES

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1 Q. When was the last time you saw him for any --

2 A. I saw him about the nerves in my feet, and he is
3 actually -- I was having so much trouble with my
4 feet, and I had used -- there's something else --
5 there's a couple of things I haven't mentioned that
6 -- and I never got any response on it. When I --
7 when I ran out of that room where I was trapped, I
8 hit the door with my shoulder. And I didn't have to
9 use my shoulder for over a year, and it -- I noticed
10 it would hurt a good bit. But I just about ruined
11 my right shoulder. And my family doctor gave me
12 those patches to put on my shoulder to stop it from
13 hurting. Well, I asked her about -- I asked Dr.
14 Oliver about putting those things on my feet, would
15 that stop my feet from hurting. He said, "Worth a
16 try." So, he prescribed them, and that's -- I've
17 been using them ever since.

18 Q. That book you have there, is that a diary or just a
19 calendar?

20 A. Somewhat. It's my dayplanner. Let me see if Dr.
21 Oliver is in here. Just Dr. Oliver.

22 Q. Okay. Do you do any type of charity or volunteer
23 work in the community?

24 A. Not really. I have -- I have a niece and a nephew
25 that are in school, and I chauffeur them around

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1 some, if you want to call that charity. It still
2 costs me.

3 MR. DUNBAR:

4 Mr. Jones, those are all the questions I have.

5

6 (There being no further questions, the deposition was

7 concluded at 11:44 a.m.).

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DEPOSITION OF A. EDDIE JONES

CERTIFICATE

I, the undersigned, Lisa M. Nowell, Notary Public in and for the State of South Carolina, do hereby certify that the foregoing deposition was taken on the 30th day of October, 2007;

That the within deponent was sworn to tell the truth and that the foregoing is an accurate transcription of the testimony taken under oath;

I further certify that I am neither Counsel nor Solicitor to any of the parties in said suit, nor interested in the event of the cause.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 15th day of November, 2007.

COPY

Lisa M. Nowell
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES 11/24/13.

A ability 3:13 18:11 20:11,11 28:12,13 about 3:6,17 6:19 9:5,7 10:2 11:7 14:25 17:11 18:15 20:3,11 20:17 21:19,21 24:10 25:13 27:10 28:12 29:7,20,21 30:14 31:10,25 32:4,14,15 33:6,15,16 37:2,10 37:13,14 accelerator 6:2,5 accept 29:1 accident 13:5 19:9 30:11 31:24 32:1,9 32:12 34:12 accommodate 3:11 accurate 39:8 acids 32:7 across 26:18 Actonel 16:19 actually 16:8 25:15 30:13 32:18 33:13 37:3 ADD 8:18,20 9:2,10,12 9:15 10:18 address 22:18 ADHD 8:20 9:2 adjust 27:20,22 36:1 admitted 7:18 affect 3:13 affected 7:23 affirmative 10:3,7 11:25 13:2 17:23 21:3 24:19 27:1 33:11 34:17 afford 25:2 after 3:18,19 8:11 20:9 21:14 28:9,11 32:12 afternoon 31:8,16,17 afterwards 28:10 again 7:7 34:18 age 4:3 ago 8:24 25:13 29:21 29:21 33:16 agreement 1:18 airway 35:14 Albuterol 15:14 alive 20:7 32:11 allows 21:7 almost 8:21,22 20:21 27:9 32:3,5 along 16:22 27:5 always 21:6 24:25 29:7 amino 32:7 AmLactin 17:12 Anderson 4:13 6:21 7:12 11:19 22:23 33:19,20 34:4,6,8 36:16,17	and/or 1:18 anesthesia 5:21,24 AnMed 5:8 36:18 another 10:24 28:17 answer 3:14 antibiotic 3:16 antibiotics 8:5,7 anxiety 30:20 anybody 10:20 25:9 29:8 anymore 15:15 16:2 anything 3:12 6:17 13:10 14:22 18:5 20:10 21:22 22:12 23:1,10 24:2,16 28:2 28:8,11 29:14 31:1 33:17 anyway 11:15 anywhere 24:3 33:7 apnea 13:15,18 35:6,9 APPEARANCES 2:3 35:17 appliance 13:12,14,22 35:17 appreciable 18:1 approve 14:3,6 approximate 4:19 approximately 14:11 22:21 Archie 1:5 4:2 arms 7:23 around 18:7,8 23:1 37:25 asked 11:22 37:13,13 asking 3:23 aspirate 35:11 assuming 26:9 assured 30:18 astute 3:22 ate 26:22 32:2,3,5 Atrovent 15:14,16 attacks 29:4,17 30:20 attend 33:19 attended 7:6 33:18 AutoCad 32:19 aware 3:22 away 21:10 29:16 awhile 17:4 A's 10:1 a.m. 1:20 38:7 B B 6:23 back 6:25 11:6 14:19 14:25 17:4,13,14 22:3 27:3,14 29:16 32:5,13,17 34:20 35:13 background 6:20 bad 3:15 12:24 16:22 16:24 19:23 20:15 23:6 33:5	bag 11:12 balancing 6:12 bandages 17:12 barely 31:3 bathroom 11:6 became 8:11 bed 31:9,10 before 1:1 3:11 8:20 19:9,14 22:6 28:2 31:24,24 34:11,15 begin 3:11 8:2 Behalf 2:7,11 being 2:14 12:4 14:18 35:7 38:6 belligerent 20:20 benefits 19:2,4 33:10 best 34:2 better 18:12,15,17 31:6 31:7,8 between 33:3 big 5:13 biggest 13:11,19 bill 13:19 bills 12:25 13:3 birth 4:5 bit 6:19 28:24 35:2 37:10 bite 32:6 bladder 11:2 12:21 blank 22:5 bled 11:14 bleeding 16:20 blood 17:15 28:16 29:25 blown 25:19 body 7:22,24 31:23,24 bone 5:11,12 17:1 bones 16:19,19,20 book 37:18 both 6:3 14:4 27:22 34:4 boy's 6:21 7:6,8,9,14 7:15 brain 28:20,21 29:12 29:13,20 30:1,2,10 30:11,17 brake 6:2,5 break 3:10 5:5 breaks 3:10 breath 14:22 23:17 breathing 14:16 29:23 35:10 Brett 10:5,6 25:21 bridge 26:15,17,18 Broad 2:9 broken 14:2 bronchial 8:4 21:8 brothers 9:3 10:18 build 23:19 burn 7:18 12:3 19:15 19:20 24:1	28:9 34:24,24 burned 7:25 8:1,12 13:13 17:16 burning 16:21,24 17:6 burns 7:22 12:24 butter 22:2 B's 10:1 B-R-E-T-T 10:5 C calendar 37:19 call 4:16 38:1 called 4:22 13:25 came 12:4 19:22 24:1 29:1 30:10 campus 36:18 cane 6:16 CANNON 1:25 capacity 14:21 car 6:4 24:5,7,14 25:1 25:1 care 5:6,7 14:4 23:3 25:24 27:4 Carolina 1:1,22,26 2:5 2:9,14 39:4,16 Carrier 1:14 cars 23:24,24 24:13 catheter 11:1,6,9,13 catheterization 12:4 cause 15:25 39:12 causing 16:14 32:25 caved 26:15,17 Celebrex 17:7 cells 28:16 center 21:14 centipede 25:15,18 CERTIFICATE 39:2 certify 39:4,10 challenging 18:4 change 20:24 changed 15:17,18 28:14 changes 31:21 charity 37:22 38:1 chauffeur 37:25 chemicals 29:13 chicken 32:4 children 9:5 Chisholm 26:6 choices 21:21,23 choose 18:19,22 Church 22:18 circumcised 11:10 city 22:23,24 Civil 2:15 Claimant 1:7 2:7 claustrophobic 33:3 close 6:10,12,14 clot 28:17 clothes 18:22 CMS 1:13	Colase 17:5 college 6:22,25 33:19 33:20,20,21 34:5,6 Comblivent 15:15,15 come 12:1 22:3 24:21 31:19 coming 14:17 commencing 1:19 COMMISSION 1:2 39:17 community 37:23 comp 13:9 compensating 6:9 COMPENSATION 1:2 complain 20:17 computer 32:20 concentrate 8:15 15:13 18:5,18,25 19:13,25 20:12 22:15 24:24 28:12 concentrating 10:22 19:17 21:15 28:23 concentration 8:14 16:12 17:22 18:11 19:1,13 27:17 32:21 35:18,22 concentration's 8:25 concluded 38:7 confused 10:8 21:25 30:14 confuses 22:5 consequence 7:21 12:2 considerably 20:13 constant 6:7 continuously 8:5 control 27:18 29:5,12 Corporation 1:9 correct 7:19 17:24 correspondence 22:11 costs 38:2 Counsel 39:10 couple 3:17,19 4:23 25:7,25 36:2 37:5 course 4:14 COURT 1:25 covering 10:14 creeps 25:18 crossed 26:15 crutch 6:16 current 3:6 curriculum 33:25 cut 16:3 17:21 18:2 23:4 25:15,20,21,25 C's 9:25 D dad 27:4 damage 28:18,20,22 29:20 30:8,17 date 4:5

zero 32:20 Zoloft 16:17				
1 1,120 15:24 1:00 31:2 10:43 1:20 100 16:17 11/24/13 39:17 11:00 31:10 11:44 38:7 112 1:25 1229 22:18 15th 39:14 150 16:16 1923 7:16 1961 7:16 1997 7:19				
2 20 21:13 200 2:9 2006 14:25 2007 1:20 39:6,14 232-9517 1:26 25 16:4,5 250 16:9 17:21 29601 1:22,26 2:5 29602 2:9				
3 3M 1:9 3:5 11:22 13:8 19:3 22:12 33:7 3rd 7:19 3/3 2:17 30th 1:20 39:5				
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8 864 1:26				
9 97 34:12 9708801 1:3				

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 9708801

EMPLOYEE/CLAIMANT: ARCHIE JONES

EMPLOYER: 3M (SPP/SMD)

INSURER: OLD REPUBLIC INSURANCE COMPANY

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

PURSUANT TO NOTICE OF WORKERS' COMPENSATION
HEARING, THE WITHIN HEARING WAS TAKEN ON THE 20TH DAY
OF NOVEMBER, 2007, COMMENCING AT THE HOUR OF 8:53 A.M.,
IN GREENVILLE, SOUTH CAROLINA, BEFORE THE HONORABLE J.
ALAN BASS, ATTENDED BY COUNSEL AS FOLLOWS:

CHRISTIAN FILES SIMPSON
VERBATIM REPORTER

DIXY MOORE TURNER ASSOC., INC.

836 SHORES BROOK DRIVE
SPARTANBURG, S.C. 29301-6515
864-574-1313

APPEARANCES

KATHRYN WILLIAMS, ESQUIRE, OF THE FIRM
KATHRYN WILLIAMS, P.A.
POST OFFICE BOX 10693
GREENVILLE, SOUTH CAROLINA 29603

ATTORNEY FOR THE CLAIMANT,

VERNON F. DUNBAR, ESQUIRE, OF THE FIRM
TURNER, PADGET, GRAHAM & LANEY, PA
POST OFFICE BOX 1 509
GREENVILLE, SOUTH CAROLINA 29603

ATTORNEY FOR THE EMPLOYER/INSURER.

ALSO ATTENDING: MR. ARCHIE JONES, CLAIMANT

I N D E X

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CERTIFICATE NOTARY PUBLIC.....	37

* RECORDED TAPES RETAINED FOR SIX (6) MONTHS FROM DATE
OF CERTIFICATION.

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PURSUANT TO NOTICE OF HEARING, THE WITHIN HEARING
WAS TAKEN BY THE ABOVE-NAMED COURT REPORTER, A NOTARY
PUBLIC FOR THE STATE OF SOUTH CAROLINA, IN GREENVILLE,
SOUTH CAROLINA.

(COURT REPORTER MARKS LETTER CLAIMANT'S EXHIBIT ONE,
RETAINED)

BY COMMISSIONER BASS:

THIS IS NOVEMBER 20TH, 2007. IT IS 8:53 IN THE
MORNING. THIS IS WCC FILE NUMBER 9708801. THIS IS
THE CLAIM OF ARCHIE JONES. MS. JONES IS PRESENT AND
REPRESENTED BY KATHRYN WILLIAMS. 3M IS THE
EMPLOYER. OLD REPUBLIC IS THE CARRIER. THEY ARE
REPRESENTED BY VERNON DUNBAR. THIS IS A 50/51
HEARING. PRIOR TO THE CALL OF THE HEARING A
PREHEARING CONFERENCE WAS HELD WITH THE ATTORNEYS.
AS A RESULT, THERE ARE A FEW THINGS I NEED TO PLACE
ON THE RECORD. FIRST OF ALL, THERE ARE NO STATED
OBJECTIONS TO JURISDICTION, VENUE, OR THE COMMISSION
FILE BEING MADE A PART OF THE RECORD WITH THE
EXCEPTION OF SELF-SERVING DECLARATIONS AND
UNSTIPULATED MEDICAL. I HAVE APA SUBMISSIONS FROM
BOTH SIDES. THERE ARE NO OBJECTIONS TO THE
DEFENDANTS' APAs. THE DEFENDANTS HAVE OBJECTIONS TO

1 THE FOLLOWING PAGES OF THE CLAIMANT'S APAs. THE
2 OBJECTION IS LACK OF TIMELINESS. THEY WERE FAXED TO
3 MR. DUNBAR YESTERDAY, 213 A AND B, 391 B, AND 583 A
4 AND B. THOSE ARE THE OBJECTIONS. LACK OF
5 TIMELINESS IS SUSTAINED. THE PARTIES STIPULATE TO
6 AN AVERAGE WEEKLY WAGE OF 675.89, COMP RATE 450.62.
7 THIS IS A DATE OF ACCIDENT, ADMITTED, JUNE 3RD,
8 1997. THE CLAIMANT ALLEGES INJURIES PRIMARILY DUE
9 TO BURNS EITHER DIRECTLY OR INDIRECTLY TO HIS ARMS,
10 HIS FEET, HIS LEGS, HIS TOES, HIS URINARY TRACT, HIS
11 LUNGS, PSYCHOLOGICAL OVERLAY, AND PHYSICAL BRAIN
12 INJURY. HE IS SEEKING A DETERMINATION OF
13 COMPENSABILITY OF THE DENIED BODY PARTS. HE ALLEGES
14 PERM TOTAL WITH PHYSICAL BRAIN INJURY, WHICH WOULD
15 ENTITLE HIM TO LIFETIME INDEMNITY AND LIFETIME
16 MEDICAL. THE DEFENDANTS ADMIT EVERYTHING OTHER THAN
17 THE PHYSICAL BRAIN INJURY AND THE E.D, WHICH I WOULD
18 ASSUME WOULD BE THE URINARY TRACT PROBLEMS. THE
19 DEFENDANTS ADMIT THE CLAIMANT IS PERMANENTLY AND
20 TOTALLY DISABLED AS A RESULT OF HIS ADMITTED
21 INJURIES. THEY CONTEND, HOWEVER, THAT BECAUSE OF
22 THE ABSENCE OF PHYSICAL BRAIN INJURY AND BECAUSE
23 THEY HAVE ALREADY PAID HIM 500 WEEKS OF INDEMNITY,
24 THE ONLY BENEFITS TO WHICH HE WOULD BE ENTITLED
25 WOULD BE MEDICAL TREATMENT FOR THE AFFECTED BODY

1 PARTS. THOSE ARE THE PRIMARY ISSUES. THERE IS AN
2 OUTSTANDING MOTION WHICH WAS, I GUESS, FILED
3 YESTERDAY THAT IS A MOTION TO COMPEL THE CLAIMANT'S
4 ATTENDANCE AT A NEUROPSYCHOLOGICAL APPOINTMENT. MR.
5 DUNBAR, I'LL LET YOU GO AHEAD AND MAKE THE ARGUMENT,
6 IF YOU WOULD, PLEASE.

7 BY MR. DUNBAR:

8 THANK YOU VERY MUCH, YOUR HONOR. WE HAD
9 NOTICED AN APPOINTMENT WITH DR. DAVID PRICE, A
10 NEUROPSYCHOLOGIST, IN ORDER TO COMBAT THE
11 NEUROPSYCHOLOGICAL EVALUATION OF DR. ROBERT MOSS.
12 UPON RECEIPT OF MS. WILLIAMS' APA SUBMISSIONS, WE
13 NOTED THAT DR. MOSS' REPORT WAS INCLUDED. PRIOR TO
14 RECEIPT OF HER APA SUBMISSIONS, WE HAD NO NOTICE
15 THAT DR. ROBERT MOSS WAS INVOLVED TO RENDER AN
16 OPINION ON CAUSATION INVOLVING A TRAUMATIC BRAIN
17 INJURY, AND AS A CONSEQUENCE WE PROMPTLY SCHEDULED
18 AN APPOINTMENT, WHICH WAS FOR NOVEMBER 15TH, 2007.
19 MS. WILLIAMS OBJECTED BY LETTER AND INFORMED ME THAT
20 SHE WOULD NOT PERMIT HER CLIENT TO SEE DR. DAVID
21 PRICE BECAUSE HE COULD NOT GET A REPORT TIMELY, AND,
22 THEREFORE, HE WOULD NOT ATTEND SUCH APPOINTMENT. WE
23 HAD ALSO SCHEDULED AN APPOINTMENT WITH A
24 NEUROLOGIST. THAT IS SCHEDULED FOR NOVEMBER 30TH,
25 2007. THE PRIMARY REASON WHY WE SCHEDULED THESE

1 APPOINTMENTS, IN LOOKING AT MS. WILLIAMS' FORM 50
2 AND ATTACHED DOCTORS, WE WERE OF THE OPINION THAT
3 THERE WAS NO MEDICAL EVIDENCE TO SUPPORT ANY
4 ALLEGATION THAT MR. JONES HAD SUSTAINED A TRAUMATIC
5 BRAIN INJURY. WE TOOK THE POSITION, YES, HE DID
6 HAVE SOME PSYCHIATRIC PROBLEMS AS A CONSEQUENCE
7 THEREOF. BUT WHEN YOU LOOK AT THE OBJECTIVE
8 DIAGNOSTIC TESTS, THAT BEING THE M.R.I., C.T. SCAN,
9 THE CLAIMANT IS UNABLE TO PROVE THAT HE SUFFERED A
10 TRAUMATIC BRAIN INJURY. THE C.T. SCAN, THE M.R.I.
11 SCANS THAT WERE TAKEN IN '97, '99, 2001, 2005, ALL
12 SHOW NO PHYSICAL DAMAGE. THEY ARE ALL NORMAL, ONLY
13 SHOW THAT THERE WAS PART OF A NORMAL AGING PROCESS.
14 THIS GENTLEMAN HAD T.I.A.s OR TRANSIENT ISCHEMIC
15 ATTACKS, ONE IN 2001 AND ONE IN 2005. AS A
16 CONSEQUENCE, M.R.I.s AND C.T. SCANS OF THE BRAIN
17 WERE TAKEN. A NEUROLOGIST OR RADIOLOGIST READ THOSE
18 M.R.I.s AND C.T. SCANS AS BEING NORMAL. THERE WAS
19 SOME LIGHT GRAY MATTER, BUT THAT WAS JUST PART OF
20 THE NORMAL AGING PROCESS. AS A CONSEQUENCE OF DR.
21 MOSS' REPORT, WE THOUGHT DUE PROCESS ENTITLED US TO
22 HAVE AN INDEPENDENT MEDICAL EVALUATION, PARTICULARLY
23 IF THE COMMISSION WERE TO AGREE TO ALLOW THAT REPORT
24 INTO EVIDENCE. THEN IF THEY GAVE IT ANY WEIGHT IT
25 WAS INCUMBENT UPON ME TO MAKE CERTAIN MY CLIENT GOT

1 THE BEST REPRESENTATION POSSIBLE IN TERMS OF PUTTING
2 THE EVIDENCE TO REFUTE A PHYSICAL BRAIN INJURY. WE
3 TAKE THE POSITION THAT IF HE DOES HAVE A BRAIN
4 INJURY, IT'S NOT PHYSICAL AND IT WOULD BE BEST
5 COMPENSATED UNDER REGULATION 11-01, WHICH HE'S
6 ALREADY BEEN COMPENSATED FOR BECAUSE HE HAS BEEN
7 DEEMED PERMANENTLY AND TOTALLY DISABLED. WE ALSO
8 TAKE THE POSITION THAT BECAUSE HE'S HAD TWO
9 INTERVENING STROKES THAT THIS COMMISSION WOULD
10 BENEFIT FROM ANOTHER NEUROLOGICAL EXAMINATION.
11 BECAUSE THIS ACCIDENT HAPPENED IN 1997 AND FOR THE
12 DELAY AND THE INTERVENING STROKES, I THINK THE
13 DOCTOR IN LACHES WOULD BE BEST ASSERTED IN THIS
14 PARTICULAR CASE.

15 BY COMMISSIONER BASS:

16 WHEN DID HE SUSTAIN THESE STROKES?

17 BY MR. DUNBAR:

18 THE FIRST ONE WAS IN 1999.

19 BY COMMISSIONER BASS:

20 WHEN WAS THE MOST RECENT STROKE THAT YOU THINK
21 MAY HAVE BEEN THE INTERVENING CAUSE OF HIS PROBLEMS?

22 BY MR. DUNBAR:

23 THERE WAS ONE IN 2005.

24 BY COMMISSIONER BASS:

25 OKAY, FAIR ENOUGH; ANYTHING ELSE?

1 BY MR. DUNBAR:

2 IT WAS CHARACTERIZED AS A T.I.A. ALSO, DR.
3 MOSS DOES NOT CORRELATE THE SLEEP APNEA THAT HE'S
4 BEEN DIAGNOSED WITH AS A PROXIMATE CAUSE FOR SOME OF
5 THE COGNITIVE IMPAIRMENTS THAT MR. JONES HAS
6 SUFFERED, AND THAT'S THE OTHER REASON WHY WE THINK A
7 NEUROLOGICAL EXAMINATION WOULD BE BENEFICIAL,
8 PARTICULARLY IF MY CLIENT WOULD HAVE TO PAY LIFETIME
9 BENEFITS AND LIFETIME INDEMNITY.

10 BY COMMISSIONER BASS:

11 I NOTE FROM READING THE FILE THAT A FORM 50 WAS
12 FIRST FILED BY THE CLAIMANT ON MAY 12TH, 1999, IN
13 WHICH HE DID NOT SEEK A HEARING, BUT IN THAT 50 HE
14 DID ALLEGE A BRAIN INJURY. I NOTE THAT SOME OF THE
15 MEDICAL RECORDS CONTAINED IN THE APAs INDICATE THAT
16 ONE OF HIS DOCTORS INDICATED THAT HE SUFFERED A
17 T.B.I., TRAUMATIC BRAIN INJURY, THOSE RECORDS BEING
18 FROM 1999. IT SOUNDS TO ME, MR. DUNBAR, AS IF
19 YOU'VE NOT BEEN SURPRISED BY AN ALLEGATION OF A
20 BRAIN INJURY. YOU JUST MADE THE JUDGMENT THAT THE
21 RECORD AS IT EXISTED PRIOR TO 15 DAYS AGO COULDN'T
22 PROVE IT.

23 BY MR. DUNBAR:

24 THAT IS CORRECT, YOUR HONOR, AND THAT IS OUR
25 POSITION. DR. RICHARDS' REPORT DOES MAKE THAT

1 ALLEGATION, BUT THE DIAGNOSTIC TESTS REFUTE THAT.

2 BY COMMISSIONER BASS:

3 I UNDERSTAND. OKAY, MS. WILLIAMS.

4 BY MS. WILLIAMS:

5 YOUR HONOR, OUR CONTENTION WOULD BE THAT THE
6 RECORDS WERE CLEAR BACK IN 1999 THAT HIS TREATING
7 PHYSICIANS THOUGHT THAT HE HAD A TRAUMATIC BRAIN
8 INJURY EARLIER WHEN HE WAS IN -- WHEN HE ARRESTED AT
9 MUSC.

10 BY COMMISSIONER BASS:

11 CLEAR OR NOT THE ISSUE WAS JOINED, WAS
12 ADDRESSED, WE'VE MENTIONED.

13 BY MS. WILLIAMS:

14 YES, SIR. YES, SIR, AND, IN FACT, IN 2000 THE
15 AUTHORIZED TREATING PSYCHIATRIST, DR. RICHARDS,
16 TRIED TO SCHEDULE A NEUROPSYCHOLOGICAL EVALUATION,
17 AND IT DID NOT GET DONE BECAUSE THE CARRIER WOULDN'T
18 AUTHORIZE IT. THE DEFENDANTS HAD ATTORNEYS IN THIS
19 CASE ALL ALONG. SO I THINK THEY'VE BEEN ON PLENTY
20 OF NOTICE THAT WE WERE ALLEGING A BRAIN INJURY AND
21 THAT THE TREATING PHYSICIANS BACKED IT UP, AND THERE
22 WAS NO ATTEMPT TO -- SINCE 2000 WHEN THE
23 PSYCHIATRIST RECOMMENDED AN NEUROPSYCH EVAL, THERE
24 HAS BEEN NO ATTEMPT BY THE DEFENDANTS TO SCHEDULE
25 ONE UNTIL SHORTLY BEFORE NOVEMBER 9TH, I THINK, WHEN

1 THE DATE OF MY LETTER WHEN I OBJECTED TO THE ONE
2 THAT WOULD NOT BE ---

3 BY COMMISSIONER BASS:

4 OKAY. MR. DUNBAR, ANYTHING IN REPLY?

5 BY MR. DUNBAR:

6 NOTHING IN REPLY, YOUR HONOR.

7 BY COMMISSIONER BASS:

8 OKAY. ALL RIGHT, BASED ON ARGUMENTS OF COUNSEL
9 AND THE CONTENTS OF THE RECORD IN ITS PRESENT STATE,
10 I'M GOING TO RESPECTFULLY DENY THE DEFENDANTS'
11 MOTION FOR THE FOLLOWING REASONS: IT IS CLEAR FROM
12 THE CONTENTS OF THE RECORD PRIMARILY COMMENCING WITH
13 THE FORM 50 THAT WAS FILED BY THE CLAIMANT --
14 UNREPRESENTED CLAIMANT AT THAT TIME IN MAY 1999 --
15 THAT HE WAS ALLEGING A BRAIN INJURY. AS EARLY AS
16 1999 ONE OF THE CLAIMANT'S TREATING PHYSICIANS WAS
17 OF THE OPINION THAT HE HAD SUFFERED A TRAUMATIC
18 BRAIN INJURY. FOR REASONS OF STRATEGY OR, I GUESS,
19 JUST A JUDGMENT CALL, THE DEFENDANTS DIDN'T BELIEVE
20 THAT THE RECORD IN THE STATE IT WAS IN UNTIL VERY
21 RECENTLY BELIEVED THAT THE CLAIMANT COULDN'T PROVE
22 THAT HE SUFFERED A TRAUMATIC BRAIN INJURY, AND AS A
23 RESULT OF THAT DECISION BY THE DEFENDANTS THEY CHOSE
24 TO DO NOTHING AS FAR AS EVALUATION IS CONCERNED.
25 THEY WERE FREE TO SEEK A NEUROPSYCHOLOGICAL

1 EVALUATION IF THEY CHOSE TO DO SO. THEY CHOSE NOT
2 TO DO SO UNTIL PRESENTED WITH DR. MOSS' REPORT IN
3 THE CLAIMANT'S APAs. AGAIN, THIS WAS A, I HESITATE
4 TO SAY CALCULATED DECISION ON THE DEFENDANTS' PART,
5 BUT IT WAS BASICALLY STRATEGY, I SUPPOSE, FOR LACK
6 OF A BETTER WAY TO PUT IT. THEY WERE NOT SURPRISED
7 BY THE ALLEGATION OF A PHYSICAL BRAIN INJURY JUST
8 PRIOR TO THE HEARING. THEY HAD KNOWN ABOUT IT FOR
9 SOME EIGHT YEARS. AND IT'S TRUE THAT DR. PRICE WAS
10 SUPPOSED TO SEE THE CLAIMANT ON NOVEMBER 15, 2007,
11 WHICH WOULD HAVE BEEN OUTSIDE THE TIME FRAME FOR THE
12 DEFENDANT TO HAVE PROVIDED APAs IN A TIMELY FASHION.
13 AND SO, FOR THOSE REASONS I RESPECTFULLY DENY THE
14 MOTION BOTH FOR A NEUROPSYCHOLOGICAL EVALUATION AND
15 THE NEUROLOGICAL EVALUATION. AGAIN, THESE STROKES
16 OR T.I.A.s THAT MR. DUNBAR MENTIONED THAT THEY THINK
17 MAY HAVE BEEN INTERVENING ACCIDENTS, THE LAST OF
18 THEM TOOK PLACE IN 2005. AGAIN, THIS WOULD HAVE
19 BEEN A STEP THAT WAS BETTER TAKEN A LONG TIME AGO.
20 ALL RIGHT, THAT BEING SAID IS THERE ANYTHING ELSE WE
21 NEED TO DO BEFORE WE BEGIN TESTIMONY, MS. WILLIAMS?

22 BY MS. WILLIAMS:

23 THE ONLY OTHER THING I WOULD DO IS PROFFER WHAT
24 I THINK YOU HAVE ALREADY RULED TO BE EXCLUDED FROM
25 THE APAs SINCE THEY ARE MERELY UPDATES FROM THE

1 AUTHORIZED TREATING PHYSICIANS.

2 BY COMMISSIONER BASS:

3 ALL RIGHT, THEY WILL BE MARKED AS PROFFERS, OR
4 AT LEAST I WON'T MARK THEM. I'M NOT GOING TO MAKE
5 THEM EXHIBITS. I'M JUST GOING TO MAKE IT CLEAR ON
6 THE FACE OF THOSE PAGES THAT THEY ARE EXCLUDED BUT
7 INCLUDED AS A PROFFER. LET ME DO THAT NOW BEFORE I
8 FORGET ABOUT IT. LET THE RECORD REFLECT THAT PAGES
9 213 A AND B, 391 B, AND 583 A AND B OF THE
10 CLAIMANT'S APAs HAVE BEEN EXCLUDED DUE TO THEIR LACK
11 OF TIMELINESS. I DO NOTE FOR THE RECORD THAT THESE
12 ARE RECENT RECORDS, AND I DON'T THINK THEY WERE
13 GENERATED BY A NEW PHYSICIAN. BUT, NEVERTHELESS,
14 THEY WEREN'T RECEIVED IN A TIMELY FASHION, AND THEY
15 ARE MARKED AS EXCLUDED BUT ALSO MARKED AS PROFFER
16 ONLY. ANYTHING FROM YOU, MR. DUNBAR?

17 BY MR. DUNBAR:

18 YES, YOUR HONOR. SEEING THAT MY MOTION HAS
19 BEEN DENIED, THERE IS ONE OTHER THING I NEED TO PUT
20 ON THE RECORD THAT DEALS WITH DR. ROBERT MOSS. I
21 WOULD MOVE TO EXCLUDE THE REPORT OF DR. MOSS ON THE
22 GROUNDS THAT A NEUROPSYCHOLOGIST OR PSYCHIATRIST
23 CANNOT DIAGNOSE A PHYSICAL BRAIN INJURY IN THAT THEY
24 CAN ONLY INTERPRET THE RESULTS OF A BRAIN INJURY, BE
25 IT FROM A STROKE OR FROM A PHYSICAL BRAIN INJURY, AND

1 THUS HIS REPORTS SHOULD BE EXCLUDED OR SHOULD NOT BE
2 GIVEN ANY WEIGHT.

3 BY COMMISSIONER BASS:

4 WHO SAYS THEY CAN'T?

5 BY MR. DUNBAR:

6 MS. WILLIAMS AND I WERE INVOLVED IN ANOTHER
7 SIMILAR CASE: MICHAEL CRISP. YOU MAY HAVE SAT IN ON
8 THE FULL COMMISSION PANEL. I CANNOT THINK OF THE
9 NEUROLOGIST'S NAME. HE THOUGHT THAT A NEUROLOGIST
10 WAS THE BEST PERSON TO INTERPRET OR TO DECIDE
11 WHETHER ---

12 BY COMMISSIONER BASS:

13 LET ME REPHRASE MY QUESTION. WHO IN THE RECORD
14 SAYS THAT THEY ---

15 BY MR. DUNBAR:

16 NO ONE SAYS THAT. THAT IS SIMPLY MY
17 MEDICAL/LEGAL ARGUMENT.

18 BY COMMISSIONER BASS:

19 OKAY, FAIR ENOUGH. MS. WILLIAMS.

20 BY MS. WILLIAMS:

21 YOUR HONOR, WELL, THAT NEUROLOGIST TESTIFIED
22 THAT HE ---

23 BY COMMISSIONER BASS:

24 LET'S GO OFF THE RECORD.

25 (OFF THE RECORD)

1 BY MS. WILLIAMS:

2 DR. MOSS IS A NEUROPSYCHOLOGIST. HE IS TRAINED
3 IN GIVING THESE NEUROPSYCHOLOGICAL TESTING. HE DOES
4 IT ALL THE TIME. HE DIAGNOSES, RULES IN OR RULES
5 OUT TRAUMATIC BRAIN INJURIES ALL THE TIME. AND NOT
6 ONLY THAT, HE'S ALSO BEEN DIAGNOSED WITH A TRAUMATIC
7 BRAIN INJURY BY HIS PSYCHIATRIST WHO IS A MEDICAL
8 DOCTOR.

9 BY COMMISSIONER BASS:

10 HE, MEANING THE CLAIMANT?

11 BY MS. WILLIAMS:

12 THE CLAIMANT. WHAT DID I SAY?

13 BY COMMISSIONER BASS:

14 I'M GOING TO RESPECTFULLY DENY YOUR MOTION.
15 I'LL READ THE REPORT AND GIVE IT THE WEIGHT IT
16 DESERVES. OKAY, THAT BEING SAID, WE'RE READY TO
17 BEGIN. MS. WILLIAMS, CALL YOUR FIRST WITNESS.

18 BY MS. WILLIAMS:

19 DERRELL JONES.

20 BY COMMISSIONER BASS:

21 MRS. JONES, RAISE YOUR RIGHT HAND, PLEASE.

22 * * * * *

23 THE WITNESS WAS DULY SWORN OR AFFIRMED TO TELL THE
24 TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH
25 CONCERNING THE MATTER HEREIN:

DERRELL JONES,

BEING FIRST DULY SWORN, TESTIFIED ON HER OATH AS FOLLOWS:

DIRECT EXAMINATION BY MS. WILLIAMS:

Q. DERRELL, HOW OLD IS EDDIE TODAY?

A. HE'S 64.

Q. HOW LONG HAVE YOU ALL BEEN MARRIED?

A. FORTY-FIVE YEARS.

Q. YOU'RE OBVIOUSLY VERY AWARE THAT HE WAS INVOLVED IN AN INJURY AT WORK ON JUNE 3RD OF 1997 AND HE WAS, I THINK, TAKEN TO GREENVILLE MEMORIAL AND THEN FLOWN TO MUSC TO THE BURN CENTER?

A. THAT'S CORRECT.

Q. AND HE WAS THERE SEVERAL MONTHS; IS THAT CORRECT?

A. YES.

Q. HAD EXTENSIVE BURNS ALL OVER HIS BODY?

A. YES, HE DID.

Q. DOES HE STILL HAVE SCARRING FROM THOSE BURNS TODAY?

A. TREMENDOUS SCARRING.

Q. DOES THE SCARRING CAUSE HIM PROBLEMS?

A. YES, ON HIS FEET.

Q. I WANT YOU TO TELL US, BECAUSE A LOT OF THIS IS IN THE MEDICAL RECORDS AND WE DON'T HAVE TO GO INTO EXTENSIVE DETAIL, BUT LET ME ASK YOU A QUESTION FIRST. WHILE HE WAS AT MUSC DID HE GO INTO RESPIRATORY ARREST?

1 BY COMMISSIONER BASS:

2 I NEED YOU TO SPEAK UP, PLEASE. I CAN'T HEAR
3 YOU.

4 WITNESS ANSWERS:

5 A. HE DID, YES.

6 DIRECT EXAMINATION RESUMED BY MS. WILLIAMS:

7 Q. AND WAS THERE DIFFICULTY GETTING HIM ENOUGH OXYGEN
8 DURING THAT TIME?

9 BY MR. DUNBAR:

10 OBJECTION, YOUR HONOR. I THINK THAT CALLS FOR
11 A MEDICAL CONCLUSION.

12 BY COMMISSIONER BASS:

13 SUSTAINED.

14 DIRECT EXAMINATION RESUMED BY MS. WILLIAMS:

15 Q. TELL US WHAT THE MAIN PROBLEMS ARE THAT HE'S HAVING
16 NOW AS A RESULT OF THE INJURIES, AND I'M TALKING
17 ABOUT FIRST FROM A PHYSICAL STANDPOINT.

18 A. WELL, FIRST FROM A PHYSICAL STANDPOINT?

19 Q. YES.

20 A. HE HAS PROBLEMS WITH HIS FEET. HE CANNOT WALK LONG
21 DISTANCES AND HAS PROBLEMS DOING ANY PROJECTS WHERE
22 HE HAS TO CLIMB A LADDER OR DO ANYTHING LIKE THAT.
23 HIS FEET ARE CONSTANTLY BREAKING DOWN. RIGHT NOW HE
24 HAS A BONE INFECTION IN HIS FOOT. WE ARE ADDRESSING
25 THAT. AND HE GOES TO WOUND CARE WITH THAT AND SEES

1 A SURGEON.

2 Q. YOU'RE TALKING ABOUT THE SKIN BREAKS DOWN?

3 A. YES, THE SKIN BREAKS DOWN, AND RIGHT NOW THE ONE
4 PLACE HAS BEEN ALL THE WAY TO THE BONE, AND THEY
5 HAVE HAD TO GO IN AND CUT SOME OF THE BONE OUT SO
6 THAT IT WOULD TRY -- IT WOULD FILL IN AND THE TISSUE
7 WOULD FILL IN. THEY'VE TRIED SEVERAL DIFFERENT
8 DRESSINGS ON IT, AND WE DRESS IT EVERY DAY. SOME
9 DAYS IT'S EVERY DAY IT'S BAD, BUT IT'S MORE. IT'S
10 GETTING WELL. BUT IT'S JUST ONE THING AFTER ANOTHER
11 WITH THIS. IT'S NOT -- AS WE'VE JUST -- YOU KNOW,
12 ARE CONSTANTLY NURSING A WOUND ON HIS FOOT.

13 Q. OKAY, WHAT ELSE LIMITS HIM?

14 A. LIMITS HIM?

15 Q. YES.

16 A. WELL, HIS -- HIS LUNGS LIMIT HIM AS FAR AS HIS
17 STAMINA AND DOING THINGS. HE'S NOT FEELING WELL
18 RIGHT NOW. HE'S NOT BREATHING WELL. AND I CAN TELL
19 WHEN HE'S NOT FEELING WELL AND HE'S NOT DOING WELL.
20 'CAUSE HIS FACE GETS VERY PUFFY AND HE'LL -- YOU
21 KNOW, HE'LL SIGH A LOT, AND HE -- I CAN JUST TELL
22 THAT, YOU KNOW. AND HE'LL SAY, "I'M JUST NOT
23 BREATHING WELL TODAY." HE HAS A VERY GOOD ATTITUDE.
24 HE DOESN'T REALLY COMPLAIN. HE DOESN'T FEEL SORRY
25 FOR HIMSELF, BUT -- AND HE DOESN'T REALLY BLAME

1 ANYBODY FOR THIS, BUT HE'S -- HE'S JUST NOT WHAT HE
2 SHOULD BE.

3 Q. OKAY. DID HE SUSTAIN A LOT OF DAMAGE TO HIS LUNGS?
4 A. HE DID. I THINK HE -- HE ONLY HAS -- HE INHALED THE
5 VAPORS OFF OF THIS OIL, AND HE ONLY HAS AROUND 45
6 PERCENT, I THINK, LUNG CAPACITY.

7 Q. AND HE'S BEING TREATED FOR ALL THOSE PROBLEMS?
8 A. YES, HE IS, EVEN THE PLACES WHERE THEY TOOK GRAFTS,
9 TOOK THE SKIN FOR HIS GRAFTS. I MEAN, HE HAS ALMOST
10 NO INTERRUPTED (SIC) SKIN.

11 Q. ALL OVER HIS BODY?
12 A. ALL OVER HIS BODY, YEAH. WHERE THEY TOOK SKIN,
13 THOSE PLACES BOTHER HIM. HE HAS TO CONSTANTLY KEEP
14 LOTION ON THEM. YOU KNOW, IT'S LIKE A SECOND DEGREE
15 BURN, BUT HE HAS TO KEEP STUFF ON HIM ALL THE TIME.
16 BUT HIS BACK, HIS ARMS, PLACES WHERE THEY TOOK SKIN
17 ARE JUST AS IRRITATING TO HIM AS THE ACTUAL SCARS.

18 Q. DOES HE HAVE PROBLEMS WITH THE MOBILITY OF HIS HANDS
19 BECAUSE OF THE SCARS?
20 A. HE DOES. YOU CAN SEE HIS HANDS AND THE SCARRING ON
21 HIS HANDS. I THINK HE DOES WELL. THEY OPERATED ON
22 HIS LITTLE FINGER HERE THAT WAS CURLED AND
23 STRAIGHTENED IT OUT, BUT HIS -- YOU KNOW, HE SEEMS
24 TO BE PRETTY AGILE WITH HIS HANDS, BUT...
25 Q. BUT IT'S MORE LIMITED THAN IT WAS?

1 A. OH, YEAH, YEAH.

2 Q. NOW, I'M GOING TO ASK YOU ABOUT SOMETHING THAT'S A

3 LITTLE BIT MORE PERSONAL. HE HAD PROBLEMS FROM

4 HAVING A CATHETER IN FOR SO LONG, IS THAT RIGHT?

5 A. YES, HE DID.

6 Q. AND THEN THERE WAS AN ACCIDENT THAT HE HAD WITH ONE?

7 A. YES.

8 Q. HE STEPPED ON IT?

9 A. YES.

10 Q. THAT CAUSED HIM A LOT OF PROBLEMS?

11 A. RIGHT.

12 Q. SINCE THAT TIME HAS HE HAD URINARY PROBLEMS?

13 A. URINARY TRACT PROBLEMS?

14 Q. URINARY TRACT PROBLEMS.

15 A. YES, GETTING UP ALL DURING THE NIGHT, AND HE -- JUST

16 HAVING PROBLEMS CONTROL -- WITH CONTROL.

17 Q. HAS HE ALSO HAD PROBLEMS WITH ERECTILE DYSFUNCTION

18 SINCE THEN?

19 A. YES, HE HAS. YES.

20 Q. FROM A PHYSICAL STANDPOINT WHAT WAS HE LIKE BEFORE

21 THIS ACCIDENT?

22 A. HE WAS THE PICTURE OF HEALTH. HE WAS A BODYBUILDER.

23 HE -- HE JUST THOUGHT ABOUT HIS HEALTH ALL THE TIME

24 AND WORKED ON HIS HEALTH. I THINK, JUST MY OPINION

25 IS THAT THE REASON THAT HE SURVIVED THIS IS BECAUSE

1 HE WAS SO HEALTHY. HE WAS JUST A PERFECT SPECIMEN.

2 Q. DID HE WORK OUT A LOT?

3 A. HE WORKED OUT ALL THE TIME. NOW HE CAN'T. HIS

4 LUNGS WON'T LET HIM. WE'VE TRIED. I'VE GONE WITH

5 HIM. WE'VE TRIED, AND HIS LUNGS WON'T LET HIM DO

6 THIS.

7 Q. AND I BELIEVE HE WAS A VEGETARIAN?

8 A. HE WAS A VEGETARIAN. HE DID NOT EAT MEAT. HE WAS

9 -- HE JUST ATE THINGS THAT WERE HEALTHY. I TRY TO

10 GO WALK NOW, AND HE TRIES TO WALK WITH ME, AND HE

11 CAN'T KEEP UP WITH ME. HE'S JUST -- IT'S JUST --

12 IT'S SO -- IT'S LIKE NIGHT AND DAY.

13 Q. OKAY, ALL RIGHT. HAVE THE PROBLEMS THAT HE'S HAVING

14 NOW FROM A PHYSICAL STANDPOINT CAUSED HIM PROBLEMS

15 EMOTIONALLY AND THE PROBLEMS FROM BEING IN THE

16 INJURY?

17 A. I THINK SO, YES.

18 Q. AND HE'S BEEN SEEING DR. RICHARDS FOR THAT FOR A

19 LONG TIME?

20 A. OH, YES, A LONG TIME.

21 Q. DID HE EVER HAVE ANY EMOTIONAL PROBLEMS BEFORE, ANY

22 PROBLEMS WITH DEPRESSION, ANYTHING LIKE THAT?

23 A. NO, NO.

24 Q. ANY PROBLEMS WITH ANXIETY?

25 A. NO.

1 Q. OKAY. HAVE YOU NOTICED A DIFFERENCE IN TERMS OF HIS
2 COGNITIVE ABILITIES, HIS ABILITY TO REMEMBER THINGS,
3 HIS ABILITY TO ORGANIZE? TELL US WHAT HE WAS LIKE
4 BEFORE THE ACCIDENT.

5 A. WELL, I'LL TELL YOU WHAT HE DID YESTERDAY. WE WERE
6 AT YOUR OFFICE, AND HE HAD ALREADY READ THE LETTER
7 ABOUT COMING OVER HERE AND THE TIME AND EVERYTHING.
8 YOU TOLD HIM THE TIME. I TOLD HIM THE TIME, AND
9 THEN LAST NIGHT HE ARGUED THAT WE WERE SUPPOSED TO
10 BE HERE AT 7:30. HE -- HE HAS PROBLEMS RECALLING
11 THINGS. HE STAMMERS, AND HE RAMBLES WHEN HE TALKS.
12 HE CLOSES HIS EYES FOR LONG PERIODS OF TIMES -- TIME
13 WHEN HE'S TALKING, AND HE GETS OFF OF THE SUBJECT,
14 AND HE JUST -- HE WAS ALWAYS REALLY, REALLY SHARP
15 AND VERY SMART. HE COULD REMEMBER THINGS. HE -- HE
16 COULD REMEMBER THINGS THAT -- JUST VERY, VERY SMART.
17 I'M TALKING ABOUT FACTS AS FAR AS SCIENCE AND
18 GEOGRAPHY AND ALL THIS KIND OF STUFF. HE WAS JUST
19 VERY SMART, AND ALL HE HAD TO DO WAS READ IT ONE
20 TIME, AND HE HAD IT. NOW HE HAS A HARD TIME READING
21 ANYTHING AND UNDERSTANDING IT. HE'LL HAVE TO GO
22 BACK AND GO OVER IT AND GO OVER IT AGAIN. I HANDLE
23 ALL THE FINANCIAL NOW. HE WILL NOT AND CANNOT MAKE
24 MANY DECISIONS. HE HAS A HARD TIME MAKING DECISIONS
25 AND COMMITMENTS. WHEN WE'RE ASKED TO DO THINGS OR

1 WE'RE HAVING TO MAKE DECISIONS ABOUT ANYTHING THAT'S
2 IMPORTANT, IT'S ALL LEFT UP TO ME 'CAUSE HE WON'T
3 COMMIT AND HE WON'T MAKE A DECISION, AND IT'S JUST
4 -- IT'S JUST VERY HARD.

5 Q. AND WHEN DID YOU FIRST NOTICE ALL THIS AFTER THE
6 ACCIDENT?

7 A. OH, IT WAS IMMEDIATE.

8 BY MS. WILLIAMS:

9 THAT'S ALL THE QUESTIONS I HAVE.

10 BY COMMISSIONER BASS:

11 MR. DUNBAR?

12 CROSS EXAMINATION BY MR. DUNBAR:

13 Q. MRS. JONES, YOU INDICATED THAT YOUR HUSBAND IS NOT
14 FEELING WELL TODAY. IS HE ABLE TO TESTIFY, OR DO
15 YOU THINK HE HAS THE ABILITY?

16 A. I THINK HE -- I THINK HE CAN. HE MIGHT -- YOU MIGHT
17 NOT UNDERSTAND A LOT OF WHAT HE SAYS. HE'LL DO LIKE
18 HE DID THE OTHER DAY WHEN YOU TALKED WITH HIM.
19 HE'LL RAMBLE.

20 Q. WHEN I TOOK HIS DEPOSITION?

21 A. MM-HMM. (AFFIRMATIVE RESPONSE)

22 Q. IT'S MY UNDERSTANDING AS A CONSEQUENCE OF THIS
23 UNFORTUNATE BURN HE TAKES A HOST OF MEDICATIONS.

24 A. HE DOES.

25 Q. AS A MATTER OF FACT, THERE'S A LIST OF MORE THAN 20

1 MEDICATIONS, AND HE REMEMBERED WHAT THE MEDICATIONS
2 WERE FOR. DID HE NOT GO THROUGH ---

3 A. HE KEEPS -- HE KEEPS A LIST. IF HE DOESN'T WRITE
4 THIS DOWN -- AND THIS IS ONE THING THAT I DON'T HELP
5 HIM WITH. HE WRITES IT ALL DOWN, AND HE KEEPS -- HE
6 PUTS IT IN THE COMPUTER. HE WRITES ON HIS
7 MEDICATION BOTTLES WHEN TO TAKE THEM, HOW TO TAKE
8 THEM. THIS IS REALLY THE ONLY THING THAT HE KEEPS
9 UP WITH AS FAR AS ANYTHING THAT I THINK WOULD BE
10 HARD TO DO. HE -- HE KEEPS UP WITH THAT, BUT HE --
11 HE WRITES IT ALL DOWN, AND THAT IS BASICALLY WHAT HE
12 DOES.

13 Q. AND YOU DON'T HAVE TO DISPENSE HIS MEDICATIONS FOR
14 HIM; HE'S ABLE TO DO THAT ON HIS OWN?

15 A. NO, I DON'T. HE TAKES HIS LITTLE DISPENSERS AS FAR
16 AS OUT BY DAY AND PUTS THEM IN THERE. IT TAKES
17 FOREVER, BUT HE DOES IT. I LET HIM DO ANYTHING HE
18 CAN DO.

19 Q. CERTAINLY, AND SOME OF THE MEDICATIONS HE TAKES MORE
20 THAN ONE TIME PER DAY; IS THAT CORRECT?

21 A. I HAVE NO IDEA. HE KEEPS UP WITH THAT.

22 Q. OKAY, AND HE DOES STILL DRIVE; DOES HE NOT?

23 A. HE DOES.

24 Q. OKAY, AND HE DOES GO GROCERY SHOPPING ON OCCASION?

25 A. ON OCCASION. HE HAS A HARD TIME IN THE GROCERY

1 STORES WALKING AROUND BECAUSE THE FLOORS ARE SO
2 HARD. AND HE HAS A HARD TIME ON OUR DRIVEWAY, YOU
3 KNOW, THINGS LIKE THAT.
4 Q. AS A MATTER OF FACT, HE TESTIFIED IN HIS DEPOSITION
5 THAT YOU RECENTLY DROVE TO MINNESOTA. HE DROVE?
6 A. YEAH.
7 Q. AND YOU ALL HELPED A FRIEND MOVE BACK TO SOUTH
8 CAROLINA, CORRECT?
9 A. MM-HMM (AFFIRMATIVE RESPONSE), BUT WE DIDN'T DO THE
10 ACTUAL MOVING.
11 Q. SURE.
12 A. HE DIDN'T DRIVE ALL THAT WAY.
13 Q. RIGHT, BUT HE TESTIFIED ---
14 A. HE DROVE SOME.
15 Q. --- HE DROVE ABOUT EIGHT HOURS?
16 A. MAYBE.
17 Q. WAS ABLE TO CONCENTRATE ON AN INTERSTATE HIGHWAY
18 GOING AT LEAST 60 MILES AN HOUR?
19 A. AND THIS WASN'T ALL IN ONE STRETCH, YOU UNDERSTAND.
20 Q. I UNDERSTAND, BUT YOU FELT COMFORTABLE WITH HIM
21 BEHIND THE WHEEL DRIVING?
22 A. AT THAT TIME. NOT AT FIRST WHEN HE FIRST CAME HOME.
23 HE -- HE WAS TRYING TO DRIVE TO GREENVILLE, YOU
24 KNOW, WHEN THEY TRIED TO GET HIM BACK TO WORK, AND
25 HE WAS TRYING TO DRIVE TO GREENVILLE, AND IT WAS

1 TERRIBLE THEN. BUT HE'S -- HE'S GOTTEN BETTER.

2 Q. SURE.

3 A. HE DRIVES NOW.

4 Q. AND WHEN DID YOU DRIVE TO MINNESOTA? WHEN DID MR.

5 JONES DRIVE TO MINNESOTA?

6 A. I DON'T KNOW.

7 Q. WITHIN THE PAST TWO YEARS?

8 A. YES.

9 Q. OKAY, AND THAT WAS ABOUT A 20-HOUR DRIVE, CORRECT?

10 A. MM-HMM (AFFIRMATIVE RESPONSE). WE STOPPED ---

11 BY COMMISSIONER BASS:

12 SAY YES OR NO, PLEASE.

13 WITNESS RESUMES:

14 A. YES. WE STOPPED TWICE AND SPENT THE NIGHT SO THAT

15 WE WOULDN'T BE SO TIRED.

16 CROSS EXAMINATION RESUMED BY MR. DUNBAR:

17 Q. CERTAINLY.

18 A. AND WE STOPPED TWICE, AND ON THE WAY BACK WE STOPPED

19 TWICE.

20 Q. HE TALKED ABOUT TEACHING HIS NIECE, TUTORING HER; DO

21 YOU RECALL THAT?

22 A. YEAH, HE HELPED HER.

23 Q. AND WHAT SUBJECTS DID HE HELP HER IN?

24 A. I THINK PHYSICAL SCIENCE, BUT HE -- HE STUDIED ALL

25 THAT AND SAT RIGHT THERE WITH THE BOOK AND HELPED

1 HER WITH THAT. HE ACTUALLY WENT INTO TOO MUCH
2 DETAIL. I DON'T KNOW HOW MUCH IT HELPED HER BECAUSE
3 HE WAS SO -- HE'S OBSESSIVE WHEN HE GETS ON
4 ANYTHING. HE'S OBSESSIVE WITH IT, BUT THEN HE
5 TRAILS OFF, AND HE LOSES INTEREST.

6 Q. SURELY. NOW, WHAT GRADE IS PHYSICAL SCIENCE; IS
7 THAT A NINTH GRADE SUBJECT? IS SHE IN THE NINTH
8 GRADE?

9 A. I DON'T REMEMBER WHAT YEAR THAT WAS. I THINK IT WAS
10 THE NINTH GRADE.

11 Q. OKAY, AND NOW IT'S MY UNDERSTANDING HE DOES SOME
12 THINGS AROUND THE HOUSE. AS A MATTER OF FACT, WHEN
13 HE HURT HIS KNEE, HE WAS CRAWLING TRYING TO DO SOME
14 PLUMBING WORK?

15 A. YEAH, HE DOES ANYTHING THAT HE CAN, AND I ENCOURAGE
16 HIM TO DO THAT. BUT USUALLY WHEN HE DOES THESE
17 THINGS HE PAYS FOR IT, YOU KNOW.

18 Q.. SURE, AND HE HAS ---

19 BY COMMISSIONER BASS:

20 IN WHAT WAY, MA'AM.

21 WITNESS RESUMES:

22 A. IN WHAT WAY, HE'LL HAVE LUNG PROBLEMS, OR HE'LL HURT
23 HIS FOOT AND MAKE HIS FEET VERY SORE AND WON'T BE
24 ABLE TO WALK FOR VERY WELL FOR A COUPLE OF WEEKS,
25 AND HE'LL BE IN THE BED JUST, YOU KNOW, RESTING HIS

1 FEET AND TRYING TO GET THEM BACK TO WHERE THEY WERE.
2 HE INJURES HIMSELF A LOT AS FAR AS -- HE'LL TRY TO
3 WORK ON HIS CARS, AND HE HITS -- YOU CAN SEE HOW
4 BRUISED UP HE IS. HE HITS HIS HANDS AND JUST STAYS
5 WITH CONSTANT BRUISES AND BAND-AIDS ON HIM, AND HE
6 -- HE'S JUST -- HE WAS A MECHANIC. HE'S BEEN A
7 MECHANIC ALL HIS LIFE AND KNEW WHAT HE WAS DOING.
8 HE USED TO WORK ON HEAVY EQUIPMENT WHEN HE WAS YOUNG
9 WITH CONSTRUCTION AND THEN WENT ON TO -- TO DO IRON
10 WORK AND THAT KIND OF STUFF AND WELDING AND USED TO,
11 YOU KNOW, BE UP IN THE AIR WELDING, AN IRONWORKER,
12 AND THAT KIND OF THING. MY GOODNESS, AND HE -- I
13 WOULDN'T WANT HIM TO GET ON THE ROOF NOW. HE HAS
14 TRIED AND GOTTEN UP THERE AND SCARED ME TO DEATH.

15 CROSS EXAMINATION RESUMED BY MR. DUNBAR:

16 Q. NOW, HE STILL TINKERS ON HIS OLD CARS; DOES HE NOT?

17 A. HE DOES.

18 Q. HOW OFTEN DOES HE GO OUT ON THE WEEKENDS?

19 A. NOT VERY -- HIS OLD CARS HE RARELY EVER TOUCHES.

20 HE'S PRETTY MUCH LOST INTEREST IN THOSE THINGS. HE
21 DID FOR A WHILE GO BACK AND FORTH WITH A FRIEND
22 TRYING TO WORK ON HIS CAR, BUT HE NEVER TAKES IT ON
23 HIMSELF TO WORK ON HIS OLD CARS. HE ALWAYS HAS TO
24 HAVE SOMEBODY WITH HIM. HE HAD THAT INTEREST
25 BEFORE. HE HAD BELONGED TO A CAR CLUB. HE NO

1 LONGER IS INTO THAT. ALL OF HIS CAR FRIENDS, HE NO
2 LONGER GOES TO THOSE MEETINGS. HE NO LONGER
3 SOCIALIZES WITH THOSE PEOPLE. HE ONLY HAS ONE
4 FRIEND FROM THAT GROUP THAT HE TALKS WITH NOW. ALL
5 OF THAT'S GONE.

6 Q. NOW, HE'S BEEN DIAGNOSED WITH ADULT ONSET OF A.D.D.?

7 A. I THINK SO.

8 Q. NOW, YOUR SON ALSO HAS BEEN DIAGNOSED WITH A.D.D.?

9 A. YES. HE'S ALWAYS HAD IT.

10 Q. AND HE HAD IT AS A TEENAGER?

11 A. HE HAD IT ALL -- HE -- BRETT WAS BORN WITH THE CORD
12 AROUND HIS NECK, AND HE -- HE WAS NOT -- HE WAS A
13 BIG BABY, BUT HE WAS IN AN ISOLETTE FOR A WEEK, AND
14 HE -- HE -- THE CORD WAS AROUND HIS NECK, AND HE WAS
15 NOT GETTING ENOUGH OXYGEN. HE WAS PURPLE WHEN HE
16 WAS BORN, AND THEY THINK THAT'S WHERE THAT CAME
17 FROM.

18 Q. OKAY. NOW, IT'S MY UNDERSTANDING THAT AFTER THIS
19 ACCIDENT YOUR HUSBAND RETURNED TO WORK FOR A
20 SUBSTANTIAL PERIOD OF TIME?

21 A. ABOUT EIGHT MONTHS, I THINK.

22 Q. YES, WORKED EIGHT HOURS A DAY OR SEVEN HOURS A DAY?

23 A. HE TRIED.

24 Q. CERTAINLY.

25 A. HE TRIED. I MEAN, IT WAS VERY HARD FOR HIM TO GET

1 UP IN THE MORNING AND TRY TO DRIVE TO GREENVILLE ON
2 THE INTERSTATE.

3 Q. AND WHERE DO YOU ALL LIVE?

4 A. WE LIVE IN ANDERSON, AND IT WAS VERY DIFFICULT, AND
5 HE DID NOT HAVE THE STAMINA TO STAY ON THIS JOB.
6 AND THEY PUT HIM IN A PLACE WHERE -- I MEAN, THEY
7 PUT HIM ON A COMPUTER, WHICH HE HAD NO KNOWLEDGE OF
8 WHATSOEVER. THEY TRIED TO TRAIN HIM IN AUDOCAT IN
9 THREE WEEKS, AND HE COULD NOT ABSORB THAT. HE WOULD
10 COME HOME VERY UPSET OVER THAT. THEY PUT HIM IN AN
11 AREA WHERE HE HAD TO WORK WITH PEOPLE COMING IN AND
12 OUT ALL AROUND HIM, DISTRACTING HIM, PEOPLE TALKING
13 TO HIM ALL DAY LONG, AND HE WAS VERY DISTRACTED.
14 AND I WENT IN OVER THERE A COUPLE OF TIMES, AND HE
15 WAS -- HE WAS -- HE WAS STUCK RIGHT IN THE MIDDLE
16 WHERE PEOPLE CAME IN AND OUT HAVING THEIR BREAKS,
17 GETTING COFFEE AND STUFF LIKE THAT. I MEAN, WITH
18 HIS PROBLEM HE SHOULD'VE BEEN OFF IN A ROOM ALONE IF
19 THEY WERE EXPECTING HIM TO PERFORM THE WAY THEY
20 WANTED HIM TO.

21 Q. NOW, IT'S MY UNDERSTANDING BECAUSE OF THE SEVERE
22 BURNS HE'S HAD A LOT OF PROBLEMS WITH HIS FEET?

23 A. THAT'S RIGHT.

24 Q. AND THE JOB AT 3M REQUIRED HIM TO STAND, DO SOME
25 WALKING?

- 1 A. THE JOB THAT HE FORMERLY HAD ---
- 2 Q. YES, MA'AM.
- 3 A. --- AS FAR AS THE MAINTENANCE WITH THEM?
- 4 Q. THAT'S CORRECT.
- 5 A. OH, YES, HE WOULD HAVE TO GO UP AND DOWN STAIRS AND
- 6 DO A LOT OF CRAWLING UNDER, BENDING, STOOPING, THAT
- 7 KIND OF THING.
- 8 Q. NOW, IT'S MY UNDERSTANDING HE LATER LEFT WORK AND
- 9 RECEIVED WORKER'S COMPENSATION BENEFITS?
- 10 A. YES.
- 11 Q. AND HE ALSO STARTED RECEIVING SOCIAL SECURITY
- 12 DISABILITY?
- 13 A. THAT'S CORRECT.
- 14 Q. HE WAS RECEIVING SOCIAL SECURITY DISABILITY BECAUSE
- 15 OF HIS LEG PROBLEMS AND BURN PROBLEMS AND LUNG
- 16 PROBLEMS; WOULD THAT BE ACCURATE?
- 17 A. YES.
- 18 Q. NOW, DO YOU WORK?
- 19 A. I DO.
- 20 Q. HOW MANY HOURS A WEEK?
- 21 A. I WORK 30 HOURS A WEEK.
- 22 Q. THIRTY HOURS A WEEK. I KNOW YOUR SON JUST MOVED IN
- 23 YOUR HOME, BUT BEFORE YOUR SON MOVED IN WOULD HE BE
- 24 AT HOME BY HIMSELF?
- 25 A. OH, YEAH.

1 BY COMMISSIONER BASS:

2 TALKING ABOUT HE, MEANING HER HUSBAND?

3 BY MR. DUNBAR:

4 YES, COMMISSIONER.

5 WITNESS RESUMES:

6 A. YES, YES.

7 CROSS EXAMINATION RESUMED BY MR. DUNBAR:

8 Q. AND THAT'S WHEN HE WOULD TINKER ON CARS AND DO
9 THINGS AROUND THE HOUSE WHILE YOU WERE AT WORK?

10 A. HE WOULD -- HE DIDN'T DO MUCH OF THAT. HE -- HE
11 MOSTLY STAYED IN THE HOUSE. HE MOSTLY STAYS IN THE
12 HOUSE NOW, BUT HE GOES OUT, AND HE'LL HELP BRETT
13 WITH THINGS. IF OUR CAR -- IF HIS TRUCK BREAKS
14 DOWN, HE GOES OUT, AND HE'LL WORK ON IT FOR A WHILE.
15 SOMETIMES HE PUSHES IT, AND HE'LL TRY TO WORK ON
16 SOMETHING FOR TWO OR THREE DAYS AT A TIME, AND THEN
17 HE'S SICK FOR THE LONGEST TIME.

18 Q. YOUR SON, BRETT, DOES HE WORK?

19 A. BRETT DOESN'T HAVE A JOB RIGHT NOW. HE JUST LEFT
20 HIS JOB IN GREER AND MOVED TO ANDERSON, SOLD HIS
21 HOUSE AND MOVED TO ANDERSON, AND HE'S WITH US RIGHT
22 NOW. HE'S LOOKING FOR A JOB.

23 Q. THAT'S A RECENT DEVELOPMENT?

24 A. OH, YES, IT JUST HAPPENED OCTOBER THE 4TH.

25 BY MR. DUNBAR:

1 OKAY, MA'AM, THANK YOU. I HAVE NO FURTHER
2 QUESTIONS.

3 BY COMMISSIONER BASS:

4 REDIRECT?

5 BY MS. WILLIAMS:

6 NOTHING.

7 BY COMMISSIONER BASS:

8 OKAY, ANY OTHER WITNESSES?

9 BY MS. WILLIAMS:

10 NO, SIR.

11 BY COMMISSIONER BASS:

12 ANY WITNESSES FROM THE DEFENSE?

13 BY MR. DUNBAR:

14 I COULD CALL MR. JONES, OR I COULD GIVE YOU HIS
15 DEPOSITION. IT'S UP TO MS. WILLIAMS, IF HE'S NOT
16 ABLE.

17 BY COMMISSIONER BASS:

18 LET'S TAKE A SHORT BREAK.

19 (OFF THE RECORD)

20 CROSS EXAMINATION RESUMED BY MR. DUNBAR:

21 Q. I JUST WANT TO ASK YOU, MRS. JONES, ONE MORE
22 QUESTION. IN 2001 AND 2005 HE HAD SOMETHING AKIN TO
23 A STROKE?

24 A. MM-HMM (AFFIRMATIVE RESPONSE). I DON'T -- I DON'T
25 REMEMBER THE 2005 THING. YOU DO? OKAY. OKAY, I

1 MEAN, HE -- HE DID -- HE HAS HAD SOME THINGS THAT
2 WERE LIKE THAT, BUT HE SAYS THAT HE DID, AND WE DID
3 -- WE DID FOLLOW UP ON SOMETHING THAT HAPPENED THEN,
4 SO...

5 Q. SO HE HAD THOSE STROKES. DID HE GET WORSE AFTER
6 HAVING THOSE STROKES, OR DID HIS CONDITION REMAIN
7 THE SAME FROM A MENTAL STANDPOINT?

8 A. HE DIDN'T GET WORSE.

9 Q. PARDON ME?

10 A. NO, HE DIDN'T GET WORSE.

11 BY MR. DUNBAR:

12 NO FURTHER QUESTIONS.

13 BY COMMISSIONER BASS:

14 OKAY. AT THIS POINT, DO YOU WANT TO PUT THE
15 CLAIMANT'S DEPOSITION IN?

16 BY MR. DUNBAR:

17 YES, YOUR HONOR, AND I LEFT THE ORIGINAL IN THE
18 OTHER STACK I TOLD YOU IN MY HASTE TO GET HERE.

19 BY COMMISSIONER BASS:

20 A COPY IS FINE, IF YOU'VE GOT A COPY. HAVE YOU
21 GOT A COPY? AND THIS WOULD BE IN LIEU OF YOUR
22 CALLING HIM?

23 BY MR. DUNBAR:

24 THAT'S CORRECT.

25 BY COMMISSIONER BASS:

1 MS. WILLIAMS, DO YOU HAVE ANY OBJECTIONS UNDER
2 THOSE CIRCUMSTANCES?

3 BY MS. WILLIAMS:

4 NO, SIR.

5 BY MR. DUNBAR:

6 I HAVE ANOTHER ONE HERE AT 10:15, SO I CAN
7 BRING IT BACK THEN. I'LL BRING THE ORIGINAL BACK
8 THEN.

9 BY COMMISSIONER BASS:

10 OKAY, THAT'S FINE. ALL RIGHT, THAT WILL BE
11 DEFENDANTS' ONE, THEN. WE'LL MARK THAT AS
12 DEFENDANTS' ONE.

13 BY MS. WILLIAMS:

14 YOU'RE GOING TO BRING IT?

15 BY MR. DUNBAR:

16 YES, I'LL BRING THE ORIGINAL.

17 BY COMMISSIONER BASS:

18 THAT WILL BE FINE.

19 BY MS. WILLIAMS:

20 THE OTHER THING THAT I WOULD LIKE TO DO, AND
21 I'M NOT SURE IF WE DID THIS AT THE BEGINNING, BUT I
22 HAD ASKED FOR UTICA MOHAWK BECAUSE HE IS ON SOCIAL
23 SECURITY DISABILITY. IT DOESN'T HELP MUCH, BUT...

24 BY COMMISSIONER BASS:

25 OKAY. ALL RIGHT, I'LL MARK THAT DOWN. MRS.

1 JONES, YOU TESTIFIED THAT YOUR HUSBAND IS ON SOCIAL
2 SECURITY DISABILITY, IS THAT RIGHT?

3 BY THE WITNESS:

4 YES, SIR.

5 BY COMMISSIONER BASS:

6 THANK YOU VERY MUCH. THIS CONCLUDES THE
7 HEARING.

8 (COURT REPORTER MARKS CLAIMANT'S DEPOSITION DEFENDANT'S
9 EXHIBIT ONE, MARKED, RETAINED)

10 (THERE BEING NO FURTHER QUESTIONS, THIS HEARING WAS
11 CONCLUDED AT THE HOUR OF 9:33 A.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 9708801

EMPLOYEE/CLAIMANT: DERRELL JONES

EMPLOYER: 3M (SPP/SMD)

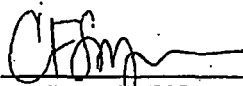
INSURER: OLD REPUBLIC INSURANCE COMPANY

I, CHRISTIAN FILES SIMPSON, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING 36 PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING HEARING OF DERRELL JONES, TAKEN ON THE 20TH DAY OF NOVEMBER, 2007.

THAT THE WITNESS WAS DULY PLACED UNDER OATH AND ADMONISHED TO SPEAK THE WHOLE TRUTH. THAT THE ORAL HEARING WAS DULY TAKEN AND TRANSCRIBED AS TO THE QUESTIONS PROPOUNDED AND THE ANSWERS GIVEN.

THAT ALL THE OFFERED EXHIBITS, STIPULATIONS AND OBJECTIONS, IF ANY, INVOLVED IN THIS CASE ARE DULY ATTACHED OR INCLUDED HEREIN.

IN WITNESS WHEREOF, I HAVE SET MY HAND AND OFFICIAL SEAL THIS 30TH DAY OF NOVEMBER, 2007.



CHRISTIAN FILES SIMPSON
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 9-3-2014

* THIS TRANSCRIPT MAY CONTAIN QUOTED MATERIAL. SUCH MATERIAL IS REPRODUCED AS READ OR QUOTED BY THE SPEAKER.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W. C. C. FILE NO. 9708801

ARCHIE EDDIE JONES,

Employee,

Claimant/Respondent,

vs.

3M CORPORATION,

Employer,

AND

**SEDGWICK CLAIMS MANAGEMENT
SERVICES,**

Carrier,

Defendants/Appellants.

RECEIVED

SEP 11 2008

FRONT DESK

**DEFENDANT'S/APPELLANT'S
BRIEF AND MEMORANDUM OF
LAW IN SUPPORT OF ITS
APPLICATION FOR REVIEW**

RECEIVED

SEP 12 2008

FRONT DESK

STATEMENT OF THE CASE

Archie Eddie Jones, the Claimant/Respondent, is a sixty-four year old, married male, who sustained compensable third degree burns over forty percent of his body on June 3, 1997. The burns to the Respondent's trunk, legs, arms and feet required extensive skin grafting during his hospitalization at the Charleston Medical Center. The Claimant's burns also caused pulmonary dysfunction, tissue and nerve damage of the lower extremities and depression. Because of the aforesaid compensable injuries, the Claimant was paid permanent and total disability compensation and lifetime medical benefits.

Subsequently, the Respondent filed a Form 50 dated July 5, 2007, alleging additional injuries involving the brain and urinary tract system, i.e., erectile dysfunction, and prostatitis

syndrome as a consequence of the admitted work related accident of June 3, 1997. The Appellants denied the compensability of the erectile dysfunction, brain injury and the associated bipolar disorder.

On November 20, 2007, this matter was heard by the Honorable J. Alan Bass to adjudicate the issues contained on the Forms 50 and 51. Commissioner Bass [hereinafter the Hearing Commissioner] also addressed the Appellants' Motion and Request to Compel the Claimant to attend medical appointments with Dr. Maria Recio, a Neurologist, and Dr. David Price, a Neuropsychologist. By Order dated June 27, 2008, the Hearing Commissioner found and determined that the Respondent had suffered a physical brain injury and suffered from erectile dysfunction as a consequence of the June 3, 1997 work related accident. The Hearing Commissioner also denied the Appellants' request to have the Respondent evaluated by a neurologist and neuropsychologist. From this decision, the Appellants timely appealed to this body.

STATEMENT OF THE FACTS

Archie Eddie Jones, the Respondent, suffered chemical burns to his body as a consequence of a compensable accident that occurred on June 3, 1997. Mr. Jones was first treated at Greenville Memorial Hospital and was later transported to the Medical University of South Carolina in Charleston. The Respondent was hospitalized for approximately three months where he received extensive treatment for his burn injuries. During the Respondent's hospitalization, he was treated for urethral erosion, which was due to long term catheter placement. The Respondent received treatment for burns to the lungs. The Respondent also underwent surgeries for scarring of the nose, left eyebrow, left ear, neck, trunk, and right arm. Further, the Respondent was treated for symptoms of depression.

The Respondent, who had began working as a mechanic for 3M, the Defendant/Employer, on May 9, 1983. He returned to work in 1998 for approximately eight to ten months in a modified capacity. (*APA, p. 794 and Deposition Transcript, p. 32, lines 12-21*).

After being released from the hospital, the Respondent had complained of problems with lethargy, fatigue and decreased mental alertness. On April 30, 1999, Dr. Robert W. Richards, a Psychiatrist, ordered an MRI. Dr. Richards had been treating the Respondent for depression and posttraumatic stress disorder as a consequence of the chemical burn injury. (*APA, p. 759*). On May 18, 1999, Dr. Terence Clark issued a report concerning the cranial MRI. Dr. Clark noted that the Respondent's MRI was within normal limits. The MRI did reveal some small scattered deep white matter signals. Dr. John F. Pilch in a report dated July 1, 1999 opined that the MRI scan with respect to the deep white matter was suggestive of subcortical vascular disease. More importantly, it was suggested that the reason for the fatigue that the Respondent was suffering was as a consequence of sleep apnea and the consumption of the medications Neurontin and Atarax. (*APA, pp. 795-796*). Dr. Pilch noted that the Respondent was "alert and appropriate in complex conversation." (*APA, p. 795*).

On June 9, 2001, the Respondent was admitted to the Anderson Area Medical Center for a transient ischemic attack (TIA) or stroke. The Respondent's stroke occurred four years after the admitted work related accident. Prior to June 2001, the Respondent had had no prior strokes or seizure activity. (*APA, p. 769*). At the time of the stroke on June 9, 2001, the Respondent had been extremely active around his house. Specifically, the Respondent reported working on his car and repairing plumbing under his house, when he began experiencing right arm numbness and a left sided headache. (*APA, pp. 769-770*). During the Respondent's hospitalization, he was

found to be neurologically intact, and he was alert and oriented. (*APA*, p. 771). In assessing a correlation between the admitted burn injury of June 3, 1997 and the TIA of June 9, 2001, Dr. Bruce R. LeForce opined that the burn injury resulted in no increased risk factors for a stroke; and that there was no association between the stroke and the burn injury. This opinion is supported by the MRI scan of the brain (*APA*, pp. 765-766) and an MRI angiography (*APA*, p. 767), and a CT scan of the brain (*APA*, p. 768).

In April 2004, the Respondent was treated by Dr. Frank E. Oliver, a Neurologist with Anderson Neurological Associates for a second TIA/stroke. (*APA*, p. 763). Dr. Oliver noted that as a consequence of the symptoms of a stroke in April 2004, the Respondent was prescribed Plavix and aspirin. Dr. Oliver noted that the stroke or TIA was as a consequence of posterior circulation. (*APA*, pp. 763-764).

In 2005, the Respondent suffered a third stroke which required him to seek treatment at ANMED Health. A report from Dr. Frank Oliver dated December 14, 2005 reflects that the Respondent underwent an MRI of the brain for vertigo and TIA. (*APA*, p. 760-762). During the hearing, the Respondent corrected his wife and advised that he had been hospitalized in 2005 for treatment associated with stroke symptoms.

The Respondent's purported brain injury as alleged to be related to the compensable brain injury is further complicated by the fact that the Respondent has been diagnosed with a bipolar disorder and ADD. (*APA*, pp. 330-331 and *Deposition Transcript*, Pg. 8, Lines 14-19). The Respondent's forty-four year old son also has ADD.

The Respondent also alleges that he has suffered injuries to his penis and neurological system, namely erectile dysfunction and prostatitis syndrome. The Respondent contends that the placement of an indwelling Folly catheter caused an erosion of the distal urethra and a urethral

stricture. However, Dr. William Hinnant, a Urologist with Anderson Urology Associates, opined that the urethra had been repaired and that the Respondent would only need to undergo periodic dilation for the stricture. The Appellants did not question that the initial injury to the urethra was as a direct and proximate consequence of the work related accident. (*APA*, p. 792). However, with respect to the Respondent's erectile dysfunction and prostate problems, such maladies are denied. As a matter of fact, Dr. Hinnant opined that the prostatitis is not related to the admitted work related accident. Id.

LEGAL ISSUES

I. THE HEARING COMMISSIONER CLEARLY ERRED IN FINDING OF THE FACT AND CONCLUDING AS A MATTER OF LAW THAT THE RESPONDENT SUSTAINED A PHYSICAL TRAUMATIC BRAIN INJURY, THE ERROR BEING THAT THE GREATER WEIGHT OF THE EVIDENCE DOES NOT SUPPORT SUCH A FINDING.

Section 42-9-10 (C) utilizes the adjective or term "physical" in defining and qualifying the type of brain injury necessary for an injured employee to receive lifetime indemnity benefits. S. C. Code Ann. § 42-9-10 (C) (2008).

Webster's New Dictionary defines the term *physical* as "material as opposed to mental or spiritual". Webster's Ninth New Collegiate Dictionary defines the term *physical* as "having material existence perceptible through the senses". In short, the term *physical* is something that is capable of being viewed or touched with respect to a physical brain injury. In the instant case, none of the diagnostic tests administered reflects a physical brain injury as a consequence of the chemical burn that occurred on June 3, 1997. (*APA*, pp. 746-747).

Aside from the objective medical reports not reflecting that the Claimant sustained a physical brain injury as a consequence of the admitted chemical burns, the reports of the authorized treating physicians reveals that the Respondent's problems with respect to memory problems and lack of alertness are as a result of sleep apnea and medications. Sleep apnea can cause cardiovascular disease, memory problems, weight gain and impotency. (*APA*, pp. 793-796). The diagnosis of sleep apnea was obviously ignored by the Hearing Commissioner or not given any appreciable weight.

Finally, the Respondent's testimony does not corroborate the occurrence of a permanent physical brain injury that occurred on June 3, 1997. Specifically, a review of the Respondent's deposition testimony taken on October 30, 2007, reflects an individual who was capable of recalling the accident and the injuries sustained as a consequence thereof. The Respondent was able to recall the medication he consumes and the amount of dosage of each medication, and the number of times the medications are taken daily. (*Deposition Transcript*, Pgs. 14-18). The Respondent testified that he works around the house (*Deposition Transcript*, Pgs. 24-25 and *APA*, pp. 769-770 and p. 773) and that he had driven to Chisholm, Minnesota to help move a friend. (*Deposition Transcript*, Pg. 26, Lines 2-25 and Pg. 27).

The Respondent also tutored his niece, a high school ninth grade student, in the subject of physical science. (*Transcript of Record*, Pg. 26-27).

In short, the Claimant's activities, diagnostic test results and the credible objective medical reports do not support any cognitive deficits associated with a physical brain injury. For these reasons, the Hearing Commissioner's decision must be reversed as a matter of law. S. C. Code § 42-9-10 (C) (2008). See also *Walker v. City Motor Car Co.*, 232 S. C. 392, 102 S.E. 2d 373 (1958).

II. THE HEARING COMMISSIONER ERRED AS A MATTER OF LAW AND ABUSED HIS DISCRETION IN DENYING THE APPELLANTS' REQUEST TO COMPEL THE RESPONDENT TO SUBMIT TO A MEDICAL EVALUATION WITH RESPECT TO HIS ALLEGATIONS OF A BRAIN INJURY.

Section 42-15-80 permits an employer to require that an injured employee submit to an examination as long as he claims compensation. S. C. Code Ann. § 42-15-80 (2006). The Appellants had scheduled appointments with Drs. David Price and Maria Recio prior to the scheduled hearing. However, Respondent's counsel objected to these examinations arguing that the reports would have to be submitted by these medical providers after the hearing had transpired. The Appellants further had requested that the record remain open or the matter be adjourned to receive these additional reports.

Despite Respondent's counsel's arguments, the Appellants did not delay in scheduling these medical evaluations. A review of the Respondent's Form 50 and list of medical providers associated thereto only reflects the identities of the authorized treating physicians. At the point of the service of the Form 50, none of the authorized treating physicians had opined to a reasonable degree of medical certainty that the Respondent had suffered a permanent physical brain injury. It was not until the receipt of Robert Moss report, (Psychologist), dated June 29, 2007, that the Appellants became aware of Robert Moss' diagnosis. Dr. Moss' report was not received until service of the Pretrial Brief in November 2007.

Interestingly, the Form 50 is dated July 5, 2007. Yet Dr. Moss' report dated June 29, 2007 is not listed by Respondent a medical provider or specialist who have seen or treated the Claimant. Thus, at the time of the receipt of the Pretrial Brief and Evidentiary Submissions dated November 2, 2007, was the first notice of evidence from a psychologist of a brain injury.

Hence, the Hearing Commissioner abused his discretion in denying the Respondent's Motion to have the Respondent seen by a neurologist and neuropsychologist in view of the fact that the Respondent is receiving lifetime medical treatment for his admitted burn injuries. Regulation 67-215 (2008).

Accordingly, the Hearing Commissioner's decision must be reversed as a matter of law.

Id.

III. THE HEARING COMMISSIONER ERRED AND ABUSED HIS DISCRETION IN FAILING TO EXCLUDE THE REPORT OF ROBERT MOSS, A PSYCHOLOGIST, AND BY RELYING UPON SUCH IN ADJUDICATING THE RESPONDENT'S ALLEGED BRAIN INJURY CLAIM COMPENSABLE.

Robert Moss performed a psychological evaluation upon the Respondent ten years after the compensable work related accident. Given the remoteness in time between accident and Robert Moss' report, such cannot be deemed reliable. Although the Hearing Commissioner has discretion to place weight upon lay and expert testimony as he or she feels such is warranted, a finding of compensability and reward of benefits cannot be based upon surmise, conjecture and speculation. *Dykes v. Daniel Construction Co.*, 262 S. C. 98, 202 S.E. 2d 646 (1974) and *Bundrick v. Powell's Garage and Wrecker Service*, 248 S. C. 496, 151 S.E. 2d 437 (1966).

The report of Robert Moss should have been excluded or not given any weight in view of the three MRI scans, CT scans and other tests showing no physical brain injury. More importantly, the MRI scans were all taken after the Respondent had suffered three strokes.

In view of the fact that Robert Moss was retained solely for the purpose of providing a favorable evaluation for the Respondent at counsel's request, his report should have been excluded on the basis that he is biased and prejudiced. More importantly, Robert Moss is

psychologist and not a medical doctor, and therefore is not qualified to render an opinion as to whether an individual has suffered physical brain damage. In short, Robert Moss does not possess a medical degree or license to read x-rays, radiographs, CT scans or an MRI. At best, a neuropsychological examination can only determine the effects of a brain injury and does not possess the ability to distinguish whether such results from occupational or congenital factors.

IV. THE HEARING COMMISSIONER ERRED IN FINDING AS A FACT AND CONCLUDING AS A MATTER OF LAW THAT THE RESPONDENT IS ENTITLED TO TREATMENT FOR PROSTATITIS AND ERECTILE DYSFUNCTION, THE ERROR BEING THAT SUCH MALADIES ARE NOT RELATED TO THE COMPENSABLE WORK RELATED ACCIDENT.

Section 42-15-60 states that compensable injuries are subject to medical treatment that is deemed reasonable and necessary. S. C. Code Ann. § 42-15-60 (2008). Dr. William Hinnant opined that only the problems with the urethra were as a consequence of the Claimant's work related accident. (*APA*, p. 792).

Accordingly, the Hearing Commissioner's decision on symptoms of erectile dysfunction and prostatitis must be reversed because such is based upon surmise, conjecture and speculation. See *Dykes v. Daniel Construction Co.*, *supra*.

IV. THE HEARING COMMISSIONER ERRED AS MATTER OF LAW IN ORDERING THE APPELLANTS TO DIRECTLY PAY TO RESPONDENT'S COUNSEL ATTORNEY'S FEES FROM THE RESPONDENT'S AWARD.

Regulation 67-1203-1206 governs the payment of attorney's fees and reimbursement of costs. These regulations require that the injured worker agree to the attorney's fees and costs as

stated in a Form 61. In the instant action, the Order does not reference an approved Form 61, nor have the Appellants been provided a copy of such.

Accordingly, the Hearing Commissioner's Order is void and must be reversed as a matter of law. Id.

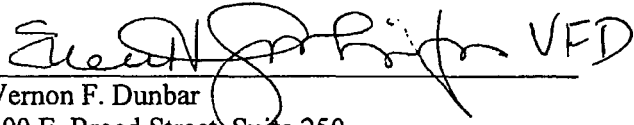
CONCLUSION

Based upon the foregoing arguments, it is respectfully submitted that the Hearing Commissioner's decision must be reversed.

Respectfully submitted,

TURNER, PADGET, GRAHAM & LANEY, P.A.

BY:


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ATTORNEYS FOR DEFENDANTS

Greenville, South Carolina

September 12, 2008

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

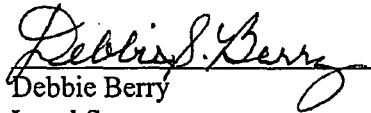
W. C. C. FILE NO. 9708801

ARCHIE EDDIE JONES,)
)
 Employee,)
)
 Claimant/Respondent,)
)
 vs.)
)
 3M CORPORATION,)
)
 Employer,)
)
 AND)
)
 SEDGWICK CLAIMS)
 MANAGEMENT SERVICES,)
)
 Carrier,)
)
 Defendants/Appellants.)

PROOF OF SERVICE

The undersigned certifies that she is an employee at TURNER, PADGET, GRAHAM & LANEY, P.A., and that the attached **Defendants'/Appellants' Brief and Memorandum of Law in Support of its Application for Review** was served upon Kathryn Williams, Esquire, the attorney for the Claimant/Respondent, this 12th day of September 2008, pursuant to Section 15-9-930 and Section 15-9-940 of the Code of Laws of South Carolina, 1976, by depositing a copy of same in the United States Mail, postage prepaid, addressed to:

Kathryn Williams, Esquire
Post Office Box 10693
Greenville, SC 29603


Debbie Berry
Legal Secretary

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

)
)
)

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT
CASE NO.: 2009-CP-23-2535

ARCHIE EDDIE JONES,

Employee,

Respondent/Claimant,

vs.

3M CORPORATION,

Employer,

AND

OLD REPUBLIC INSURANCE COMPANY,

Carrier,

Appellants/Defendants.

**APPELLANTS' BRIEF
AND
MEMORANDUM OF LAW**

STATEMENT OF THE CASE

Archie Eddie Jones, Claimant/Respondent [hereinafter "Respondent"], is a sixty-seven (67) year old, married male. Respondent graduated from high school and attended college. Respondent began working at 3M on May 9, 1983. On June 3, 1997, Respondent suffered a work related accident in which he sustained compensable third degree burns over forty (40%) percent of his body. Specifically, Respondent suffered burns to his legs, arms, feet and trunk. Respondent's burn injuries required extensive skin grafting during his hospitalization at the Medical University of South Carolina Burn Center.

Respondent's burns resulted in depression and pulmonary dysfunction, and damaged tissue and nerves of the lower extremities. Because of the aforesaid compensable injuries, the Respondent was paid permanent and total disability compensation and lifetime medical benefits.

After Respondent had been paid permanent and total disability compensation benefits, he filed a Form 50 dated July 5, 2007, alleging additional injuries involving the brain and urinary tract system, i.e., erectile dysfunction, and prostatitis syndrome as a consequence of the admitted work related accident of June 3, 1997. Appellants denied Respondent's allegations of erectile dysfunction, a physical brain injury and bipolar disorder as proximately emanating from the admitted burn injury of June 3, 1997.

On November 20, 2007, this matter was heard by the Honorable J. Alan Bass to adjudicate the issues contained on the Forms 50 and 51. Commissioner Bass [hereinafter the "Hearing Commissioner"] addressed Appellants' Motion and Request to Compel Claimant to attend medical appointments with Dr. Maria Recio, a Neurologist, and Dr. David Price, a Neuropsychologist. By Order dated June 27, 2008, the Hearing Commissioner found and determined that Respondent had suffered a physical brain injury and suffered from erectile dysfunction as a consequence of the June 3, 1997 work related accident. The Hearing Commissioner also denied Appellants' request to have Respondent evaluated by Drs. Recio and Price, although at the time of the scheduled hearing, appointments with the aforesaid had been scheduled. Appellants timely appealed the Hearing Commissioner's Decision to the Full Commission Appellate Panel.

By Order dated February 25, 2009, the South Carolina Workers' Compensation Full Commission Appellate Panel affirmed the Hearing Commissioner's Decision. From this Decision, Appellant's timely appealed to this Court.

STATEMENT OF THE FACTS

Respondent, suffered chemical burns to his body as a consequence of a compensable accident that occurred on June 3, 1997, during the course and scope of his employment at 3M Corporation, Employer/Appellant. Respondent was first treated at Greenville Memorial Hospital and was later transported to the Medical University of South Carolina in Charleston. Respondent was hospitalized for approximately three months at the Medical University of South Carolina. During Respondent's hospitalization, he was treated for urethral erosion, which was due to long term catheter placement. Respondent received treatment for burns to the lungs. Respondent also underwent surgeries for scarring of the nose, left eyebrow, left ear, neck, trunk, and right arm. Further, Respondent was treated for symptoms of depression.

After recovering from the chemical burn injury, Respondent returned to work in 1998 for approximately eight to ten months in a modified capacity. (*APA, p. 794 and Deposition Transcript, p. 32, lines 12-21*).

Upon being released from the hospital, Respondent had complained of problems with lethargy, fatigue and decreased mental alertness. On April 30, 1999, Dr. Robert W. Richards, a psychiatrist, ordered an MRI. Dr. Richards had been treating Respondent

for depression and posttraumatic stress disorder as a consequence of the chemical burn injury. (*APA, p. 759*).

On May 18, 1999, Dr. Terence Clark issued a report resulting from findings contained on a cranial MRI. Dr. Clark noted that Respondent's MRI study of the brain was within normal limits, although the MRI did reveal some small scattered deep white matter signals. In a subsequent report dated July 1, 1999, Dr. John F. Pilch, neurologist, opined that the MRI scan reflecting the deep white matter was suggestive of subcortical vascular disease and was associated with Respondent's age. More importantly, Dr. Pilch suggested that the subcortical vascular disease was not the cause of Respondent's fatigue and decreased alertness, but rather resulted from sleep apnea and the consumption of prescriptive medications, namely Neurontin and Atarax. (*APA, pp. 795-796*). Dr. Pilch noted that Respondent was "alert and appropriate in complex conversation." (*APA, p. 795*).

On June 9, 2001, Respondent was admitted to the Anderson Area Medical Center for a transient ischemic attack (TIA) or stroke. Respondent's stroke occurred four years after the admitted work related accident. Prior to June 2001, Respondent had suffered no strokes or seizure activity. (*APA, p. 769*). At the time of the stroke on June 9, 2001, Respondent had been extremely active around his house. Specifically, Respondent reported working on his car and repairing plumbing under his house, when he began experiencing right arm numbness and a left sided headache. (*APA, pp. 769-770*). During the Respondent's hospitalization, he was found to be neurologically intact, and he was alert and oriented. (*APA, p. 771*). In assessing a correlation between the

admitted burn injury of June 3, 1997 and the TIA of June 9, 2001, Dr. Bruce R. LeForce opined that the burn injury resulted in no increased risk factors for a stroke; and that there was no association between the stroke and the burn injury. In short, there was simply no evidence of any brain injury from the occurrence of Respondent's work related accident in 1997 until he suffered a stroke on June 9, 2001. This opinion is supported by the MRI scan of the brain (*APA, pp. 765-766*) and an MRI angiography (*APA, p. 767*), and a CT scan of the brain (*APA, p. 768*).

In April 2004, Respondent was treated by Dr. Frank E. Oliver, a Neurologist with Anderson Neurological Associates for a second TIA/stroke. (*APA, p. 763*). Dr. Oliver noted that as a consequence of the symptoms of a stroke in April 2004, Respondent was prescribed Plavix and aspirin. Dr. Oliver noted the stroke or TIA was as a consequence of posterior circulation. (*APA, pp. 763-764*).

In 2005, Respondent suffered a third stroke which required him to seek treatment at ANMED Health. A report from Dr. Frank Oliver dated December 14, 2005 reflects that Respondent underwent an MRI of the brain for vertigo and TIA. (*APA, p. 760-762*).

The Respondent's purported physical brain injury is alleged to be related to the 1997 chemical burn injury. Respondent's purported cognitive dysfunction is complicated by Respondent's diagnoses of ADD and bipolar disorder. (*APA, pp. 330-331 and Deposition Transcript, Pg. 8, Lines 14-19*). Respondent's forty-eight (48) year old son also has ADD. More telling is Respondent's three (3) strokes, which occurred after his

work related accident. Undoubtedly, three strokes have resulted in a decline and decrease in Respondent's cognitive function.

Additionally, Respondent also alleges he has suffered injuries to his penis and neurological system, namely erectile dysfunction and prostatitis syndrome. Respondent contends that the placement of an indwelling Folly catheter caused an erosion of the distal urethra and a urethral stricture.

Dr. William Hinnant, an urologist with Anderson Urology Associates, opined that the urethra had been repaired and that Respondent would only need to undergo periodic dilation for the stricture. Appellants do not question that the initial injury to the urethra was as a direct and proximate consequence of the work related accident. (*APA*, p. 792). However, Appellants deny Respondent's erectile dysfunction, prostate problems, and other such maladies are related to the work related accident. Appellants rely upon the opinion of Dr. Hinnant that the prostatitis is not related to the admitted work related accident as the basis for its denial of Respondent's allegations of compensable maladies involved in erectile dysfunction and prostate problems. *Id.*

ARGUMENTS

I. THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION ERRED IN FINDING OF THE FACT AND CONCLUDING AS A MATTER OF LAW THAT RESPONDENT SUFFERED A PHYSICAL TRAUMATIC BRAIN INJURY, THE ERROR BEING THAT THE GREATER WEIGHT OF THE EVIDENCE NOR THE LAW SUPPORT SUCH A FINDING AND LEGAL CONCLUSION.

Section 42-9-10 (C) utilizes the adjective or term "physical" in defining and qualifying the type of brain injury necessary for an injured employee to receive lifetime indemnity benefits. S. C. Code Ann. § 42-9-10 (C) (2008).

Webster's New Dictionary defines the term *physical* as "material as opposed to mental or spiritual". Webster's Ninth New Collegiate Dictionary defines the term *physical* as "having material existence perceptible through the senses". In short, the term *physical* is something that is capable of being viewed or touched with respect to a physical brain injury. In the instant case, none of the diagnostic tests administered reflects a physical brain injury as a consequence of the chemical burn that occurred on June 3, 1997. (*APA*, pp. 746-747).

Aside from the objective medical reports not reflecting that Respondent sustained a physical brain injury as a consequence of the admitted chemical burns, the reports of the authorized treating physicians reveals that Respondent's problems with respect to memory problems and lack of alertness are as a result of sleep apnea and medications. Sleep apnea can cause cardiovascular disease, memory problems, weight gain and impotency. (*APA*, pp. 793-796). The diagnosis of sleep apnea was clearly and obviously ignored by the Commission, which constitutes a legal error and an abuse of discretion. Etheredge v. Monsanto Co., 349 S.C. 451, 562 S.E.2d 679 (Ct. App. 2002).

As a matter of fact, Respondent's testimony does not corroborate the occurrence of a permanent physical brain injury that occurred on June 3, 1997. A review of Respondent's deposition testimony taken on October 30, 2007, reflects an individual who was capable of recalling the accident and the injuries sustained as a consequence

thereof. Respondent was able to recall the medication he consumes and the amount of dosage of each medication, and the number of times the medications are taken daily. (*Deposition Transcript, Pgs. 14-18*). Respondent testified that he works around the house (*Deposition Transcript, Pgs. 24-25 and APA, pp. 769-770 and p. 773*) and that he had driven to Chisholm, Minnesota to help move a friend. (*Deposition Transcript, Pg. 26, Lines 2-25 and Pg. 27*).

Respondent also tutored his niece, when she was in the ninth grade, in the subject of physical science. (*Transcript of Record, Pg. 26-27*). During the hearing, the Respondent corrected his wife and advised that he had been hospitalized in 2005 for treatment associated with stroke symptoms.

In short, Respondent's activities, diagnostic test results and the credible objective medical reports do not support any cognitive deficits associated with a physical brain injury. For these reasons, the Commission's Decision must be reversed as a matter of law. S. C. Code § 42-9-10 (C) (2008). See also *Walker v. City Motor Car Co.*, 232 S. C. 392, 102 S.E. 2d 373 (1958).

II. THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION ERRED AS A MATTER OF LAW AND ABUSED ITS DISCRETION IN DENYING APPELLANTS' REQUEST TO COMPEL RESPONDENT TO SUBMIT TO A MEDICAL EVALUATION WITH REGARD TO ALLEGATIONS OF A PHYSICAL BRAIN INJURY.

Section 42-15-80 permits an employer to require that an injured employee submit to an examination as long as he claims compensation. S. C. Code Ann. § 42-15-80 (2006). Appellants had scheduled appointments with Drs. David Price and Maria

Recio prior to the scheduled hearing. However, Respondent's counsel objected to these examinations arguing that the reports would have to be submitted by these medical providers after the hearing had transpired. Appellants further had requested that the record remain open or the matter be adjourned to receive these additional reports. See e.g., Trotter v Trane Coil Facility, 681 S.E.2d 36 (2009).

Despite Respondent's counsel's arguments, Appellants did not delay in scheduling these medical evaluations. A review of the Respondent's Form 50 and list of medical providers associated thereto only reflects the identities of the authorized treating physicians. At the point of the service of the Form 50, none of the authorized treating physicians had opined to a reasonable degree of medical certainty that Respondent had suffered a permanent physical brain injury. It was not until the receipt of Robert Moss' report, dated June 29, 2007, that Appellants became aware of Robert Moss' diagnosis. Dr. Moss' report was not received until service of the Pretrial Brief on November 2, 2007.

Interestingly, the Form 50 is dated July 5, 2007. Dr. Moss' report is dated June 29, 2007 and is not listed by Respondent as a medical provider or specialist who had evaluated and/or treated him. Thus, at the time of the receipt of Respondent's Pretrial Brief and Evidentiary Submissions dated November 2, 2007, constituted the first notice to Appellants that there was evidence of an alleged brain injury from a psychologist. Under these circumstances, the Commission clearly abused its discretion in denying Respondent's Motion to have Respondent evaluated and/or treated by a neurologist and neuropsychologist. The Commission's error and abuse of discretion is even more

evident when viewed from the perspective that Respondent was receiving lifetime medical treatment for his admitted burn injuries. Regulation 67-215 (2008).

III. THE COMMISSION ERRED AND ABUSED ITS DISCRETION IN FAILING TO EXCLUDE THE REPORT OF ROBERT MOSS, A PSYCHOLOGIST, AND BY RELYING UPON SUCH IN ADJUDICATING RESPONDENT'S ALLEGED PHYSICAL BRAIN INJURY CLAIM COMPENSABLE.

Robert Moss performed a psychological evaluation upon Respondent ten (10) years after the compensable work related accident. Given the remoteness in time between accident and Robert Moss' report, such cannot be deemed reliable. Although the Commission has discretion to place weight upon lay and expert testimony as it deems such is warranted, a finding of compensability and award of benefits cannot be based upon surmise, conjecture and speculation. *Dykes v. Daniel Construction Co.*, 262 S. C. 98, 202 S.E. 2d 646 (1974) and *Bundrick v. Powell's Garage and Wrecker Service*, 248 S. C. 496, 151 S.E. 2d 437 (1966).

The report of Robert Moss should have been excluded or not given any weight in view of the three MRI scans, CT scans and other tests showing no physical brain injury. More importantly, the MRI scans were all taken after Respondent had suffered three strokes.

In view of the fact that Robert Moss was retained solely for the purpose of providing a favorable evaluation for the Respondent at counsel's request, his report should have been excluded on the basis that he is biased and prejudiced. More importantly, Robert Moss is a psychologist. He is not a medical doctor, and therefore,

Moss is not qualified to render an opinion as to whether an individual has suffered physical brain damage. In short, Moss does not possess a medical degree or a license to read x-rays, radiographs, CT scans or an MRI. At best, a neuropsychological examination can only determine the effects of a brain injury and does not distinguish whether such results from occupational or congenital factors.

IV. THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION ERRED IN FINDING AS A FACT AND CONCLUDING AS A MATTER OF LAW THAT RESPONDENT IS ENTITLED TO MEDICAL TREATMENT FOR PROSTATITIS AND ERECTILE DYSFUNCTION, THE ERROR BEING THAT SUCH MALADIES ARE NOT RELATED TO THE COMPENSABLE WORK RELATED ACCIDENT.

Section 42-15-60 states that compensable injuries are subject to medical treatment that is deemed reasonable and necessary. *S. C. Code Ann. § 42-15-60* (2008). Dr. William Hinnant opined that only the problems with the urethra were as a consequence of Respondent's work related accident. (*APA*, p. 792).

Accordingly, Commission's Decision finding the conditions of erectile dysfunction and prostatitis compensable must be reversed because such is based upon surmise, conjecture and speculation. See *Dykes v. Daniel Construction Co.*, *supra*.

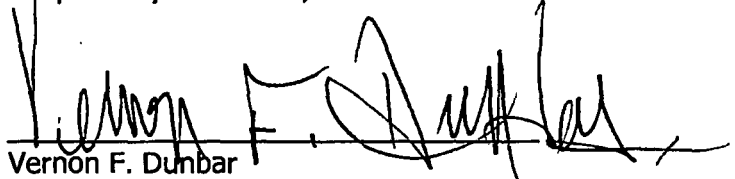
IV. THE COMMISSION ERRED TO PAY DIRECTLY TO RESPONDENT'S COUNSEL ATTORNEY'S FEES FROM THE AWARD.

Regulations 67-1204 - 1206 govern the payment of attorney's fees and reimbursement of costs. These regulations require that the injured worker agree to the attorney's fees and costs as stated in a Form 61. In the instant action, the Order does not reference an approved Form 61, nor have Appellants been provided a copy of such.

CONCLUSION

Based upon the foregoing arguments, it is respectfully submitted the Commission's Decision be reversed as a matter of law. In the alternative, Appellants request that case be remanded to permit a neuropsychologist and neurologist to evaluate Respondent.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Vernon F. Dunbar", is written over a horizontal line.

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April 12, 2011

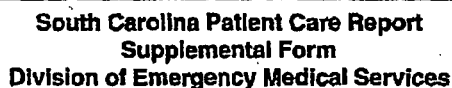
REPORT NO. (1-6) 000725718

DHEC PATIENT CARE FORM

Q.A. NO. TRIP NO. 12723

PATIENT IDENTIFICATION (Please Print)			DISPOSITION (101-102)		TYPE OF INCIDENT		PATIENT STATUS		
LAST NAME (10-25) FIRST NAME (30-45) M.I. (46)			01 ☐ TREATING TRANS. 02 ☐ DOA AT SCENE		TRAUMA (103) MEDICAL (104)		TO SCENE (105) ON SCENE (106) FROM SCENE (107)		
STREET (47-71) APT. # (72-80) CITY (72-80) STATE (88-89) ZIP CODE (90-99)			03 ☐ HOSPITAL ER 04 ☐ HOSP. DIR. ADMIT. 05 ☒ TRAUMA CENTER		1 ☐ MVA 2 ☐ MC 3 ☐ BIKES 4 ☐ PED 5 ☐ ASSAULT 6 ☐ FALL 7 ☐ FIRE 8 ☐ INTERFAC 9 ☐ OTHER		1 ☒ EMERGENCY 2 ☐ NONEMERGENCY 3 ☐ CODE 4 ☐ EMERGENCY 5 ☐ NONEMERGENCY 6 ☐ CODE 7 ☐ EMERGENCY 8 ☐ NONEMERGENCY 9 ☐ CODE		
SEX (95) RACE (96) AGE (97-100)			06 ☐ PATIENT'S HOME 07 ☐ NURSING HOME 08 ☐ DR.'S OFFICE 09 ☐ OUTPATIENT 10 ☐ PT. REFUSED TREAT		1 ☐ ENVIRON 2 ☐ BEHAV 3 ☐ OB/GYN 4 ☐ RESP 5 ☐ CARDIAC 6 ☐ INTERFAC 7 ☐ OTHER		INCIDENT LOCATION:		
1 ☒ Male 2 ☐ Female 3 ☐ Undetermined			01 ☒ White 02 ☐ Black 03 ☐ Am. Indian 04 ☐ Hispanic 05 ☐ Asian 06 ☐ Other		ST. OR HWY. NAME OR NO. 3m 1400 Perimeter Rd		CITY 604 SC. COUNTY 23		
CHECK ONE 1 ☐ YRS. 2 ☐ MOS. 3 ☐ DAYS			01 ☐ Seizure 02 ☐ Diabetic 03 ☐ Abrasion/Contusions 04 ☐ Laceration 05 ☐ Fracture		74 ☐ Respiratory Distress 80 ☐ Coronary Problems 83 ☐ Cardiac Arrest		SAFETY EQP (110): 1 ☐ Seatbelts 2 ☐ Helmets 3 ☐ Airbags		
PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (112-115)			01 ☐ Seizure 02 ☐ Diabetic 03 ☐ Abrasion/Contusions 04 ☐ Laceration 05 ☐ Fracture		74 ☐ Respiratory Distress 80 ☐ Coronary Problems 83 ☐ Cardiac Arrest		SITE OF INCIDENT (111): 1 ☐ ROADWAY 2 ☐ RESIDENCE 3 ☐ AGRICULTURAL		
PRIMARY IMPRESSION (154-155)			ADVANCED PROCEDURES (155-157)		TREATMENT PROCEDURES (157-158)		DRUGS USED (193-200)		
1 ☒ EXAM Monitored 2 ☐ First Defib Attempted 3 ☐ Second Defib Attempted 4 ☐ Third Defib Attempted			Rhythm SR to T 0908		01 ☒ Dressing Applied 02 ☐ Unb Splinted 03 ☐ Spine Immobilized 04 ☐ Neck Immobilized 05 ☐ OB Assistance 06 ☐ Oral Airway Used		07 ☒ Oxygen Given 08 ☐ Suction Used 09 ☐ Antishock Trousers 10 ☐ Airway Maintained 11 ☐ Antishock Treatment 12 ☐ Artificial Resp.		
SITE OF TRAUMA (155-164)			5 ☐ Intubated (Method) 6 ☐ External Pacing 7 ☐ Blood Drawn 8 ☐ IV Started/Change 9 ☐ IV Started/Change 10 ☐ Pleural Decompression 11 ☐ Intraosseous Inf. 12 ☐ Automatic Defib 13 ☐ Patient Assisted Meds.		1 ☐ Head 2 ☒ Face 3 ☐ Neck 4 ☐ Chest 5 ☐ Abdomen 6 ☐ Hip/Pelvis 7 ☐ Upper Ext. 8 ☐ Lower Ext. 9 ☐ Back		GCS: (208) EYES 2 (210) VERBAL 2 (211) MOTOR 2 (212-213) GLASGOW 15 = 4		
EXPOSURE TO PT'S BODY FLUIDS (223)			1 ☐ YES 2 ☒ NO		REVISED TRAUMA SCORE		VITAL SIGNS		
1ST Responder (224) 1 ☒ YES Name 2 ☐ NO			1 ☐ YES 2 ☒ NO		GCS: (208) EYES 2 (210) VERBAL 2 (211) MOTOR 2 (212-213) GLASGOW 15 = 4		BP 110/70 PULSE 90 RESPIRATIONS 20 PUPILS 4/4 LEVEL OF CONSC. A. 9/10		
COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)			1 ☐ YES 2 ☒ NO		GCS: (208) EYES 2 (210) VERBAL 2 (211) MOTOR 2 (212-213) GLASGOW 15 = 4		BP 110/70 PULSE 90 RESPIRATIONS 20 PUPILS 4/4 LEVEL OF CONSC. A. 9/10		
PATIENT CARE FORM LEFT IN: 1 ☒ ED 2 ☐ ICU 3 ☐ OTHER			1 ☐ YES 2 ☒ NO		GCS: (208) EYES 2 (210) VERBAL 2 (211) MOTOR 2 (212-213) GLASGOW 15 = 4		BP 110/70 PULSE 90 RESPIRATIONS 20 PUPILS 4/4 LEVEL OF CONSC. A. 9/10		
TIME RECORD			DHEC PERMIT NO. (257-261)		ATTENDANT'S SIGNATURE & CERTIFICATION NO.		PATIENT'S SIGNATURE & CERTIFICATION NO.		
RUN DATE (223-232)			03014		3/23/16		823416		
MONTH 03 DAY 03 YEAR 97			RECEIVING AGENCY (262-265)		1007		830211		
SENDING AGENCY (266-269)			PROVIDER TIME (OPTIONAL)						
CAUSE OF DELAY			RECEIVER'S COPY						

See Page II



Address: 1229 Salem Ch Rd Anderson SC. 29625

83031

GREENVILLE HOSPITAL SYSTEM REGISTRATION FACESHEET
PAGE 1

SSN ~~000000000~~ NAME JONES, ARCHIE EDWARD
 ADMIT DATE 06/03/97 ADMIT TIME 09:16 PHYSICIAN
 PAT. TYPE E PHYS SERV CLERK ALM
 REFER PHYS EXPECTED DATE OF DELIVERY
 BIRTHDATE ~~000000000~~ AGE 053 SEX M RACE CA MARITAL STAT M
 CREATE DATE 06/03/97 EC 62 RELIGION BAP LOS
 PREFER NAME
 HOME ADDRESS 1229 SALEM CHURCH RD CNTY 004 ANDERSON
 CITY ANDERSON STATE SC ZIP 29625 EXT 1310
 PHONE 864 224-2669 WORK PHONE 803
 MOTHER
 NO. LEGAL DEP 02 NUM. EMPLOYED 02 VETERAN STATUS
 PREADMIT TEST
 ADM. CATEGORY EM BAD DEBT FLAGS COURTESY DISCH
 LOCATION 08ED 0000 00 PREV ADMIT
 REQ. ACCOM.
 DIAGNOSIS CHEMICAL BURN TO BODY SPECIALTY CODE 041
 ACCIDENT EMPLOYMENT RELATED ACCID DATE 06/03/97 TIME 09:00
 PLACE WORK
 HOW OCCURRED CHEMICAL BURN TO BODY
 COMMENTS TRAUMA #13
 NEXT OF KIN JONES, DERRELL RELATION SPOUSE
 ADDRESS 1229 SALEM CHURCH RD EMPLOYMENT STATUS 01
 CITY ANDERSON STATE SC ZIP 29625 EXT 0000
 PHONE 864 224-2669 WORK PHONE 803 225-0523 EXT
 EMPLOYER POPE DRIVE BAPT. CHRUCH OCCUPATION SECRETARY
 LOCAL CONTACT TATE, MARJORIE RELATION OTHER
 ADDRESS
 CITY
 PHONE 864 226-5629 WORK PHONE 803

GREENVILLE HOSPITAL SYSTEM REGISTRATION FACESHEET
PAGE 2

PATIENT NAME	JONES, ARCHIE EDWARD		ACCOUNT #	080000854384	
EMPLOYER	3-M COMPANY		OCCUPATION	MECHANIC	
EMPLOYR ADDR	DONALDSON CENTER				
EMPLOYR CITY	GREENVILLE	STATE SC	ZIP 29605	EXT	0000
EMPLOY STATUS	01	EMPLOY LENGTH	6Y	STUDENT STATUS	
DIAGNOSIS	CHEMICAL BURN TO BODY		SPECIALTY CODE	041	
ACCIDENT PLACE	EMPLOYMENT RELATED ACCID WORK		DATE	06/03/97	TIME 09:00
HOW OCCURRED	CHEMICAL BURN TO BODY				
COMMENTS	TRAUMA #13				
GUARANTOR	JONES, ARCHIE EDWARD				
BIRTHDAY	07/30/1943	RACE CA	SEX M	RELATION	PATIENT
ADDRESS	1229 SALEM CHURCH RD				
CITY	ANDERSON	STATE SC	ZIP 29625	EXT	1310
PHONE	864 224-2669	WORK PHONE	803		
EMPLOYER	3-M COMPANY		OCCUPATION	MECHANIC	
ADDRESS	DONALDSON CENTER		LENGTH EMPLOY	6Y	
CITY	GREENVILLE	STATE SC	ZIP 29605	EXT 0000	EMP. STAT 01
INSURANCE 1	WORKERS COMP-SC-PER DIEM		INS. TYPE	GRP	
INSURED NAME	JONES, ARCHIE EDWARD		RELATION	PATIENT	
BILL TO NAME	GAB		ATTENTION		
ADDRESS	3000 HIWOODS BLVD				
CITY	RALEIGH	STATE NC	ZIP 27604	EXT	0000
POLICY #					
EFFECTIVE DT					
ROOM _BOARD					
M/M DEDUCTBL	MISC.				
OUT OF POCKT	M/M PERCNT				
PLANHOLDER	DAYS COVER				
VERIFIED	N	PERCENT REQ.?			BASIC DED.
COMMENTS					
INSURANCE 2			INS. TYPE		
INSURED NAME			RELATION		
BILL TO NAME			ATTENTION		
ADDRESS					
CITY		STATE	ZIP	EXT	
POLICY #		GROUP #			
EFFECTIVE DT	/ /	INS.CARRIER	- - -	EXT	
ROOM _BOARD		MISC.		BASIC DED.	
M/M DEDUCTBL		M/M PERCNT		M/M LIMIT	
OUT OF POCKT		DAYS COVER		NURSERY	
PLANHOLDER	-	PRIMARY PHY			
VERIFIED		PERCENT REQ.?		AUTH. #	
COMMENTS					
INSURANCE 3			INS. TYPE		
INSURED NAME			RELATION		
BILL TO NAME			ATTENTION		
ADDRESS					
CITY		STATE	ZIP	EXT	
POLICY #		GROUP #			
EFFECTIVE DT	/ /	INS.CARRIER	- - -	EXT	
ROOM _BOARD		MISC.		BASIC DED.	
M/M DEDUCTBL		M/M PERCNT		M/M LIMIT	
OUT OF POCKT		DAYS COVER		NURSERY	
PLANHOLDER	-	PRIMARY PHY			
VERIFIED		PERCENT REQ.?		AUTH. #	
COMMENTS					

GHS
EMERGENCY DEPARTMENT
Point of Entry History

08-0854384
JONES, ARCHIE EDWARD
N/A OR UNKNOWN
ENS 62 ALN 06-03-77
PCANDS 07-30-943
WORKERS COMP-SC-PER
JONES, LADIE

NAME: ARCHIE JONES AGE: 63 SEX: M
ARRIVAL DATE: 6.3.97 TIME: 0925 WT. 170 PDS 13

MODE OF ARRIVAL: ☒ EMS ☒ STRETCHER ☐ WALKED ☐ CARRIED ☐ W/C
PRIMARY CARE PROVIDER _____ CONTACTED: ☐ YES ☐ NO ER TO TREAT ☐ YES ☐ NO

TRIAGED TIME: 0925 TRIAGE LEVEL: T TRIAGED TO: ☐ CC ☐ IMC ☐ ROOM #
CHIEF COMPLAINT/HP: Chemical burn to face ☐ O₂ Sat ☐ TRAUMA ☐ PEDS ☐ OTHER

PAIN N/A LOCATION Face ONSET 6:30 PM DURATION 1 hour CHARACTER Chemical QUALITY (0-5) 10
PPMH / SURGERIES None

MEDICATIONS: None

IMMUNIZATIONS: Unknown UP TO DATE TETANUS: < 5 YRS > 5 YRS N/A OTHER: _____

ALLERGIES: MEDICATIONS: None FOOD None LATEX ☐ YES ☐ NO
(KID, BANANAS, SHELL FISH) (ANY SENSITIVITY TO RUBBER PRODUCTS OR HISTORY OF SPINA BIFIDA)

PHYSICIAN ASSESSMENT _____ DICTATION _____ TIME _____

TO MUSC Burn Center

PHYSICIAN'S ORDERS			LABORATORY			REFERRAL/TESTS			SIGNATURE		
TIME	TEST	RESULTS	TIME	TEST	RESULTS	TIME	TEST	RESULTS	TIME	TEST	RESULTS
	CBC			CC UA			XRAY/TIME:			ORDERS/MEDICATIONS/TREATMENTS	HUC/TIME
	LYTES			CATH UA							
	BUN			DIP UA			MEDS/TIME: <u>MS 5-10mg IV q 5min</u>				
	BS			C & S UA							
	CREATININE			BHCG			IV/TIME:				
	AMYLASE			TRAUMA PROFILE							
	PT/PTT			OLD PEDIATRIC			RESPIRATORY TREATMENT/TIME:				
	CARDIAC ENZYME			EKG							
				ABG							

PROMOTIONAL DIAGNOSIS: 40% 2nd/3rd degree Burns

DISPOSITION: ☐ DISCHARGE ☐ HOME ☐ OTHER ☐ ADULT ROOM NO. ☐ ADULT TO 210

VIA ☐ AMBULATORY ☐ WHEELCHAIR ☐ STRETCHER

TRANSFERRED TO _____ REferred TO _____

PATIENT INSTRUCTIONS _____

NURSING ASSESSMENT		TIME: 0925
NEURO	APPEARANCE: ☐ CLEAN ☐ UNKEMPT ☐ OTHER _____ BEHAVIOR: ☒ COOPERATIVE ☐ AGITATED ☐ RESTLESS ☐ HOSTILE ☐ CONFUSED ☐ OTHER _____	
	ORIENTATION: ☒ PERSON ☒ PLACE ☒ TIME SPEECH: ☐ CLEAR ☐ APPROPRIATE ☐ INAPPROPRIATE ☐ SLURRED ☐ APHASIC SENSORY: ☐ NO DEFICIT ☐ NUMBNESS ☐ TINGLING LOCATION _____ HEARING: ☒ NO DIFFICULTY ☐ LIMITED ☐ DEAF R L BOTH RESPONSE TO STIMULUS: ☐ SPONTANEOUSLY ☐ TO SOUND ☐ TO SHAKE ☐ TO PAIN ☐ NO RESPONSE EXTREMITY MOVEMENT: RUE _____ RLE _____ LUE _____ LLE _____ PUPILS: L _____ R _____	
	AIRWAY: ☒ CLEAR ☐ OBSTRUCTED ☐ ORAL ☐ ET ☐ TRACH S ₂ O ₂ _____ RESPIRATIONS: ☐ SPONTANEOUS ☒ LABORED ☐ ASSIST ☐ O ₂ _____ ☐ ABSENT ☐ HYPERVENTILATION ☐ SHALLOW ☐ RETRACTIONS ☐ FLARING BREATH SOUNDS: ☒ CLEAR ☐ RALES _____ RHONCHI _____ ☐ WHEEZES _____ ☐ DECREASED _____ ☐ ABSENT _____ COUGH: ☐ PRODUCTIVE ☐ UNPRODUCTIVE ☐ SPUTUM _____ NASAL CONGESTION _____	
	RHYTHM: ☒ REGULAR ☐ IRREGULAR ☐ PACEMAKER CAP REFULL: ☐ < 3 SECS ☐ 3 SECS HEART SOUNDS: _____ NECK VEINS: ☐ FLAT ☐ DISTENDED EDEMA: ☐ ABSENT ☒ SLIGHT ☐ MILD ☐ MODERATE ☐ SEVERE LOCATIONS: <u>to back area</u> PULSE: RADIAL R <u>2+</u> <u>2+</u> DP R _____ L _____ OTHER _____ R _____ L _____ MONITOR: <u>USIL</u>	
CARDIOVASCULAR	☒ NO COMPLAINT BOWEL SOUNDS: ☐ PRESENT ☐ ABSENT ☐ HYPOACTIVE ☐ HYPERACTIVE ABDOMEN: ☒ SOFT ☒ TENDER ☐ FLAT ☐ DISTENDED ☐ NAUSEA ☐ VOMITING ☐ DIARRHEA ☐ CONSTIPATED LAST BM: _____ DIFFICULTY SWALLOWING _____ WEIGHT: _____ HEIGHT: _____ UNINTENTIONAL WEIGHT LOSS: POUNDS _____ IN 6 MONTHS	
	LMP: _____ PREGNANT ☐ YES ☐ NO ☐ UNCERTAIN URINARY: ☒ NO PROBLEM ☐ FREQUENCY ☐ URGENCY ☐ BURNING ☐ HEMATURIA ☐ PRESSURE VAG BLEED AMT: _____ DIAPERS: ☐ NORMAL ☐ DECREASED URINE OUTPUT # DIAPERS _____ DISCHARGE: ☐ VAGINAL ☐ PENILE COLOR: _____	
GASTROINTESTINAL	SKIN: ☐ ELASTIC ☐ TENTING ☐ DRY ☒ WET INJURY: ☐ LACERATION ☐ ABRASION ☒ BURN ☐ RASH ☐ ULCER AREA: <u>face, torso, arms, legs & feet</u> BLEEDING: ☐ CONTROLLED ☐ CONTINUING TEMPERATURE: ☐ NORMAL ☐ WARM ☐ COLD ☒ HOT ☐ PALE ☐ CYANOTIC ☐ FLUSHED ☐ JAUNDICED	
	INTACT ☒ INJURY: ☐ DEFORMITY LOCATION _____ ☐ POSSIBLE OPEN FX LOCATION _____ ☐ DECREASED ROM LOCATION _____ TRAUMA: ☐ BLUNT LOCATION _____ ☐ GSW _____ ☐ STAB _____	
MUSCULO-SKELETAL	MOTOR: N=NORMAL W=WEAK F=FLACCID P=PURPOSEFUL NP=NONPURPOSEFUL DT=DECORTICATE DB=DECEREBRATE PULSE: A=ABSENT 1+=WEAK 2+=NORMAL 3+=STRONG 4+=BOUNTING D=DOPPLER PUPIL REACTION: B=BRISK S=SLUGGISH H=HIPPIUS N=NONE	
	TRIAGE RN <u>N. Kelly Pa</u> MED RN <u>N. Kelly Pa</u> ADMITTING RN _____	

08-0854384

JOES, ARCHIE EDWARD

MARRIAGE, UNKNOWN

01-03-97

SOCIAL HISTORY: 2 ALN

SMOKING HISTORY: ☐ YES ☒ NO 5 CIGS PER DAY 10 YEARS SMOKING WHEN QUIT _____

ALCOHOL HISTORY: ☐ YES ☒ NO FREQUENCY _____ LAST DRINK _____

SPECIAL DIET: ☐ NONE ☐ YES SPECIFY _____ LAST MEAL _____

APPETITE: ☐ POOR ☐ FAIR ☐ GOOD

SLEEPING HABITS: _____ # PILLOWS _____

PSYCHO-SOCIAL HISTORY: unable to answer

WE ARE ROUTINELY SCREENING FOR DOMESTIC VIOLENCE, HAVE YOU BEEN HIT, KICKED, VERBALLY OR SEXUALLY ABUSED BY A FAMILY MEMBER OR SIGNIFICANT OTHER? ☐ YES ☒ NO

DO YOU WANT HELP WITH THIS TODAY? ☐ YES ☒ NO unable to answer

TRIAGE PROTOCOLS X-RAYS _____

LABS: CBC BETA HCG CV PANEL UA FSBG _____

TX: ICE WOUND DRESSING SPINAL IMMOBILIZATION _____

MEDS: _____

MULTIDISCIPLINARY PROBLEMS LIST

PROBLEM _____ SIGNATURE _____

1. _____

2. _____

3. _____

EDUCATIONAL NEEDS ASSESSMENT

EDUCATION: YEARS _____ ABLE TO ☐ READ ☐ WRITE ☐ SPEAK ENGLISH ☐ OTHER _____

COMMUNICATION DEFICITS: ☐ NONE ☐ BLIND ☐ DEAF ☐ NEEDS INTERPRETER ☐ OTHER _____

WHAT QUESTIONS/CONCERNS DO YOU HAVE ABOUT YOUR ILLNESS? _____

POTENTIAL INSTRUCTION NEEDED: ☐ NONE IDENTIFIED ☐ MEDS ☐ DIET ☐ DISEASE PROCESS

☐ EQUIPMENT ☐ PRE-OP/PROCEDURE INSTRUCTION ☐ POST-OP SELF-CARE

☐ OTHER: unable to answer

ACTIVITIES OF DAILY LIVING

FEEDING _____ BATHING _____

DRESSING _____ TOILETING _____

AMBULATING _____

DISCHARGE ASSESSMENT/POTENTIAL NEEDS
(Complete for patients staying > 24 hours)

☐ 1. Assistance with ADL	☐ 12. Medical equipment/Supplies
☐ 2. Dressing/Treatments (Home Bound)	☐ 13. Home Health/Hospice
☐ 3. History of non-compliance	☐ 14. Private duty (RN, LPN, Aide)
☐ 4. Crisis Intervention (Psychiatric/Drug Related)	☐ 15. Nursing Home Placement
☐ 5. Abuse/Neglect	☐ 16. Transfer to Specialty Hospital
☐ 6. Home Environment Assessment	☐ 17. Mental Health/State Hospital
☐ 7. Psycho-social Assessment	☐ 18. Other Placement Needs
☐ 8. Socio-economic Assistance	☐ 19. Other Community Agency
☐ 9. Financial Assistance	☐ 20. Other _____
☐ 10. Medication Assistance	☐ 21. None Identified at this time
☐ 11. Meals on Wheels	☐ 1-20. Social Services notified by: _____

ER - 2 A91393

GREENVILLE HOSPITAL SYSTEM
EMERGENCY DEPARTMENT

DATE: 6.3.97
ALLERGIES: _____
ACUITY LEVEL: I

08-0854384
JONES, ARCHIE EDWARD
N/A OR UNKNOWN
EMS 12 ALN 06-03-97
N. ANOS3

VITAL SIGNS								OTHER							
TIME	T	P	R	BP	Sp-O ₂	CRT	TRAUMA SCORE	TIME	T	P	R	BP	Sp-O ₂	CRT	TRAUMA SCORE
0925	100	85	18	150/90				1050	110	76	15	100			
0930		86	16	144/87	98			1055		76	15	100			
0935		114	16	155/90	94			1100		108	15	100			
0940		118	16	159/88	99			1105		100	15	100			
0945		97	16	155/83	99			1110		100	15	100			
0950		97	16	155/83	100			1115		76	15	100			
0955		97	16	155/83	100			1120		72	15	100			
1000		88	16	155/81	100			1125		76	15	100			
1015		122	16	150/85	100			1130		84	15	100			
1022		82	16	150/84	100			1135		94	15	100			
1030		106	16	154/88	99										
1035		92	16	150/73	100										
1040		72	16	154/53	100										
1045		66	16	155/55	100										

TIME	MD / NURSES NOTES IMPLEMENTATION	INITIALS
0925	50 TRBI via EMS. Place on all monitors. Hypertension. Pt. is in good condition. Pt. is on 3. Oxygenation. TSE. Miller. <i>ML</i>	
0934	Pt. intubated & #2 ET tube. <i>ML</i>	
0940	Pt. received ~ 1000 cc NS IV. PTA. D. C. Over to LR. <i>ML</i>	
0945	IV 1000 cc NS. <i>ML</i>	
1000	NOB's. Pt. is on 3. Normal measures. Pt. is on 3. <i>ML</i>	
1015	Normal measures. <i>ML</i>	
1025	Pt. is on 3. <i>ML</i>	
1030	Pt. is on 3. <i>ML</i>	
1040	Normal measures. <i>ML</i>	
1100	NOB's. <i>ML</i>	
1115	Pt. is on 3. <i>ML</i>	
1130	NOB's. <i>ML</i>	
1200	On IV. <i>ML</i>	
1205	#14. <i>ML</i>	
1215	MUSC. <i>ML</i>	
1245	DC to MUSC. <i>ML</i>	

EVALUATION: OUTCOMES MET ☐ YES ☐ NO EXPLAIN: _____

DISCHARGE: TIME _____ TO ☐ HOME ☐ OTHER _____ BY ☐ STRETCHER ☐ W/C ☐ AMBULATORY ☐ CARRIED

ACCOMPANIED BY ☐ FAMILY ☐ SELF ☐ EMS ☐ OTHER _____ TIME OF DEATH _____

ED DISCHARGE SHEET ☐ COMPLETED AND ☐ SIGNED _____ CORONER CALLED ☐ YES ☐ NO TIME _____

ADMITTED TIME _____ TO ROOM _____ TO OR TRANSFER ROOM _____ YES

REPORT CALLED TO: _____ BY _____ TIME 1215

TRANSPORTED BY: ☐ STRETCHER ☐ W/C ☐ EMS ☐ HT ☐ POV

TRANSPORTED ON: ☐ CARDIAC MONITOR ☐ PULSE OX ☐ O₂ ☐ LITERS _____ ☐ PATENT N SITE ☐ OTHER _____

OLD RECORDS TRANSFERRED WITH PATIENT: ☐ YES ☐ NO ☐ N/A BELONGINGS SENT WITH PATIENT ☐ YES ☐ NO EXPLAIN _____

08-0854384
 JONES, ARCHIE EDWARD
 A/A OR UNKNOWN
 EAS 08-03-97
 PLAN 053
 WORKERS COMP-SC-PER

TRAUMA PATIENT

Date	Notes Should Be Signed by Physician
6/2/97	Trauma Attending
100A	53yob/w/o → worker @ 3M working on valve, sustained hot oil burn to splashed out of valve.
Copd H/OH NKA	Transported to Trauma Resuscitation Bay NO stable in moderate discomfort 2 tachypnea Burns evident in oropharynx RST performed Attempted #2 ETT but cords already edematous so #7 ETT inserted Wt ~ 110 kg 890 8.0 190/100 ~ 40mg ms given thus far Burns ① 3rd degree ② frontal area ~ 1% BSA ② 2nd degree ③ shoulder/axilla ~ 2% ④ bilateral UE 2nd degree below elbow ~ fingers ~ 10% BSA ⑤ 3rd degree abdominal wall below Umbilicus ~ 3% BSA ⑥ 2nd/3rd degree 10% on LE bil./3rd both calves 25% Total 2nd/3rd degree ~ 40% Val/ETox inserted, clear Vline/backland formula initiated. Wound applied wound/Bs soaked dressing Transport to MISC - accepted by Dr. J. J. J. J. via fixed wing. Disposed along with wife. Initial exam 7:32/48/100/180 Richard Miller

A23981

PROGRESS NOTES

**GREENVILLE HOSPITAL SYSTEM
EMERGENCY DEPARTMENT
TRANSFER FORM TO/FROM
ANOTHER FACILITY**

08-0854384
JOHN. W. H. EDWARDS
E/1 DR. HESBVE
E/1 62 ALB 04-03-97
K14023
NOTICE: COMP-EC-PER

Addressograph

SECTION I Complete the following:

Physician requesting transfer: Richard Miller, MD
Transferring facility: Greenville Memorial Hospital
location: Greenville, SC
Physician accepting transfer: Danney Yarbrough
Accepting facility: MUSC Barn Center
location: Charleston, SC

SECTION II Check one of the following:

- A. ☒ The patient has been stabilized such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during transfer (proceed to SECTION IV)
- B. ☐ Patient's condition has not been stabilized (complete SECTION III).
- C. ☐ Patient in active labor (complete SECTION III)

SECTION III Complete only if SECTION II (B) or (C) checked

- A. ☐ Patient or legally responsible person acting on patient's behalf requests transfer prior to stabilization TRANSFER REQUEST (Patient request) has been signed.
- B. ☐ Certification: Based on the reasonable risks and benefits to the patient, and based upon the information available at the time of the patient's examination, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks, if any, to the individual's medical condition from affecting this transfer. Summary of risks and benefits upon which above certification is based:

SECTION IV

Check below as appropriate

- A. ☒ The receiving facility has available space and qualified personnel for the treatment of the patient
- B. ☒ The receiving facility has agreed to accept transfer and to provide appropriate medical treatment
- C. ☒ The receiving facility will be provided with appropriate medical records of the examination and treatment of the patient
- D. ☒ The patient will be transferred by qualified personnel and transportation equipment, as required
- E. ☒ Reason for transfer: 40% ASA Burns

I certify that I have answered the above questions based upon the information available to me at the time of the patient's examination or the transferring physician's call.

Physician's Signature

Date and Time

6/3/97 10am

Clinical Information (for Incoming transfers only):

Accepting Physician's Signature

Date and Time

TRANSFER REQUEST (Patient Request)

I acknowledge that my medical condition has been evaluated and explained to me by the emergency services physician or other qualified medical person and/or my attending physician who has recommended and offered to me further medical examination and treatment. The potential benefits of such further medical examination and treatment as well as the potential risk associated with transfer to another facility have been explained to me, and I request transfer to:

Signature of Patient/Responsible Person

Witness

Relationship to Patient

Date and Time

TRANSFER REFUSAL

I acknowledge that my medical condition has been evaluated and explained to me by the emergency services physician or other qualified medical person and/or my attending physician, who has recommended that

I be transferred to the service of Dr. _____ at _____

The potential benefits of such transfer, the potential risk associated with transfer, and probable risk associated with transfer, and the probable risk of not being transferred have been explained to me, and I fully understand

them. Even though Dr. _____ believes it is in my best interest to be transferred, I refuse to be transferred, and I request instead to continue receiving treatment at _____

Signature of Patient/Responsible Person

Witness

Relationship to Patient

Date and Time

TRANSFER CONSENT

I acknowledge that my medical condition has been evaluated and explained to me by the emergency services

physician or other qualified person and/services of Dr. Miller at GHS

The potential benefits of such a transfer and the probable risks associated with such transfer, (to include

the inherent risk of emergent ground and/or flight transport) are as follows: To be transferred

for lower risk of loss of life

and I fully understand them. With this knowledge and understanding, I agree to be transferred.

Donnell W. Jones
Signature of Patient/Responsible Person

[Signature]
Witness

Wife
Relationship to Patient

10-3-97 10:25
Date and Time

**GREENVILLE HOSPITAL SYSTEM
NURSING TRANSFER CHECKLIST**

Addressograph

PROVISIONAL DIAGNOSIS(ES): _____

ACCEPTING MD and TIME OF CONTACT: _____

MODE OF TRANSFER: ☐ Auto ☐ Ambulance ☐ Helicopter ☐ Other _____

VS ON TRANSFER: Time 1210 BP 157/79 Pulse 94 Resp Vent Temp 100.8

AIRWAY	☐ Patent	☒ Maintained by <u>7.0 ET tube</u>
BREATHING	☐ Unlabored	☐ Assisted by <u>Vent</u>
BBS:	☐ Clear	☐ Other _____
CIRCULATION	☐ Rhythm _____	Cap Refill: ☒ < 2 sec ☐ > 2 sec
NEURO	☐ Alert & oriented x _____	☒ Other <u>Paralyzed</u>
	☐ At baseline status	Suicidal/Homicidal: ☐ Yes ☐ No

SEDATIVES/PARALYTICS GIVEN:
(Time/Drug/Dose)

MS 10mg IVP
Norman 10mg IVP

IV/DRIPS
(Time initiated/Drip/Concentration)

LRX 2 @ 500cc/20L

ACCOMPANYING PERSONNEL: ☐ EMT ☒ EMT-P ☒ RN ☐ MD ☐ None
☐ Other _____

MEDICAL DATA SENT WITH PATIENT: ☒ Emergency Department Record(s)
☒ X-Rays ☐ EKG ☒ Lab Reports ☐ Nursing Notes ☒ Transfer Form
☐ Other Medical Record(s) ☐ Other _____

ORDERS DURING TRANSPORT: ☒ Routine ACLS Protocol ☐ BLS
☐ Special Orders (list): _____

DISPOSITION OF PATIENT'S PERSONAL EFFECTS (Clothes or valuables):

☐ None ☐ With patient ☒ Family/significant (who): wife
☐ Other (list): _____

Family Status: ☒ Notified (who): wife ☐ On the way ☐ None

Primary Nurse [Signature]

In the event of acute deterioration, refractory chest pain, respiratory or cardiac arrest, divert to the nearest hospital capable of emergency intervention and notify the sending Physician ASAP.

Sending Physician _____ MD

(1-6) 000858367

No. 96-7541

PATIENT IDENTIFICATION (Please Print)			POSITION (101-102)		TYPE OF INCIDENT		PATIENT STATUS																																						
LAST NAME (10-20) FIRST NAME (30-45) MI (46)			01 ☐ TREATMENT TRANS.		TRAUMA (103) MEDICAL (104)		TO SCENE (105) ON SCENE (106) FROM SCENE (107)																																						
JONES, Archie Edwards			02 ☐ DOA AT SCENE		1 ☐ MYA 1 ☐ ENVIRON		1 ☒ EMERGENT 1 ☒ EMERGENT 1 ☒ EMERGENT																																						
STREET (47-71) APT. #			03 ☐ HOSPITAL ER		2 ☐ MC 2 ☐ BEHAV		2 ☐ NONEMERGENT 2 ☐ NONEMERGENT 2 ☐ NONEMERGENT																																						
1719 Salem Church Rd.			04 ☐ HOSP. DIR. ADMIT.		3 ☐ BIKES 3 ☐ OB/GYN		CODE _____ CODE _____																																						
CITY (72-87) STATE (88-89) ZIP CODE (90-94)			05 ☐ TRAUMA CENTER		4 ☐ PED 4 ☐ RESP		INCIDENT LOCATION																																						
Anderson SC 29625			06 ☐ PATIENT'S HOME		5 ☐ ASSAULT 5 ☐ CARDIAC		ST. OR HWY. Greenville Mem. Hosp.																																						
SEX (95)	RACE (96)	AGE (97-100)	07 ☐ NURSING HOME		6 ☐ FALL 6 ☐ INTERFAC		CITY Greenville COUNTY (108-109)																																						
1 ☒ Male	1 ☐ White	63	08 ☐ DR.'S OFFICE		7 ☐ FIRE 7 ☐ OTHER		SAFETY EOP (110) SITE OF INCIDENT (111)																																						
2 ☐ Female	2 ☐ Black	CHECK ONE	09 ☐ OUTPATIENT		8 ☐ INTERFAC		1 ☐ Seatbelts 4 ☐ Child Seat 1 ☐ ROADWAY 4 ☐ RECREATIONAL																																						
3 ☐ Undetermined	3 ☐ Am. Indian	1 ☒ YRS.	10 ☐ PT. REFUSED TREAT.		9 ☐ OTHER		2 ☐ Helmets 5 ☐ None 2 ☐ RESIDENCE 5 ☐ AGRICULTURAL																																						
	4 ☐ Hispanic	2 ☐ MOS.																																											
	5 ☐ Asian	3 ☐ DAYS																																											
	6 ☐ Other																																												
PRELIMINARY IMPRESSIONS (MARK NO MORE THAN 4) (112-119)																																													
03 ☐ Seizure 24 ☐ Multi-trauma/Shock 74 ☐ Respiratory Distress																																													
04 ☐ Diabetic 30 ☐ Head Injury 80 ☐ Coronary Problems																																													
11 ☐ Abrasion/Contusions 32 ☐ Spinal Injury 83 ☐ Cardiac Arrest																																													
13 ☐ Laceration 33 ☐ Stroke 77 ☐ Other 84 ☐ Other																																													
23 ☐ Fracture 51 ☐ G.I. Problems 85 ☐ Other 86 ☐ Other																																													
TREATMENT PROCEDURES (120-153)																																													
01 ☒ Dressing Applied 07 ☐ Oxygen Given 13 ☐ Cardiac Massage																																													
02 ☐ Limb Splinted 08 ☐ Suction Used 14 ☐ Bleeding Controlled																																													
03 ☐ Spine Immobilized 09 ☐ Antishock Trousers 15 ☐ Cold Application																																													
04 ☐ Neck Immobilized 10 ☐ Airway Maintained 16 ☐ Patient Reassured																																													
05 ☐ OB Assistance 11 ☐ Antishock Treatment 17 ☐ Other (Use Comments)																																													
06 ☐ Oral Airway Used 12 ☐ Artificial Resp.																																													
DRUGS USED (193-208)																																													
<table border="1"> <thead> <tr> <th>DRUG</th> <th>DOSE</th> <th>TIME</th> <th>DRUG</th> <th>DOSE</th> <th>TIME</th> </tr> </thead> <tbody> <tr> <td>2-2</td> <td>10mg</td> <td>15:30</td> <td>2-2</td> <td>10mg</td> <td>15:30</td> </tr> <tr> <td>2-2</td> <td>10mg</td> <td>15:30</td> <td>2-2</td> <td>10mg</td> <td>15:30</td> </tr> <tr> <td>2-2</td> <td>10mg</td> <td>15:30</td> <td>2-2</td> <td>10mg</td> <td>15:30</td> </tr> </tbody> </table>										DRUG	DOSE	TIME	DRUG	DOSE	TIME	2-2	10mg	15:30	2-2	10mg	15:30	2-2	10mg	15:30	2-2	10mg	15:30	2-2	10mg	15:30	2-2	10mg	15:30												
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2-2	10mg	15:30	2-2	10mg	15:30																																								
REVISED TRAUMA SCORE																																													
GCS: (208) EYES _____ (214-216) SBP _____ (210) VERBAL _____ (217-219) RR _____ (211) MOTOR _____ (220) ANATOMICAL INJ. 1 ☐ YES 2 ☐ NO																																													
VITAL SIGNS																																													
<table border="1"> <thead> <tr> <th>BP</th> <th>PULSE</th> <th>RESPIRATIONS</th> <th>PUPILS</th> <th>LEVEL OF CONSC.</th> <th>TIME</th> </tr> </thead> <tbody> <tr> <td>167/102</td> <td>88</td> <td>12</td> <td>EQUAL</td> <td>E</td> <td>11:23</td> </tr> <tr> <td>178/120</td> <td>115</td> <td>12</td> <td>EQUAL</td> <td>E</td> <td>11:30</td> </tr> <tr> <td>167/89</td> <td>111</td> <td>12</td> <td>EQUAL</td> <td>E</td> <td>11:34</td> </tr> <tr> <td>177/95</td> <td>119</td> <td>12</td> <td>EQUAL</td> <td>E</td> <td>11:40</td> </tr> <tr> <td>170/90</td> <td>118</td> <td>12</td> <td>EQUAL</td> <td>E</td> <td>11:43</td> </tr> </tbody> </table>										BP	PULSE	RESPIRATIONS	PUPILS	LEVEL OF CONSC.	TIME	167/102	88	12	EQUAL	E	11:23	178/120	115	12	EQUAL	E	11:30	167/89	111	12	EQUAL	E	11:34	177/95	119	12	EQUAL	E	11:40	170/90	118	12	EQUAL	E	11:43
BP	PULSE	RESPIRATIONS	PUPILS	LEVEL OF CONSC.	TIME																																								
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177/95	119	12	EQUAL	E	11:40																																								
170/90	118	12	EQUAL	E	11:43																																								
EXPOSURE TO PT'S BODY FLUIDS (223) 1 ☐ YES 2 ☐ NO																																													
1ST Responder (224) 1 ☒ YES Name Greenville EMS/ER/CLINICAL																																													
COMMENTS (INCLUDE CHIEF COMPLAINTS, OBSERVATIONS AT SCENE, RESPONSE TO STIMULI)																																													
pt. X-rayed from Greenville Memorial U/E/O to MUSC. BURN ICU for 40-50% 2+3° burns from work related accident. pt. splashed w/ thermomix 66° liquid for melting plastic. pt. brought to local EPP by EMS. X-ray to MUSC. 10A pt. on bed w/ 1 IV L.R. @ 1000 cc 500 cc - NIG. Foley. 20% @ 100% on vent TV 900/1MV 12. + 5cm zpp. 100% FiO2. pt. packaged for X-ray via fixed line and EMS truck to + from A.R. briefed, analyzed, sedated, Mody enroute. PAIN pain. pt. X-rayed to MUSC. BURN UNIT 12° change: report to RN enroute.																																													
Patient Care Form Left In: 1 ☐ ED 2 ☒ ICU 3 ☐ OTHER																																													
TIME RECORD																																													
RUN DATE (225-232) MONTH DAY YEAR																																													
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DHEC PERMIT NO. (257-261) _____																																													
RECEIVING AGENCY (262-265) _____																																													
SENDING AGENCY (266-269) _____																																													
PROVIDER TIME (OPTIONAL) _____																																													
ATTENDANT'S SIGNATURE & CERTIFICATION NO.																																													
PRIMARY PATIENT ATTENDANT (270-274) _____																																													
2ND ATTENDANT/DRIVER (275-279) _____																																													
3RD ATTENDANT/DRIVER (280-284) _____																																													
(RECEIVING NURSE OR PHYSICIAN)																																													

DHEC 10501 gnb

RECEIVER'S COPY



MUSC MEDICAL CENTER
CHARLESTON, S.C.

Name _____
Address _____

HRN 000971560 P/T I
JONES ARCHIE E
PAT 101451573 SUP
W/H 008 YARBROUCH
WX WORK COMP
EXP. 404. 6/03/97

Age 53 Sex W Race M Marital Status married History No. _____
Service burn unit Referring Physician Miller

Patient's History

Chief Complaints (Use patient's own words)

Present Illness

Pt is a 53 y/o W/M worker at 3M factory who suffered hot chemical spill at ~0900 this am. Pt spilled Thermal ~~66~~ which was reported to be >300°. Pt initially evaluated at Greenville Memorial. He was awake & alert initially, but had some respiratory distress and was noted to have swelling in the posterior oropharynx and elective intubation performed. Resuscitation begun @ ER. Pt was reported to have stable VSS and good uop. Pt flown to MUSC. Arrived at burn unit a 1430.

PMH: borderline HTN, sinus problems
(by wife)
Meds: cardura, rest unknown
Allergies: NKDA
Surgeries: tonsillectomy, ? sinus surgery



MUSC MEDICAL CENTER
PHYSICAL EXAMINATION

MRN 000971562 P/T I
JONES ARCHIE E
PAT 101451573 SJP
W/H DOB [REDACTED] YARBROUSH
WX WORK C34P
EXP. ADM. 6/03/97

Name _____
Age _____ Sex _____ Race _____
Height _____ Weight _____ Average Weight _____
Temp. _____ a.m. _____ p.m.
Pulse _____ Respiration _____

General Appearance Sedated

Skin 2nd & 3rd degree burns (see burn sheet)

Head-Sinuses _____

Eyes edema of conjunctiva on Left

Ears 2nd degree burns on (R) helix

Nose 2nd degree burns

Tongue, Lips, Oral Cavity and Teeth _____

ET tube in place

Tonsils and Pharynx-Larynx _____

Lymph Nodes _____

Neck- (Thyroid) 1st degree burn anteriorly

Hair Changes-Endocrine Stigmata _____

Breasts _____

Chest and Lungs _____

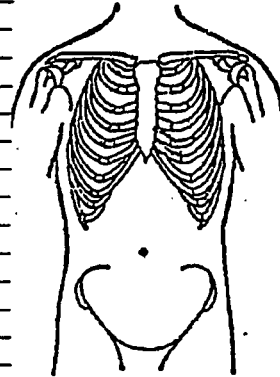
Lungs CTAB = equal BS (B)

no chest burns

Cardiovascular System-Heart, Arteries, Veins-B.P. Right _____ Left _____

RR, tachy

palpable distal pulses in all extremities



Abdomen _____

2nd & 3rd degree burns over lower abdomen

Hernia none palpable

Genito-Urinary System urine initially brownish/red
genital warts on scrotum, small blisters on penis
Rectum _____
Prostate _____
Pelvis (Female) _____

Muscles-Bones-Joints-Foot Arches-Posture-Spine
2nd & 3rd degree burns to majority of lower extremities, and
smaller areas on forearms (B)

Neurological Findings-Cranial Nerves
pt. heavily sedated

Reflexes _____

Motor Disturbances
moving all extremities

Sensory Disturbances _____

Positive Findings_History and Physical _____

Impression of Examiner ~35% TBSA 2nd & 3rd degree chemical/heat
burn & majority to lower extremities

Signed _____

Intern/Resident

Comment by Attending and Tentative Diagnosis

ACree H. & J. reviewed & signed
pt. examined ACree & assessment,
freed from plan.

Plan of Study _____

Signature, Attending Physician/Surgeon.

Date _____

Time _____

Patient: 4BR
Status:
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALEH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1108702 3-Jun-97 5:56 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
35% CHEMICAL BURNS
Alt. Bill Codes: 46710109

CHEST, 6/3/97

COMPARISON: Earlier same day at 16:09 hours.

CLINICAL HISTORY: Chemical burns to evaluate for central line placement.

FINDINGS: AP view of the chest shows that the patient remains intubated with a nasogastric tube and now with a right subclavian central venous catheter in position. The tip is present in the expected location of the SVC. Lung volumes remain low though overall aeration has improved just slightly. Patchy atelectasis is present at both medial lung bases.

IMPRESSION:

Interval placement of right subclavian central venous catheter with no definite pneumothorax. Low lung volumes.

Approved by:
Lynn Coppage, M.D. (A) / signed by/ Lynn Coppage, M.D. (A)
Dictated on: 3-Jun-97 6:16 PM by Lynn Coppage, M.D. (A)
Transcribed on: 3-Jun-97 7:53 PM by Sharon Leviner
Finalized on: 3-Jun-97 8:15 PM by Lynn Coppage, M.D. (A)
Authenticated on: 3-Jun-97 8:15 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L



Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 1108639

MRN: 000971560
Date Exam Completed: 06/03/1997 16:05
Last Update: 06/03/1997

CHEST, 6/3/97

FINDINGS: Single portable frontal film of the chest, unfortunately without any prior films for comparison, reveals an endotracheal tube overlying tracheal air column, tip projected well above carina, nasogastric tube distal tip not visible overlying upper abdomen. The aorta is unfolded. The cardiac silhouette is enlarged. I do not see any radiographic evidence to strongly suggest either pneumonia from aspiration or other cause or edema.

IMPRESSION:

Intubation. No radiographic evidence of pneumonia as yet.

History: CHEM BURNS

Technologist: BUFORD GARMON
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated: 06/03/1997 16:28

Proxy Signer:

Authenticating Radiologist:
Date Authenticated:

Transcribed by: SHARON LEVINER

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 04/23/2007 9:29 AM
Printed by: CANTRELL, EVELYN

Page: 1

Patient: 4BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1108749 4-Jun-97 6:07 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW.

A d d e n d e d R e p o r t

Assessment:

EXAM DIAGNOSIS:
53 YO WM WITH CHEMICAL 35% TBSA BURNS AND PROBABLE INHALATION INJURY
HISTORY: LUNG INJURY BY TUBE PLACEMENT
Alt. Bill Codes: 46710109

CHEST PORTABLE, 6/4/97

Portable supine film of the chest compared with our prior examination dated 6/3/97, again reveals endotracheal tube overlying tracheal air column well above carina, nasogastric and nasocenteric tubes distal tips not visible overlying upper abdomen, subclavian venous catheter right, tip overlying superior vena cava. No sign of recurrence of pneumothorax is visible. Normal opacity is present in the lower two-thirds of the left chest with a veil of opacity and downward displacement of the left hilum appearance suggesting left lower collapse and a small pleural effusion. These findings are both new since the prior exam. I do not see any other new findings.

IMPRESSION:

Left lower lobe collapse. Left pleural effusion.

Addendum:

ADDENDED BY DR. SCHABEL, 6/4/97

Case discussed with Dr. Merz through the scrub nurse in the Operating Room at 8:13 AM this morning.

Approved by:

Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 4-Jun-97 7:37 AM by Stephen Schabel, M.D. (A)
Transcribed on: 4-Jun-97 7:55 AM by Carolyn Chambers
Added on: 4-Jun-97 8:37 AM by Carolyn Chambers
Finalized on: 4-Jun-97 10:04 AM by S. I. Schabel, M.D.
Authenticated on: 4-Jun-97 10:04 AM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 1560
JONES, ARCHIE E
DOB: 02-28-1943

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1109369 5-Jun-97 5:13 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
53 YO WF WITH HOT CHEMICAL BURN TO 40% TBSA AND PROBABLY CHEMICAL
HISTORY: INHALATION
LUNG INJURY TRANSPYLONIC TUBE PLACEMENT
Alt. Bill Codes: 46710109

CHEST 6/5/97

HISTORY: 53 year old with chemical burns.

COMPARISON: 6/4/97

FINDINGS: AP view of the chest shows that the patient remains intubated with a nasogastric tube, nasocenteric feeding catheter and right subclavian central venous catheter in position. There is interval reduction in lung volumes with mild interstitial pulmonary edema and bilateral pleural effusions. No definite pneumothorax is visualized.

IMPRESSION:

Interval reduction in lung volumes with interstitial edema and bilateral pleural effusions.

Approved by:

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 5-Jun-97 9:05 AM by Lynn Coppage, M.D. (A)
Transcribed on: 5-Jun-97 10:24 AM by Nora Hollingsworth
Finalized on: 5-Jun-97 10:54 AM by Lynn Coppage, M.D. (A)
Authenticated on: 5-Jun-97 10:54 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient : 04BR
Status: I
MFID: 000971560

Sex: M
000 1560
JONES, ARCHIE E
DOB: 06-11-42

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1109377 5-Jun-97 5:13 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:

53 YO WF WITH HOT CHEMICAL BURN TO 40% TBSA AND PROBABLE CHEMICAL
HISTORY: INHALATION
LUNG INJURY TRANSPYLORIC TUBE PLACEMENT
Alt. Bill Codes: 46740007

ABDOMEN, 06-05-97

HISTORY: 53 year old with chemical burns to evaluate Dobb-Hoff tube placement

COMPARISON: None

FINDINGS: AP view of the abdomen with the pelvis excluded by collimation demonstrates both nasogastric and nasocenteric feeding catheter in position. Both tips are noted in the stomach just beyond the gastroesophageal junction. There is an overall paucity of bowel gas. Free intraperitoneal air cannot be excluded on this limited radiograph. Haziness to the abdomen may suggest ascites. There are osteoarthritic changes of the lower dorsal and lumbar spine.

IMPRESSION:

Nasocenteric feeding catheter and nasogastric tube tips in the stomach just beyond the gastroesophageal junction. Paucity of bowel gas.

Approved by:

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 5-Jun-97 9:02 AM by Lynn Coppage, M.D. (A)
Transcribed on: 5-Jun-97 10:21 AM by Eileen Rogers
Finalized on: 5-Jun-97 10:54 AM by Lynn Coppage, M.D. (A)
Authenticated on: 5-Jun-97 10:54 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 1560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1109963 6-Jun-97 6:02 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
BURNS
HISTORY: SUSPECT PNEUMONIA/OBSTR
Alt. Bill Codes: 46710109

SINGLE AP VIEW OF CHEST, 6/6/97

CLINICAL HISTORY: 53 year old with burns, inhalation injury and pulmonary edema.

COMPARISON: 6/5/97

FINDINGS: AP view of the chest shows that the patient remains intubated with a nasogastric tube, nasocenteric feeding catheter and right subclavian central venous catheter in position. The heart is enlarged, there is persistent pulmonary edema in association with bilateral pleural effusions. Confluent air-space disease is now noted in the right mid zone where superimposed pneumonia cannot be excluded.

IMPRESSION:

Persistent interstitial edema with bilateral pleural effusions. Focal air-space disease now in the right mid zone where superimposed pneumonia cannot be excluded.

Approved by:
Lynn-Coppage, M.D. (A) // signed by/ Lynn Coppage, M.D. (A)
Dictated on: 6-Jun-97 8:30 AM by Lynn Coppage, M.D. (A)
Transcribed on: 6-Jun-97 9:37 AM by Carol-Ann Rhoads
Finalized on: 6-Jun-97 12:53 PM by Lynn Coppage, M.D. (A)
Authenticated on: 6-Jun-97 12:53 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1109964 6-Jun-97 6:03 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:

BURNS

HISTORY: SUSPECT PNEUMONIA/OBSTR

Alt. Bill Codes: 467400D7

AP VIEW OF THE ABDOMEN, 6/6/97

CLINICAL HISTORY: To evaluate Dobb-Hoff tube placement.

COMPARISON: 6/5/97

FINDINGS: AP view of the abdomen with the left flank and lower pelvis excluded by collimation demonstrates a nasogastric tube with tip in the region of the gastric pylorus. Nasogastric tube is also present with its tip in the region of the gastric fundus. Bibasilar air-space disease is noted. There is no definite evidence of a mechanical bowel obstruction. There is a rounded area of increased density in the right mid abdomen which may represent contrast within the gallbladder or right kidney. There are osteoarthritic changes of the lower dorsal and lumbar spine.

IMPRESSION:

Nasogastric feeding catheter tip in the region of the gastric pylorus.

Approved by:

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)

Dictated on: 6-Jun-97 8:33 AM by Lynn Coppage, M.D. (A)

Transcribed on: 6-Jun-97 9:42 AM by Carol-Ann Rhoads

Finalized on: 6-Jun-97 12:53 PM by Lynn Coppage, M.D. (A)

Authenticated on: 6-Jun-97 12:53 PM by Lynn Coppage, M.D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR

Status: I

MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0

JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BRUNSON, GENE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110439 7-Jun-97 6:01 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:

53 YO S/P CHEMICAL INHALATION AND 40 % TBSA

HISTORY: B EFFUSIONS ATELECTASIS

Alt. Bill Codes: 46710109

PORTABLE CHEST: 06/07/97

COMPARISON: 06/06/97

HISTORY: 53 year-old status post chemical inhalation and 40% TBSA burn.

INDICATION: Bilateral effusions, atelectasis.

FINDINGS: A portable frontal view of the chest compared with a prior study performed the previous day again demonstrates patient remains intubated with endotracheal tube overlying the tracheal air column, tip well above the carina, nasogastric tube with distal tip excluded by collimation and right subclavian central venous line with tip overlying superior vena cava. Lung volumes remain low with perihilar haze and perihilar air space opacities. There is increased opacification of the lower lung zones and patchy air space opacity in the right upper lung zone.

IMPRESSION:

Bilateral pleural effusions and pulmonary interstitial edema. Worsening air space disease and a superimposed pneumonia can not be excluded. Clinical correlation is required.

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

DC 30

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Quintana, John MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110487 7-Jun-97 7:52 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW

Assessment:

EXAM DIAGNOSIS:
DOBBHOFF
Alt. Bill Codes: 46740007

ABDOMEN: 06/07/97

COMPARISON: 06/06/97

HISTORY: 53 year-old white man with 40% total body surface area,
increasing residuals with tube feeds.

INDICATION: Dobb-Hoff placement.

FINDINGS: A single portable frontal view of the abdomen collimated
over the mid abdomen which is extremely technically limited
demonstrates distal extent of a nasogastric tube with tip in the
gastric fundus. A nasocenteric feeding catheter is identified with tip
in the region of the distal stomach or proximal duodenum.

IMPRESSION:

Nasocenteric feeding catheter with tip most likely in the proximal
duodenum. Can not definitively exclude tip in distal gastric antrum.

Approved by:
Glenn Blackwood, M.D. (R) /signed by/ Charles Tubbs, M.D. (A)
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: 7-Jun-97 10:55 AM by Charles Tubbs, M.D. (A)
Transcribed on: 7-Jun-97 11:35 AM by Lori O'Neal
Last Edited on: 8-Jun-97 12:28 PM by Charles Tubbs, M.D. (A)
Finalized on: 8-Jun-97 12:28 PM by Charles Tubbs, M.D. (A)
Authenticated on: 8-Jun-97 12:28 PM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110613 8-Jun-97 5:45 AM Requested by: James (R) Craigie
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
BURN
HISTORY: DHT PLACEMENT
Alt. Bill Codes: 46710109

CHEST, PORTABLE, 6/8/97

COMPARISON: 6/7/97

HISTORY: 53 year old with burn

INDICATION: Possible pneumonia

FINDINGS: A portable frontal view of the chest demonstrates patient remains intubated with endotracheal tube, nasogastric tube, right subclavian central venous line, relatively unchanged in position. The right costophrenic angle and hemidiaphragm are now well defined. There is persistent right medial lower lung zone air space opacity and left lower lung zone air space opacity. There is persistent central vascular congestion with improved distinction of the perihilar pulmonary vessels.

IMPRESSION:

Improving right basilar atelectasis and unchanged left lower lobe air space disease. Slightly improved perihilar pulmonary edema.

Approved by:
Glenn Blackwood, M.D. (R) /signed by/ Glenn Blackwood, M.D. (R)
Ephram P. Weingarten, M.D. (I) /signed by/ Ephram P. Weingarten, M.D. (I)
Dictated on: 8-Jun-97 10:12 AM by Ephram P. Weingarten, M.D. (I)
Transcribed on: 8-Jun-97 10:38 AM by Nancy Nazer
Last Edited on: 8-Jun-97 10:41 AM by Nancy Nazer
Finalized on: 9-Jun-97 3:10 PM by Ephram P. Weingarten, M.D. (A)
Authenticated on: 9-Jun-97 3:10 PM by Ephram P. Weingarten, M.D. (I)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110614 8-Jun-97 5:45 AM Requested by: James (R) Craigie
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
BURN
HISTORY: DHT PLACEMENT
Alt. Bill Codes: 46740007

ABDOMEN, 6/8/97

COMPARISON: 6/7/97

HISTORY: 53 year old man with burn

INDICATION: DHT placement

FINDINGS: A portable supine AP view of the abdomen is compared with a prior study performed the previous day. The diaphragm and inferior pelvis is excluded by collimation. An enteric feeding catheter is seen with distal metal tip in the expected location of the second portion of the duodenum. Other than difference in technique, there is no significant interval change.

IMPRESSION:

Dobb-Hoff tube in place with tip in duodenum. No significant interval change.

Approved by:
Glenn Blackwood, M.D. (R) /signed by/ Glenn Blackwood, M.D. (R)
Ephram P. Weingarten, M.D. (I) /signed by/ Ephram P. Weingarten, M.D. (I)
Dictated on: 8-Jun-97 10:15 AM by Ephram P. Weingarten, M.D. (I)
Transcribed on: 8-Jun-97 10:40 AM by Nancy Nazer
Last Edited on: 8-Jun-97 10:42 AM by Nancy Nazer
Finalized on: 9-Jun-97 3:10 PM by Ephram P. Weingarten, M.D. (A)
Authenticated on: 9-Jun-97 3:10 PM by Ephram P. Weingarten, M.D. (I)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient #: 04BR
Status: I
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110795 9-Jun-97 6:10 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:

53 YO WM S/P 40% TBSA BURN AND CHEMICAL INHALATION INJURY
HISTORY: B EFFUSIONS EDEMA RESP FAILURE
Alt. Bill Codes: 46710109

AP VIEW OF THE CHEST, 6/9/97

HISTORY: 53 year old with 40% total body surface area burns,
bilateral pleural effusions and pulmonary edema.

COMPARISON: 6/8/97

AP portable view of the chest shows that the patient remains
intubated with a nasogastric tube, nasenteric feeding catheter and
right subclavian central venous catheter in position. There is
considerable motion artifact present. Bilateral interstitial and
airspace disease has increased in the interval. Bilateral pleural
effusions are once again noted.

IMPRESSION:

Worsening interval and airspace disease which most likely represents
worsening pulmonary edema. However, pneumonic process cannot be
excluded. Bilateral pleural effusions are again noted and could be
further quantitated with decubitus views if clinically indicated.

Approved by:

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)

Dictated on: 9-Jun-97 7:51 AM by Lynn Coppage, M.D. (A)

Transcribed on: 9-Jun-97 8:40 AM by Carolyn Chambers

Last Edited on: 9-Jun-97 1:30 PM by Lynn Coppage, M.D. (A)

Finalized on: 9-Jun-97 1:30 PM by Lynn Coppage, M.D. (A)

Authenticated on: 9-Jun-97 1:30 PM by Lynn Coppage, M.D. (A)

I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BRUNSON, GENE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1110439 7-Jun-97 6:01 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Approved by:
Glenn Blackwood, M.D. (R) /signed by/ Charles Tubbs, M.D. (A)
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: 7-Jun-97 11:00 AM by Charles Tubbs, M.D. (A)
Transcribed on: 7-Jun-97 11:39 AM by Lori O'Neal
Finalized on: 8-Jun-97 12:30 PM by Charles Tubbs, M.D. (A)
Authenticated on: 8-Jun-97 12:30 PM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient: 04BR
Status: I
MFID: 000954348

Sex: F
00054348
ROBERTSON, MISTY

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: ICZ-101434603
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1111621 10-Jun-97 4:22 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
18 YO WF WITH TEN E/O PNEUMO CONT FEVERS
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

PORTABLE CHEST, 06-10-97

INDICATION: TEN, rule out pneumonia

COMPARISON: 05-30-97

FINDINGS: Portable AP supine radiograph of the chest reveals no change in position of endotracheal tube. There has been passage of a nasogastric tube in the interval, distal tip not included on field of view. The lungs remain hypoaerated with subsegmental, atelectatic strands bilaterally. No focal consolidation is seen to suggest pneumonia.

IMPRESSION: No change in atelectasis.

[21~

Approved by:
Jon Horn, M.D. (R) /signed by/ Charles Tubbs, M.D. (A)
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: 10-Jun-97 10:24 AM by Charles Tubbs, M.D. (A)
Transcribed on: 10-Jun-97 11:01 AM by Eileen Rogers
Last Edited on: 11-Jun-97 11:15 PM by Charles Tubbs, M.D. (A)
Finalized on: 11-Jun-97 11:15 PM by Charles Tubbs, M.D. (A)
Authenticated on: 11-Jun-97 11:15 PM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E
DOB: 000000

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MANIGAULT, RAY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1111127 9-Jun-97 2:56 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
SUSPECT PTX
Alt. Bill Codes: 46710109

CHEST, 6/9/97

INDICATION: Pneumothorax, right subclavian placement

COMPARISON: 6/9/97, earlier in the day

FINDINGS: Portable AP supine radiograph of the chest demonstrates no change in position of endotracheal tube. Dobb-Hoff tube and nasogastric tube remain in position, distal tips not visualized. There has been the interval placement of right subclavian central venous catheter whose distal tip overlies the superior vena cava without resultant pneumothorax. Bilateral diffuse and patchy air space significant opacity is present, predominately in the lung bases, certainly compatible with infection, or patchy pulmonary edema.

IMPRESSION:

1. No pneumothorax following central line placement.
2. Patchy extensive air space disease in this burn patient, compatible with infection or fluid overload.

Approved by:
Jon Horn, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 9-Jun-97 5:46 PM by Lynn Coppage, M.D. (A)
Transcribed on: 9-Jun-97 7:54 PM by Nancy Nazer
Last Edited on: 11-Jun-97 9:25 AM by Lynn Coppage, M.D. (A)
Finalized on: 11-Jun-97 9:25 AM by Lynn Coppage, M.D. (A)
Authenticated on: 11-Jun-97 9:25 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: C4BR
Status: I
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E
DOB: 06-08-43
A

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: BEARD, MANDY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1111757 10-Jun-97 10:19 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
BURNS/ DDT PLACEMENT
Alt. Bill Codes: 46740007

ABDOMEN, 06-10-97

HISTORY: Burns, feeding tube placement

COMPARISON: 06-08-97

FINDINGS: AP view of the abdomen reveals a Dobb-Hoff feeding tube with tip projecting in the region of the distal duodenum, near the ligament of Treitz. A nasogastric tube is seen with tip overlying the gastric body. The bowel gas pattern is unremarkable.

IMPRESSION:

Feeding tube tip overlying the distal duodenum.

Approved by:
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: by Charles Tubbs, M.D. (A)
Transcribed on: 10-Jun-97 12:35 PM by Eileen Rogers
Finalized on: 11-Jun-97 11:28 PM by Charles Tubbs, M.D. (A)
Authenticated on: 11-Jun-97 11:28 PM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: I
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E
DOB: 10-10-1928

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1111622 10-Jun-97 4:22 AM Requested by: Jeff Marz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
53 YO WM S/P 40 % TBSA BURN AND CHEMICAL INHALATION
HISTORY: B EFFUSIONS, EDEMA, ATELECTASIS
Alt. Bill Codes: 46710109

CHEST, 6/10/97

INDICATION: Chemical inhalation, bilateral effusions, edema

COMPARISON: 6/9/97

FINDINGS: Portable AP supine radiograph of the chest reveals no significant change in position of the endotracheal tube and central venous catheter. Enteric tube and nasogastric tube are in good position, tip excluded from field of view. Continued hypoaeration, bibasilar airspace disease, vascular engorgement with indistinctness persists, not significantly changed from prior examination.

IMPRESSION:

Stable appearance of the chest compatible with inhalational injury, pulmonary edema or less likely infection.

Approved by:
Jon Horn, M.D. (R) /signed by/ Charles Tubbs, M.D. (A)
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: 10-Jun-97 9:53 AM by Charles Tubbs, M.D. (A)
Transcribed on: 10-Jun-97 10:34 AM by Carolyn Chambers
Last Edited on: 11-Jun-97 8:06 AM by Charles Tubbs, M.D. (A)
Finalized on: 11-Jun-97 8:06 AM by Charles Tubbs, M.D. (A)
Authenticated on: 11-Jun-97 8:06 AM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

MUSC MEDICAL CENTER
MEDICAL RECORDS
(803) 792-3881

MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

4/22 4/22 E

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 06/11/97

Drs. Yarbrough/Merz/Craigie

PREOPERATIVE DIAGNOSIS: Status post 40% total body surface area burns.

POSTOPERATIVE DIAGNOSIS: Status post 40% total body surface area burns.

PROCEDURE: Excision and placement of homograft (23 strips of approximately 75 cm square on bilateral lower extremities.

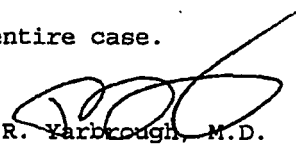
ANESTHESIA: General.

FINDINGS: Full-thickness burns to lower extremities.

PROCEDURE IN DETAIL: After induction of general endotracheal anesthesia, the patient was placed in the supine position. The Weck dermatome and Watson blade were used for excision of the full-thickness burns of the lower extremities. Hemostasis was obtained with intraoperative soaks and electrocautery. Homograft was applied and the wounds were dressed. Patient was transferred to recovery in stable condition.

Dr. Yarbrough was present and scrubbed for the entire case.

James E. Craigie, M.D.
Resident


Dabney R. Yarbrough, M.D.
Attending

JEC:757/2093
DD: 06/11/97
DT: 06/11/97
Additional CC: _____

Patient c: 04BR
Status: 1
MFID: 000971560

Sex: M
0 0 0 7 1 5 6 0
JONES, ARCHIE E
DOB: 03-01-1938

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: WAINWRIGHT, STANLEY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1112966 12-Jun-97 7:18 AM Requested by: Jeff Marz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
INTUBATION
Alt. Bill Codes: 46710109

PORTABLE CHEST, 06-12-97

INDICATION: Re-intubation

COMPARISON: Earlier same day at 5:22 a.m.

FINDINGS: Portable AP supine radiograph of the chest demonstrates endotracheal tube overlying tracheal air column, distal tip halfway between the thoracic inlet and carina in good location. Nasogastric tube and Dobhoff catheter remain in position, distal tips not included on field of view. Generalized, interstitial and mild, alveolar edema has slightly increased from prior examination. Bibasilar air space disease persists, not significantly changed, left greater than right.

IMPRESSION:

1. Endotracheal tube in expected location.
2. Slightly increased generalized moderate pulmonary edema.
3. Bilateral air space disease of the lung bases persists.

Approved by:
Jon Horn, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 12-Jun-97 9:27 AM by Lynn Coppage, M.D. (A)
Transcribed on: 12-Jun-97 10:36 AM by Eileen Rogers
Last Edited on: 12-Jun-97 2:49 PM by Lynn Coppage, M.D. (A)
Finalized on: 12-Jun-97 2:49 PM by Lynn Coppage, M.D. (A)
Authenticated on: 12-Jun-97 2:49 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MRID: 000971560

Sex: M
00071560
JONES, ARCHIE E
DOB: 06-03-23

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DAENEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1112946 12-Jun-97 5:15 AM Requested by: James (R) Craigie
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
40 % TBSA CHEMICAL BURN
HISTORY: POST OP
Alt. Bill Codes: 46710109

PORTABLE CHEST, 06-12-97

INDICATION: Chemical burns, pneumonia

COMPARISON: 06-10-97

FINDINGS: Portable AP supine radiograph of the chest demonstrates no change in position of endotracheal tube. Dobb-Hoff tube and nasogastric tube in place, distal tips not included. There has been slightly improved overall better aeration from the prior examination with persistent, bibasilar air space disease and mild, generalized, pulmonary edema.

IMPRESSION:

Improved aeration.

Approved by:
Jon Horn, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 12-Jun-97 9:29 AM by Lynn Coppage, M.D. (A)
Transcribed on: 12-Jun-97 10:39 AM by Eileen Rogers
Finalized on: 12-Jun-97 2:49 PM by Lynn Coppage, M.D. (A)
Authenticated on: 12-Jun-97 2:49 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DANEY R., M.D. (A) Visit number: IWK-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1113570 13-Jun-97 5:30 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
CHEMICAL INJURY AND 40%TBSA
HISTORY:PNEUMO
Alt. Bill Codes: 46710109

PORTABLE CHEST, 6/13/97.

IMPRESSION:

Nasogastric tube and a Dobb-Hoff type feeding catheter are noted, as well as a right-sided CVP line as well as a endotracheal tube. Patchy pneumonia involving the left lower lung is present associated with a moderate sized left-sided pleural effusion. There are minimal congestive changes.

Approved by:
Arch Templeton, M.D. (A) /signed by/ Arch Templeton, M.D. (A)
Dictated on: 13-Jun-97 7:38 AM by Arch Templeton, M.D. (A)
Transcribed on: 13-Jun-97 8:55 AM by Carol-Ann Rhoads
Finalized on: 13-Jun-97 12:41 PM by Arch Templeton, M.D. (A)
Authenticated on: 13-Jun-97 12:41 PM by Arch Templeton, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: ~~Intermittent~~
MFID: 000954348

Sex: F
00054348
ROBERTSON, MISTY
DOB: ~~20-Mar-78~~

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: ICZ-101434603.
Technologist: BEARD, MANDY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1113599 13-Jun-97 1:14 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
ASPIRATION
Alt. Bill Codes: 46710109

CHEST, 6/13/97

INDICATION: Risk of aspiration.

COMPARISON: 6/12/97

FINDINGS: Portable AP supine radiograph of the chest again demonstrates tracheostomy tube in place. Nasogastric tube remains in position, a side-port over body of stomach. The right subclavian central venous catheter tip crosses the midline and has been retracted slightly from prior examination. No pneumothorax is visualized and there is no evidence of focal air space disease to represent pneumonia or aspiration.

IMPRESSION:

No evidence of aspiration or pneumonia.

Approved by:
Jon Horn, M.D. (R) /signed by/ Jon Horn, M.D. (R)
Arch Templeton, M.D. (A) /signed by/ Arch Templeton, M.D. (A)
Dictated on: 13-Jun-97 1:48 PM by Arch Templeton, M.D. (A)
Transcribed on: 13-Jun-97 2:38 PM by Carol-Ann Rhoads
Last Edited on: 13-Jun-97 3:40 PM by Jon Horn, M.D. (R)
Finalized on: 13-Jun-97 7:41 PM by Arch Templeton, M.D. (A)
Authenticated on: 13-Jun-97 7:41 PM by Arch Templeton, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1114187 14-Jun-97 5:05 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
40% TBSA BURNS AND INHALATION INJURY
HISTORY: PULM EDEMA/PNEUMO.
Alt. Bill Codes: 46710109

PORTABLE CHEST: 06/14/97

COMPARISON: 06/13/97

HISTORY: Burns, inhalational injury, possible pneumonia or pulmonary edema.

FINDINGS: AP view of the chest reveals coarse interstitial opacities throughout both lungs, with patchy air space opacity within the perihilar regions and lung bases. The right subclavian line and endotracheal tube are unchanged in position. The feeding tube tip is not identified.

IMPRESSION:

Diffuse interstitial and patchy alveolar opacities bilaterally, with slight interval improvement within the left upper lobe. No other significant interval changes.

Approved by:
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: by Charles Tubbs, M.D. (A)
Transcribed on: 14-Jun-97 11:07 AM by Lori O'Neal
Finalized on: 16-Jun-97 11:20 AM by Charles Tubbs, M.D. (A)
Authenticated on: 16-Jun-97 11:20 AM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

MUSC MEDICAL CENTER
MEDICAL RECORDS
(803) 792-3881

MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

46K

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 06/15/97

Drs. Yarbrough/Craigie/Blue/Merz/Everman

PREOPERATIVE DIAGNOSIS: Forty percent total body surface area burn.

POSTOPERATIVE DIAGNOSIS: Forty percent total body surface area burn.

PROCEDURE: Debridement of burns lower extremity and placement of homograft. Total placement of 39 sheets of approximately 100 sq cm homograft were placed.

ANESTHESIA: General.

(Dr. Yarbrough was present and scrubbed for the entire case.)

DESCRIPTION OF PROCEDURE: After induction of general anesthesia, the extremities and groin area were sterilely prepped and draped. Previously placed homograft was removed from the lower extremity, and the thighs were debrided using the Weck dermatome and the Watson knife. Electrocautery and phenylephrine were used for hemostasis. After excision of the burn full thickness areas, homograft was placed as described above. The wounds were then sterilely dressed with interface, Kerlix, and burn dressings. The patient was then transferred back to the burn unit still intubated.

James E. Craigie, M.D.
Resident

Dabney E. Yarbrough, M.D.
Attending

JEC:754/2647
DD: 06/16/97
DT: 06/17/97
Additional CC: _____

Patient ID: 04BR
Status: 1
MFID: 000971560

Sex: M
0 0 0 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1114384 15-Jun-97 5:53 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
CHEMICAL BURNS
HISTORY: INFILTRATE
Alt. Bill Codes: 46710109

PORTABLE CHEST, 1 VIEW, 6/15/97

COMPARISON: 6/14/97

INDICATION: Patient with chemical burns, rule out infiltrate.

FINDINGS: Single AP radiograph of the chest demonstrates an endotracheal tube, nasogastric tube, and right subclavian central venous catheter, unchanged in position from prior exam. Diffuse coarse interstitial and air space opacities are noted throughout both lungs with more focal areas of increased density in the right perihilar region and the left retrocardiac region. Findings may represent pulmonary edema with a superimposed infectious process in the appropriate clinical setting. Overall, there has been no significant interval change. A veiling opacity is noted overlying the entire left hemithorax which may represent a pleural effusion.

IMPRESSION:

Persistent diffuse interstitial and air space disease with focal areas of increased density in the right perihilar and left retrocardiac regions, unchanged from prior examination. Left pleural effusion. No evidence of pneumothorax.

Patient ID: 04BR Sex: M
Status: I 00071560
MFID: 000971560 JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1114384 15-Jun-97 5:53 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Approved by:
Patricia Davis, M.D. (R) /signed by/ Ephram P. Weingarten, M.D. (I)
Ephram P. Weingarten, M.D. (I) /signed by/ Ephram P. Weingarten, M.D. (I)
Dictated on: 15-Jun-97 10:30 AM by Ephram P. Weingarten, M.D. (I)
Transcribed on: 15-Jun-97 11:32 AM by Nancy Nazer
Finalized on: 16-Jun-97 10:42 AM by Ephram P. Weingarten, M.D. (A)
Authenticated on: 16-Jun-97 10:42 AM by Ephram P. Weingarten, M.D. (I)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient: 04BR
Status: I
MFID: 000971568

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: DONOHUE, JAMES MEDICAL UNIVERSITY OF SOUTH CAROLINA
1114553 16-Jun-97 4:57 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
40% TBSA BURNS AND INHALATION INJURY
HISTORY: PNEUMO/PULM EDEMA
Alt. Bill Codes: 46710109

CHEST: 06/16/97

INDICATION: Pneumonia, pulmonary edema.

COMPARISON: 06/15/97

FINDINGS: Portable AP supine radiograph of the chest demonstrates no change in position in tubes or catheters. Patchy air space disease involving the lobes of the left lung and the right infrahilar region persists and there is slight interval improvement of the aeration of the left lower lobe appreciated.

IMPRESSION:

1. Slight improvement of left lower lobe aeration in this patient with patchy air space disease. It is difficult to discern infectious process from patchy pulmonary edema in this patient given patchy and bilateral distribution.

Approved by:
Jon Horn, M.D. (R) /signed by/ Jon Horn, M.D. (R)
Charles Tubbs, M.D. (A) /signed by/ Charles Tubbs, M.D. (A)
Dictated on: 16-Jun-97 9:21 AM by Charles Tubbs, M.D. (A)
Transcribed on: 16-Jun-97 10:11 AM by Lori O'Neal
Last Edited on: 16-Jun-97 10:27 AM by Jon Horn, M.D. (R)
Finalized on: 17-Jun-97 8:21 AM by Charles Tubbs, M.D. (A)
Authenticated on: 17-Jun-97 8:21 AM by Charles Tubbs, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 / 1560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: CHISOLM, CHERYL MEDICAL UNIVERSITY OF SOUTH CAROLINA
1115187 17-Jun-97 7:58 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
ASSESS LINE PLACEMENT
HISTORY: SUSPECT PTX
Alt. Bill Codes: 46710109

PORTABLE CHEST: 06/17/97

INDICATION: Central line placement.

COMPARISON: 06/16/97

FINDINGS: Portable AP supine radiograph of the chest again demonstrates endotracheal tube and both the nasogastric tube and Dobb-Hoff tube catheter in place. The right central venous catheter may have been exchanged however its tip remains at the superior vena cava. The lungs are hypo-aerated with mild to moderate interstitial diffuse edema which may be slightly improved from the prior examination; however interval development of air space disease of the left lower lobe which now partially silhouettes the hemidiaphragm has occurred. There is lucency over the distal aspect of the endotracheal tube suggesting overdistention of the cuff.

IMPRESSION:

1. Interval development of left lower lobe pneumonia.
2. Central venous catheter location remains at superior vena cava.
3. Possible overdistention of endotracheal tube cuff. Please correlate with pressure readings.

Patient: 04BR
Status: I
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGE, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: GARMON, BUFORD MEDICAL UNIVERSITY OF SOUTH CAROLINA
1115458 17-Jun-97 3:07 PM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
GASTRIC OUTLET SYNDROME
Alt. Bill Codes: 46740007

PORTABLE ABDOMEN: 06/17/97

INDICATION: Tube position.

COMPARISON: 06/10/97

FINDINGS: Portable AP supine view of the abdomen, the right lateral portion excluded from field of view demonstrates interval retraction of Dobb-Hoff tube catheter, its weighted portion now overlying the second portion of the duodenum. Bowel gas pattern is remarkable for copious amount of stool in the cecum. There is no evidence of bowel obstruction. The nasogastric tube seen on prior exam is not identified on the field of view.

IMPRESSION:

1. Retraction of Dobb-Hoff tube to the second portion of duodenum.
2. Stool filled cecum without evidence of focal ileus or mechanical obstruction.

Approved by:
Jon Horn, M.D. (R) /signed by/ Jon Horn, M.D. (R)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 17-Jun-97 4:34 PM by Lynn Coppage, M.D. (A)
Transcribed on: 17-Jun-97 6:06 PM by Lori O'Neal
Finalized on: 18-Jun-97 10:58 AM by Lynn Coppage, M.D. (A)
Authenticated on: 18-Jun-97 10:58 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: ~~XXXXXXXXXX~~
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E
~~NAME: XXXXXXXX~~

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1116369 19-Jun-97 4:15 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
53 YO WM WITH 40% TBSA BURN RESP FAILURE
HISTORY: PULM EDEMA PNEUMO
Alt. Bill Codes: 46710109

PORTABLE VIEW OF CHEST, 6/19/97

INDICATION: Pulmonary edema, pneumonia.

COMPARISON: 6/17/97

FINDINGS: Portable AP supine radiograph of the chest demonstrates no change in position of endotracheal tube nor central venous catheter. Nasogastric tube and Dobhoff tube are again noted, distal tips not included on field of view. There has been slightly improved aeration of the left lung base, however, more air-space opacity of the right lung base has occurred. Central vascular congestion persists.

IMPRESSION:

Shifting basilar air-space disease from left to right. Infectious cause remains primary concern and possibly secondary to aspiration.

Approved by:
Jon Horn, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 19-Jun-97 9:19 AM by Stephen Schabel, M.D. (A)
Transcribed on: 19-Jun-97 10:18 AM by Carol-Ann Rhoads
Finalized on: 19-Jun-97 11:01 AM by S. I. Schabel, M.D.
Authenticated on: 19-Jun-97 11:01 AM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: c: 04BR
Status:
MFID: 000971560

Sex: M
00 71560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1117521 22-Jun-97 5:20 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
INTUBATED
HISTORY: BURNS
Alt. Bill Codes: 46710109

SINGLE FRONTAL VIEW OF THE CHEST, 6/22/97

COMPARISON: 6/19/97

INDICATION: 53 year old white male with 40% total body surface area burns, intubated. Please evaluate for pneumonia, pulmonary edema.

Single frontal view of the chest once again demonstrates the presence of an endotracheal tube at the level of the thoracic inlet. A nasogastric and nasenteric catheter are seen, unchanged, as is the right central venous catheter over the superior vena cava. Bilateral air space opacities and central venous congestion have markedly improved. The cardiac silhouette is of normal size. The aorta is mildly unfolded.

IMPRESSION:

Overall improvement in bilateral pulmonary edema and central venous congestion.

Approved by:
Veena Chandler, M.D. (R) /signed by/ David R. Feldman, M.D. (A)
David R. Feldman, M.D. (A) /signed by/ David R. Feldman, M.D. (A)
Dictated on: 22-Jun-97 8:06 AM by David R. Feldman, M.D. (A)
Transcribed on: 22-Jun-97 9:33 AM by Nancy Nazer
Finalized on: 22-Jun-97 11:34 AM by David R. Feldman, M.D. (A)
Authenticated on: 22-Jun-97 11:34 AM by David R. Feldman, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
0071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGE, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: DAVIS, JOHN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1117739 22-Jun-97 7:54 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
BURNS
Alt. Bill Codes: 46710109

CHEST 6/22/97

INDICATION: Evaluate central venous catheter placement.

HISTORY: Burn patient.

FINDINGS: AP view of the chest shows that the patient remains intubated with a nasogastric tube, nasocenteric feeding catheter and right subclavian central venous catheter in position. No definite pneumothorax is visualized. There is slight interval increase in the diffuse interstitial pattern which may represent worsening pulmonary edema.

IMPRESSION:

Interval increase in diffuse interstitial disease compatible with worsening pulmonary edema. No definite pneumothorax with lines, tubes and catheters as discussed above.

Approved by:
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 23-Jun-97 8:24 AM by Lynn Coppage, M.D. (A)
Transcribed on: 23-Jun-97 8:53 AM by Nora Hollingsworth
Finalized on: 23-Jun-97 2:30 PM by Lynn Coppage, M.D. (A)
Authenticated on: 23-Jun-97 2:30 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: DAVIS, JOHN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1118459 24-Jun-97 4:49 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
53 YO WM WITH BURN AND INHALATION INJURY INCREASING VENT REQ
HISTORY: PNEUMO PULM EDEMA
Alt. Bill Codes: 46710109

SINGLE PORTABLE VIEW OF CHEST, 6/24/97

INDICATION: Evaluate triple lumen catheter, burn and inhalation injury with ventilator requirement, history of pneumonia and pulmonary edema.

FINDINGS: Portable supine film of the chest, compared to the prior examination dated 6/22/97 reveals a nasogastric feeding tube and nasogastric tube, distal tips not visible overlying upper abdomen; endotracheal tube overlying tracheal air column well above carina and subclavian venous catheter right, tip overlying superior vena cava. Both hila are enlarged, suggesting enlarged lymph nodes or distended central pulmonary vessels. The heart size being normal makes lymph nodes seem more likely. There is a generalized increase in interstitial densities in the lung, scattered in all lung zones, slightly more marked in the base and worse than on the earlier film. Exclusion of pneumonia, either from aspiration or other cause at the left lung base would be difficult from the radiographic appearance. The lungs have certainly improved in appearance since 6/8, though the hila do seem more prominent. Correlation with clinical history suggested. If pulmonary hypertension is not present clinically and lymph nodes would be important to document, further imaging might be considered.

IMPRESSION:

Enlarging hila suggesting enlarging lymph nodes or pulmonary vessels. Generalized lung disease improving since earlier in the month with persistent opacity at left base, where pneumonia is not excluded.

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 06/25/97

Drs. Yarbrough/Craigie

PROCEDURES:

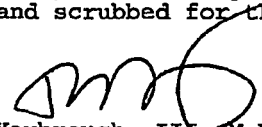
1. Percutaneous tracheostomy.
2. Burn debridement with placement of homograft (45 sheets of homograft placed).

ANESTHESIA:

General.

INDICATIONS: The patient is a 57-year-old white male, status post 40% burn, who has been debrided several times with placement of homograft here for further debridement excision of burns and percutaneous tracheostomy.

PROCEDURE: After placement in the supine position, the lower extremities, upper and lower abdomen and groins were sterilely prepped and draped. The abdomen and groin regions were excised using the Watson blade and Weck dermatome. The homograft was removed from the lower extremities, hemostasis was obtained, and homograft was replaced. Hemostasis was obtained on the abdomen, a homograft was placed there likewise, and then the wounds were sterilely dressed. At this time, attention was directed to the neck. The neck was sterilely prepped and draped. A small incision was made over the trachea. Hemostasis was obtained. Seldinger modified technique was used to cannulate the trachea when the endotracheal tube was pulled back, and the wire was passed. The trachea was then sequentially dilated and then a #8 Shiley was placed and secured. We will check a chest x-ray in recovery. Please note that Dr. Yarbrough was present and scrubbed for the entire procedures #1 and #2.


Dabney R. Yarbrough, III, M.D.
Attending

JEC:753/3817
DD: 06/25/97
DT: 06/28/97
Additional CC: _____

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BEARD, MANDY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1119148 25-Jun-97 10:49 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment: 0

EXAM DIAGNOSIS:
SUSPECT PTX
Alt. Bill Codes: 46710109

PORTABLE CHEST, 06-25-97

INDICATION: Suspect pneumothorax, tracheostomy placement, pneumonia

FINDINGS: Single portable frontal film of the chest, compared to the prior examination dated 06-24-97, reveals that the endotracheal tube has been replaced with tracheostomy, tip overlying the tracheal air column well above the carina; subclavian venous catheter from right, tip overlying the superior vena cava; nasogastric and nasocenteric tubes, nasogastric tip overlying expected location body of stomach and nasocenteric distal tip not visible overlying upper abdomen; and abnormal patches of alveolar opacity in both lungs, more marked on the left side than the perihilar zone, more marked than on the earlier film. There is no evidence of pneumothorax. I do not see any sign of cavitation.)

IMPRESSION:

No evidence of pneumothorax following tracheostomy placement.
Bilateral air space opacities, compatible with pneumonia.

Approved by:
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 25-Jun-97 11:38 AM by Stephen Schabel, M.D. (A)
Transcribed on: 25-Jun-97 11:52 AM by Eileen Rogers
Finalized on: 25-Jun-97 1:06 PM by S. I. Schabel, M.D.
Authenticated on: 25-Jun-97 1:06 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 1119610

MRN: 000971560
Date Exam Completed: 06/26/1997 05:45
Last Update: 06/26/1997

PORTABLE CHEST, 06-26-97

HISTORY: Thermal burns

INDICATION: Possible pneumonia

COMPARISON: 06-25-97

FINDINGS: AP view of the chest demonstrates tracheostomy tube, nasogastric tube and right subclavian central venous catheter in position. Overall aeration has improved slightly, but there is persistent, bilateral, interstitial and air space disease, which may represent pulmonary edema or pneumonia. Clinical correlation is recommended.

IMPRESSION:

Slight interval increase in lung volumes with persistent, bilateral, interstitial and air space disease, as described above.

History: SUSPECT PTXPNEUMONIA

Technologist: GLEN SNIPE

Proxy Signer:

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Printed: 04/23/2007 9:25 AM
Printed by: CANTRELL, EVELYN

Page: 1

Patient: **JONES, ARCHIE**
Procedure: **DIAG CHEST PORTABLE 1 VIEW**
Accession #: **1119610**

MRN: **000971560**
Date Exam Completed: **06/26/1997 05:45**
Last Update: **06/26/1997**

Interpreter 1: **LYNN COPPAGE**
Interpreter 2:
Interpreter 3:
Date Dictated: **06/26/1997 08:24**

Authenticating Radiologist:
Date Authenticated:

Transcribed by: **EILEEN ROGERS**

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Printed: **04/23/2007 9:25 AM**
Printed by: **CANTRELL, EVELYN**

Page: **2**

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 1560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: DONOHUE, MAX MEDICAL UNIVERSITY OF SOUTH CAROLINA
1120916 29-Jun-97 5:10 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
SUSPECT PTX
HISTORY: PNEUMONIA
Alt. Bill Codes: 46710109

CHEST, SINGLE FRONTAL VIEW: 06/29/97

COMPARISON: 06/26/97

INDICATION: Chemical inhalational injury. Please evaluate lung status.

FINDINGS: Single frontal view of the chest once again demonstrates the presence of a tracheostomy, a nasocenteric catheter, and a right central venous catheter, unchanged. Diffuse bilateral interstitial with alveolar opacity at the bases are still identified, unchanged. Mild central venous congestion is identified. Mild improved aeration at the left base is identified.

IMPRESSION:

1. Overall unchanged appearance of bilateral air space opacities with mild improvement in aeration at the left base.
2. Tracheostomy.

Approved by:
Veena Chandler, M.D. (R) /signed by/ Veena Chandler, M.D. (R)
Jeremy Young, M.D. (A) /signed by/ Jeremy Young, M.D. (A)
Dictated on: 29-Jun-97 7:22 AM by Jeremy Young, M.D. (A)
Transcribed on: 29-Jun-97 8:49 AM by Lori O'Neal
Finalized on: 29-Jun-97 9:23 AM by Jeremy Young, M.D.
Authenticated on: 29-Jun-97 9:23 AM by Jeremy Young, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 / 1560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MARSHALL, JENNIFER MEDICAL UNIVERSITY OF SOUTH CAROLINA
1121161 30-Jun-97 9:12 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
PTX
Alt. Bill Codes: 46710109

CHEST, 1 VIEW

INDICATION: Pneumothorax, line placement, burn patient, new central line

Single portable frontal film of the chest compared with our prior examination dated 6/29 reveals permanent tracheostomy, tip overlying tracheal air column, well above carina. Nasoenteric tube, distal tip not visible overlying upper abdomen. Subclavian venous catheter right, tip overlying superior vena cava. Widespread patches of alveolar opacity present in both lungs, more marked in the perihilar and upper lung zone right. Peripheral and lower lung zone left, unchanged since the earlier film. There is no new evidence to suggest pneumothorax.

IMPRESSION:

No significant interval change.

Approved by:
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 30-Jun-97 9:47 AM by Stephen Schabel, M.D. (A)
Transcribed on: 30-Jun-97 11:48 AM by Nancy Nazer
Finalized on: 30-Jun-97 11:56 AM by S. I. Schabel, M.D.
Authenticated on: 30-Jun-97 11:56 AM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

MUSC MEDICAL CENTER
MEDICAL RECORDS
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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

43A

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 07/02/97

Drs. Harvey/Gayoso/O'Neill/O

PREOPERATIVE DIAGNOSIS: Chemical burns to chest, abdomen,
back and bilateral lower extremities.

POSTOPERATIVE DIAGNOSIS: Chemical burns to chest, abdomen,
back and bilateral lower extremities.

PROCEDURE: Tangential excision and split
thickness skin grafting to the
posterior aspect of bilateral lower
extremities (600 cm sq).

INDICATIONS: Patient is a 54-year-old white male who sustained
significant burns secondary to a chemical explosion and was in need
of tangential excision and split thickness skin grafting of lower
extremities.

DESCRIPTION OF PROCEDURE: Patient was taken to the operating room,
induced with general anesthesia, and placed in a prone position.
Patient's lower extremities were then prepped with Hibiclens and
draped in the usual sterile fashion. Tangential excision was
performed using wet blades over the posterior aspects of both lower
extremities from the thigh down to the ankles until healthy tissue
was encountered. Hemostasis was achieved with cautery, as well as
phenylephrine-soaked lap pads. Ten millimeter skin grafts were
harvested from the left thigh as well as the back using a Zimmer
dermatome. The skin grafts were meshed 1:1.5 and secured to the
previously-debrided sites with staples. Adequate coverage was
obtained of the posterior aspect of both lower extremities
encompassing a total of 600 cm sq of skin graft. Wounds were then
dressed with interface, Red Cross cotton, and then Kerlix. A
Biobrane membrane was applied to the donor sites and secured with
staples, and covered with dry dressings. Patient was then returned
to a supine position and general anesthesia stopped. Patient was
then transported to the burn unit in stable condition.

ESTIMATED BLOOD LOSS: 1 liter.

IV FLUIDS: 3800 cc of crystalloid, 500 cc of
albumin, and two units packed red

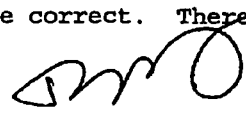
HOSPITAL OPERATIVE REPORT.

Patient Name: JONES, ARCHIE
MRN: 00971560
PAGE 2

blood cells.

At the end of the procedure, all counts were correct. There were no apparent intraoperative complications.

Seung-Jun O, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

SJO:757/4806
DD: 07/02/97
DT: 07/06/97
Additional CC: _____

MUSC MEDICAL CENTER
MEDICAL RECORDS
(803) 792-3881

MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

4811

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 07/02/97

Drs.

ADDENDUM TO PREVIOUSLY DICTATED OR NOTE:

DESCRIPTION OF PROCEDURE: On the split-thickness skin grafting which totalled 600 cm squared, 520 cm were placed on the posterior aspects of the bilateral lower extremities, and 80 cm were placed on the bilateral feet.

Seung-Jun O, M.D.
Resident


Attending

:752/4812
DD: 07/02/97
DT: 07/06/97
Additional CC: _____

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SEYLE, RUSSELL MEDICAL UNIVERSITY OF SOUTH CAROLINA
1122815 2-Jul-97 5:08 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
PULMONARY EDEMA
Alt. Bill Codes: 46710109

PORTABLE CHEST, 07-02-97

INDICATION: Burn patient with chemical inhalation, increasing peak
respiratory pressures

COMPARISON: 06-03-97

IMPRESSION:

Portable chest film demonstrates tracheostomy tube in place. Feeding
tube is seen coursing through the stomach, tip not visualized. The
same can be said for nasogastric tube. The patient has a right
subclavian catheter, tip in the superior vena cava. The lungs show
some mild, interstitial edema but essentially unchanged from
06-30-97. No other changes are appreciated.

Approved by:
William F. Conway, M.D. (A) /signed by/ William F. Conway, M.D. (A)
Dictated on: 2-Jul-97 6:56 PM by William F. Conway, M.D. (A)
Transcribed on: 2-Jul-97 8:32 PM by Eileen Rogers
Finalized on: 3-Jul-97 8:16 AM by William F. Conway, M.D. (A)
Authenticated on: 3-Jul-97 8:16 AM by William F. Conway, M.D. (A)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DARNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1122945 3-Jul-97 4:32 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
FACIAL BURNS TRACHEOSTOMY CHEST X RAY FOR LUNG STATUS
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

CHEST ONE VIEW, 7/3/97

INDICATION: Burn patient with clinical inhalation. Tracheostomy. Lung status. Pneumonia.

FINDINGS: Single portable frontal film of the chest compared with our prior examination dated 7/2/97 again reveals permanent tracheostomy, tip overlying tracheal air column well above carina; nasogastric feeding catheter, distal tip not visible overlying upper abdomen; subclavian venous catheter right, tip overlying superior vena cava. Abnormal air-space opacity is present in the base of the lung on the left side causing increasing density in the lower third of the left chest and indistinctness to the dome of the diaphragm, more marked than on the prior examination, certainly compatible with pneumonia. Distribution would be unusual for an inhalational injury alone. Aspiration might have contributed to this appearance. Skin staples overlie the right chest, compatible with prior skin grafts.

IMPRESSION:

Worsening consolidation left lower lobe compatible to pneumonia.
Prior tracheostomy.

Approved by:
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 3-Jul-97 7:58 AM by Stephen Schabel, M.D. (A)
Transcribed on: 3-Jul-97 9:52 AM by Carolyn Chambers
Finalized on: 3-Jul-97 3:05 PM by S. I. Schabel, M.D.
Authenticated on: 3-Jul-97 3:05 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BRUNSON, GENE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1123884 6-Jul-97 7:07 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment: M
NA

EXAM DIAGNOSIS:
30 % TSAB
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

PORTABLE CHEST

HISTORY: 30% total body burns

INDICATION: Clinical suspicion of pneumonia

COMPARISON: 7/3/97

FINDINGS: Single frontal portable chest radiograph shows the tracheostomy tube overlying expected projection of the tracheal lumen. Enteric feeding tube is noted in left upper quadrant. Left subclavian central venous catheter overlies expected projection of superior vena cava. Left lower lobe air space disease is unchanged as is bilateral perihilar interstitial markings suggestive of fluid overload. Surgical skin staples overlie right thorax, suggestive of skin graft.

IMPRESSION:

Left lower lobe air space disease and moderate congestion.

Approved by:

Pavel Krapiva, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 6-Jul-97 10:15 AM by Stephen Schabel, M.D. (A)
Transcribed on: 6-Jul-97 12:46 PM by Nancy Nazer
Finalized on: 6-Jul-97 5:14 PM by S. I. Schabel, M.D.
Authenticated on: 6-Jul-97 5:14 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1124039 7-Jul-97 5:45 AM Requested by: Seugn Jun O
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
BURN
HISTORY: PNEUMO
Alt. Bill Codes: 467.0109

AP PORTABLE VIEW OF CHEST, 7/7/97

CLINICAL HISTORY: Burns.

CLINICAL INDICATION: Pulmonary edema.

COMPARISON: 7/6/97

FINDINGS: AP view of the chest with both costophrenic angles excluded by collimation, again demonstrates a tracheostomy tube, nasocenteric feeding catheter, nasogastric tube and right subclavian central venous catheter in position. There is persistent but slightly improved generalized interstitial pulmonary edema.

IMPRESSION:

Persistent but improved pulmonary edema pattern.

Approved by:
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 7-Jul-97 8:06 AM by Lynn Coppage, M.D. (A)
Transcribed on: 7-Jul-97 8:22 AM by Carol-Ann Rhoads
Finalized on: 7-Jul-97 1:56 PM by Lynn Coppage, M.D. (A)
Authenticated on: 7-Jul-97 1:56 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Gadsden, Carolyn MEDICAL UNIVERSITY OF SOUTH CAROLINA
1124712 8-Jul-97 9:15 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
PTX
Alt. Bill Codes: 46710109

PORTABLE CHEST, ONE VIEW: 07/08/97

COMPARISON: 07/07/97

INDICATION: Chemical burns with clinical suspicion of pneumothorax.

FINDINGS: There is a tracheostomy tube tip visible overlying tracheal air column well above carina. There is a right subclavian catheter with tip overlying expected location in superior vena cava. Skin staples visible overlying the right lung field. Cardiac lead monitors are visible. There is bilateral lower lung field opacification worse on the left than on the right. NG tube is visible with the tip not visible.

IMPRESSION:

1. Worsening bilateral pulmonary edema.
2. Tracheostomy tube, right subclavian catheter and nasogastric tube in position as described previously on comparison to the film from 07/07/97.

Approved by:
Mike Couden, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 8-Jul-97 10:50 AM by Stephen Schabel, M.D. (A)
Transcribed on: 8-Jul-97 11:07 AM by Lori O'Neal
Finalized on: 8-Jul-97 1:01 PM by S. I. Schabel, M.D.
Authenticated on: 8-Jul-97 1:01 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

MUSC MEDICAL CENTER
MEDICAL RECORDS
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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

4BR 41BR

HOSPITAL OPERATIVE REPORT

JONES, ARCHIE E.
MRN 00971560-101451573
Date of Surgery: 7/10/97

Drs. Harvey/O'Neill/O

PREOPERATIVE DIAGNOSIS: Third degree thermal burns to torso and circumferential bilateral lower extremities.

POSTOPERATIVE DIAGNOSIS: Third degree thermal burns to the torso and circumferential bilateral lower extremities.

PROCEDURES PERFORMED: Tangential excision and split-thickness skin grafting of anterior legs and feet bilaterally.

ANESTHESIA: General.

INDICATIONS: The patient is a 53 year old man, who suffers from significant third degree thermal burns to his torso and bilateral lower extremities circumferentially. Patient has undergone previous tangential excision with homograft placement and also additional tangential excision and split-thickness skin grafting of his posterior legs bilaterally. Patient now presents for removal of homograft, tangential excision and split-thickness skin grafting of the anterior aspect of his legs and feet bilaterally.

FINDINGS: The homograft was well stuck in all areas of the anterior legs and feet bilaterally, with the exception of the dorsum of the right foot which had extensor hallucis longus tendon exposed and slightly desiccated. After homograft removal, excellent blood flow was noted to all areas. After tangential excision of the superficial aspects of the new granulation tissue, good healthy viable and bleeding tissues were noted in all areas except for the dorsum of the right foot, and possibly the dorsum of the left foot.

DESCRIPTION OF THE PROCEDURE: The patient was brought to the main operating room and general anesthesia was induced through the tracheostomy. Patient was placed in the prone position, prepped and draped in the usual sterile manner using Hibiclens solution. 1200 sq cm of split-thickness skin graft measuring 16/1000th of an inch thick were taken from the patient's back. Hemostasis was obtained and Xeroform followed by burn dressing was placed over this. The patient was then flipped to the supine position. The skin which was harvested was meshed in a 1.5 to 1 ratio. In a non-sterile environment, the dressings were removed from the legs and the homograft was removed along with multiple staples. All persons were regowned and gloved. The legs were prepped sterily with multiple Hibiclens, and the patient was draped in the usual sterile manner. Tangential excision of the superficial granulation tissue was accomplished with a combination of Zimmer dermatome set at 10/1000th of an inch, and a Weck blades also set at 1000th of an inch. Hemostasis was

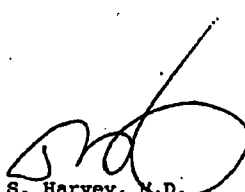
HOSPITAL OPERATIVE REPORT

JONES, ARCHIE E.
MRN 00971560-101451573
Page 2

obtained with electrocautery and Neo-Synephrine soaked lap pads. Skin graft was laid down on the top of the tissue beds and stapled into position with metal staples. Coverage included the entire left anterior lower extremity down to the ankle, but not including the foot. It also included the entire right thigh, down to and just below the knee. The remainder of the burn areas were covered with Homograft. N-terface followed by .25% Neomycin soaked gauzes wrapped with Kerlex completed the dressing.

The patient was returned to his Clinitron bed where lower extremity dressings were placed on the patient. The patient was returned to the burn unit in hemodynamically stable condition. Estimated blood loss was 2.5 liters. There were no complications.

:Patrick J. O'Neill, M.D.
:Resident in Plastic Surgery


:Tracy S. Harvey, M.D.
:Attending in Plastic Surgery

PJO:me
DD: 07/11/97
DT: 07/15/97
cc: 1 each surgeon

Patient: 04BR
Status: I
MFID: 000971560

Sex: M
000 / 156-0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWK-101451573
Technologist: DONOHUE, MAX MEDICAL UNIVERSITY OF SOUTH CAROLINA
1126431 10-Jul-97 6:44 PM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
BURN
Alt. Bill Codes: 46710109

PORTABLE CHEST, 07/10/97

INDICATION: Pneumonia.

COMPARISON: 07/08/97.

FINDINGS: Portable AP supine radiograph of the chest reveals interval improvement of the air space opacity at the left lung base from prior exam. Tracheostomy tube, enteric tube, nasogastric tube, and subclavian central venous catheter remain in position, unchanged. No pneumothorax is seen. Central pulmonary edema persists.

IMPRESSION:

- 1) Improved left lung basilar air space disease.
- 2) Central pulmonary prominence, unchanged.

Approved by:
Jon Horn, M.D. (F) / signed by/ Jon Horn, M.D. (F)
Dictated on: by Jon Horn, M.D. (F)
Transcribed on: 11-Jul-97 6:38 AM by Sherry Morrison
Last Edited on: 11-Jul-97 7:07 AM by Jon Horn, M.D. (R)
Finalized on: 11-Jul-97 7:07 AM by Jon Horn, M.D. (R)
Authenticated on: 11-Jul-97 7:07 AM by Jon Horn, M.D. (F)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Gadsden, Carolyn MEDICAL UNIVERSITY OF SOUTH CAROLINA
1126595 11-Jul-97 9:50 AM Requested by: Dabney R. Yarbrough, M.D. (A)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
DE PLACEMENT
Alt. Bill Codes: 46740007

PORTABLE SINGLE AP VIEW OF ABDOMEN, 7/11/97

COMPARISON: 7/7/97

INDICATION: Patient with a history of burns; status post Dobb-Hoff tube placement.

FINDINGS: There is a non-specific gas pattern present. No signs of any intraperitoneal free air. Nasoenteric tube present with tip overlying region of the second part of the duodenum.

IMPRESSION:

1. Non-specific gas pattern with no radiographic evidence of any free air or obstruction.
2. Nasoenteric tube present with tip overlying region of the second part of the duodenum.

Approved by:
Mike Couden, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 11-Jul-97 11:16 AM by Lynn Coppage, M.D. (A)
Transcribed on: 11-Jul-97 12:20 PM by Carol-Ann Rhoads
Finalized on: 11-Jul-97 4:01 PM by Lynn Coppage, M.D. (A)
Authenticated on: 11-Jul-97 4:01 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: I
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: INX-101451573
Technologist: DONOHUE, JAMES MEDICAL UNIVERSITY OF SOUTH CAROLINA
1127464 14-Jul-97 5:11 AM Requested by: Jeff Merz, MD (R)
PORTABLE CHEST 1 VIEW
Assessment: E

EXAM DIAGNOSIS:
BURN PT W/PNEUMO
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

CHEST 7/14/97

HISTORY: Patient with burns.

INDICATION: Pneumothorax.

FINDINGS: Single portable frontal film of the chest excludes the right costophrenic angle by columnation and is compared with the prior examination dated 7/10 and reveals a permanent tracheostomy tip overlying tracheal air column well above carina. Subclavian venous catheter right tip overlying superior vena cava. Skin staples overlying thorax compatible with prior skin grafts and nasocenteric feeding catheter distal tip not visible overlying upper abdomen. Abnormal air space opacities are present in the peripheral right lung and left lung base worse than on the prior examination compatible with areas of pneumonia or infarction. There was no sign of pneumothorax.

IMPRESSION:

Worsening basal air space opacities compatible with pneumonia.

Approved by:
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 14-Jul-97 7:31 AM by Stephen Schabel, M.D. (A)
Transcribed on: 14-Jul-97 8:06 AM by Nora Hollingsworth
Finalized on: 14-Jul-97 10:25 AM by S. I. Schabel, M.D.
Authenticated on: 14-Jul-97 10:25 AM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L



Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient: JONES, ARCHIE
Procedure: ANG EXTREMITY UNILAT
Accession #: 1128067

MRN: 000971560
Date Exam Completed: 07/14/1997 18:38
Last Update: 07/17/1997

LOWER EXTREMITY ARTERIOGRAM: 07/14/97

INDICATION: Burn victim. Patient needs graft for lower extremity. Evaluate vasculature.

METHOD: After obtaining informed written consent, using sterile technique and local lidocaine the left common femoral artery was accessed with an anterior wall puncture. A 4 French pigtail catheter was advanced into the distal aorta over a wire and an arteriogram was performed. The pigtail catheter was exchanged for a SOS OMNI 4 French catheter and the right common iliac artery was selectively catheterized. An angiogram of the right lower extremity was then performed. At the end of the procedure the catheter was withdrawn and hemostasis obtained. The patient tolerated the procedure well.

FINDINGS: Digital subtraction angiography images demonstrate no flow limiting lesions in the distal abdominal aorta or right lower extremity to the level of the popliteal artery. There is a normal trifurcation. However, the patient has a small anterior tibial artery which tapers at the mid leg. The peroneal artery is the dominant vessels and supplies the dorsalis pedis of the right foot. The posterior tibial artery is normally patent.

IMPRESSION:

1. Small right anterior tibial artery which tapers in the mid leg as described above. Otherwise normal vasculature in the right lower extremity.

History: EVALUATE BLOOD SUPPLY FOR FLAP

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 04/23/2007 9:24 AM
Printed by: CANTRELL, EVELYN

Page: 1

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radio: 1010 g y C on s k u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BEARD, MANDY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1128256 15-Jul-97 10:18 AM Requested by: Jeff Metz, MD (R)
PORTABLE CHEST 1 VIEW

Assessment

EXAM DIAGNOSIS

LINE PLACEMENT

HISTORY: SUSPECT PTX

Alt. Bill Codes: 46710109

PORTABLE CHEST 1 VIEW, 7/15/97

INDICATION: New line change; line placement

FINDINGS: Right subclavian catheter is present with tip overlying expected location of superior vena cava. There is no sign of a pneumothorax. Surgical staples present overlying right lateral chest wall and right axillary region. Cardiac lead monitors noted overlying chest wall. Tracheostomy tube present with tip overlying tracheal air column, well above the carina. Bilateral air space opacity is present which could represent either pneumonia or edema. Clinical correlation is recommended.

IMPRESSION:

Bilateral air space opacities present right and left lungs. There is no sign of pneumothorax. Right subclavian line present with tip overlying expected location of superior vena cava.

Approved by:

Mike Couden, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)

Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)

Dictated on: 15-Jul-97 11:47 AM by Stephen Schabel, M.D. (A)

Transcribed on: 15-Jul-97 1:25 PM by Nancy Nazer

Finalized on: 15-Jul-97 5:10 PM by S. I. Schabel, M.D.

Authenticated on: 15-Jul-97 5:10 PM by Stephen Schabel, M.D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

489

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 07/18/97

Drs. Harvey/Cannova

PREOPERATIVE DIAGNOSIS: Burn.

POSTOPERATIVE DIAGNOSIS: Burn.

PROCEDURE: Full thickness skin graft to left brow.

ANESTHESIA: General by endotracheal tube.

PROCEDURE: The patient was taken to the operating room and placed in the supine position. The recipient site had very vascular heat granulation tissue which was debrided bluntly down to a bleeding recipient base. An appropriate size full thickness skin graft was then taken in an elliptical fashion from behind the left ear. This was then thinned appropriately and placed into position after pie crusting with 5-0 chromic suture. 6-0 silk sutures, Xeroform and cotton balls with mineral oil were then placed in a tie over dressing over the skin graft site. The donor site was then elevated posteriorly using Bovie cautery and then reapproximated over a #7 found Blake drain with 3-0 Monocryl in an interrupted fashion and a running 4-0 Prolene. Bacitracin ointment was then placed over the wound. The patient then went to the recovery room in good condition and has done well postoperatively.

Joseph V. Cannova, M.D.
Resident

Tracy S. Harvey, M.D.
Attending

JVC:752/6668
DD: 07/18/97
DT: 07/18/97
Additional CC: _____

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0788

4611

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 07/18/97

Drs. Harvey/O/Rast

PREOPERATIVE DIAGNOSIS: Sixty percent total body surface area burns to chest, back, and bilateral lower extremities.

POSTOPERATIVE DIAGNOSIS: Sixty percent total body surface area burns to chest, back, and bilateral lower extremities.

OPERATION: Tangential excision of split-thickness skin grafting to bilateral feet, right leg, and lower abdominal wall.

PROCEDURES: The patient was taken to the operating room and placed in the supine position. General anesthesia was established through a previously placed tracheostomy. Upper abdomen and chest were prepped and draped in the usual sterile fashion. Bilateral legs were prepped with Hibiclens. Tangential excision performed with Weck blade over bilateral feet and lower aspect of right leg, as well as abdominal wall. Skin graft sites prepared with enterocleisis on the anterior chest wall by instillation of saline solution. Skin graft was harvested from this area encompassing a total of 1850 cm squared. The skin was meshed in an 1:2 fashion, and then placed on bilateral feet, lower right leg and abdominal wall, and secured in place using clips. Interface, burn dressing, Kerlix and Brook were used to dress the legs. Dry dressings were placed after interface placement on the abdominal wall. Skin graft sites were covered with Xeroform. The patient tolerated the procedure well. There were no apparent complications. Estimated blood loss was 500 cc. Fluids were 2600 crystalloid, two units.

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
PAGE 2

packed cells. Dr. Harvey was present for a portion of this procedure.

Sonny O, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

SO:609/6682
DD: 07/18/97
DT: 07/20/97
Additional CC: _____

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MEDICAL RECORDS
(803) 792-3881

MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

4BR

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 07/18/97

Drs. Harvey/O/Cannova/Reft

PREOPERATIVE DIAGNOSIS: Deep second- and third-degree burns, involving the feet, arms, and face.

POSTOPERATIVE DIAGNOSIS: Deep second- and third-degree burns, involving the feet, arms, and face.

OPERATION: Tangential excision and debridement of both legs, both feet, and forehead; debridement with full-thickness skin grafting to 4 x 6 cm defect of the left forehead with associated debridement and split-thickness skin grafting to the left and right leg of 1250 sq cm and skin grafting of bilateral feet of 425 sq cm bilaterally.

INDICATIONS: The patient presents following extensive chemical burning. The patient was noted to have burns involving both extremities and forehead and now presents for staged operative debridement and coverage.

DESCRIPTION OF OPERATIVE PROCEDURE: The patient was laid supine on the operating table. The patient was all prepped and draped utilizing Hibiclens and Betadine. The homografts were removed from the legs; viable beds were noted. These were all excised down to bleeding healthy tissue. The same procedure was performed on the forehead. A left posterior auricular graft was harvested. This was defatted and placed on recipient bed and sewn in with #5-0 Monocryl. The donor site was closed with #5-0 Monocryl and #5-0 Prolene.

Attention was then turned to the legs where they were debrided down to good bleeding tissue, including the feet. There was extensor tendon exposure on the right foot of the extensor hallucis longus tendon; this was all irrigated with antibiotic irrigation. Enteroclysis was performed on the abdomen. Split-thickness skin grafts were harvested and meshed 1.5:1; these were placed on the legs, totaling 1400 sq cm on both feet, measuring also 1200 sq cm with additional 425 sq cm being put on both feet.

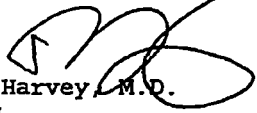
HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE

MRN: 00971560

PAGE 2

The patient tolerated the procedure well and went to the intensive care unit in guarded but stable condition.


Tracy S. Harvey, M.D.
Attending

TSH: 608/6680

DD: 07/18/97

DT: 07/20/97

Additional CC: _____

Patient: 04BR
Status: I
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1131050 21-Jul-97 6:00 AM Requested by: Seugn Jun O
DIAG CHEST SINGLE VIEW, FRONTAL /PORTABLE

Assessment:

EXAM DIAGNOSIS:
35% CHEMICAL BURN WITH INHALATION
HISTORY: CLINICAL INDICATION PNEUMONIA
Alt. Bill Codes: 46710109

AP PORTABLE CHEST: 07/21/97

COMPARISON: 07/15/97

HISTORY: Chemical inhalation burns.

INDICATION: Pneumonia.

FINDINGS: AP view of the chest demonstrates a tracheostomy tube, nasogastric feeding catheter, nasogastric tube and right subclavian central venous catheter in position. Both costophrenic angles are excluded by collimation. Bilateral interstitial and air space disease is noted and essentially unchanged. This may represent a picture of cardiogenic or noncardiogenic pulmonary edema or widespread bilateral pneumonia.

IMPRESSION:

1. Persistent bilateral interstitial and air space disease.

Approved by:
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 21-Jul-97 9:06 AM by Lynn Coppage, M.D. (A)
Transcribed on: 21-Jul-97 10:57 AM by Lori O'Neal
Finalized on: 21-Jul-97 11:06 AM by Lynn Coppage, M.D. (A)
Authenticated on: 21-Jul-97 11:06 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

Copy to: HARVEY, TRACY S., M.D. (O)

F I N A L

Patient: c: 04BR
Status: I
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DANEY R., M.D. (A) Visit number: IWX-101451573
Technologist: ANDERSON, LORRY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1131114 21-Jul-97 7:50 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
DHT PLACEMENT
Alt. Bill Codes: 467400D7

AP UPPER ABDOMEN: 07/21/97

HISTORY: Burns.

INDICATION: To evaluate Dobb-Hoff tube placement.

FINDINGS: AP view of the upper abdomen with the left flank excluded by collimation demonstrates a nasocenteric feeding catheter with tip in the region of the pylorus. Nasogastric tube is present with tip in the stomach.

Approved by:
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 21-Jul-97 9:07 AM by Lynn Coppage, M.D. (A)
Transcribed on: 21-Jul-97 10:58 AM by Lori O'Neal
Finalized on: 21-Jul-97 11:06 AM by Lynn Coppage, M.D. (A)
Authenticated on: 21-Jul-97 11:06 AM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 04BR
MFID: 000971560

Sex: M.
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGE, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALPH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1131752 22-Jul-97 8:59 AM Requested by: Jeff Merz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
C/S OF OBSTRUCTION
Alt. Bill Codes: 46740007

ABDOMEN, 7/22/97

COMPARISON: Single view of the abdomen, 7/21/97

INDICATION: Burn patient with continued feeding problems. Evaluation of Dobb-Hoff placement.

FINDINGS: View of the abdomen reveal the nasogastric tube in place in the fundus of the stomach. Dobb-Hoff feeding tube in place with the tip overlying the antrum of the stomach and the holes in the body of the stomach. This is essentially unchanged from prior film. There are multiple skin staples noted overlying the right lower quadrant and right hemipelvis as well as the upper right quadrant, consistent with prior skin graft.

IMPRESSION:

Feeding tube with tip in the antrum of the stomach.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 22-Jul-97 1:36 PM by Stephen Schabel, M.D. (A)
Transcribed on: 22-Jul-97 2:32 PM by Nancy Nazer
Finalized on: 22-Jul-97 3:59 PM by S. I. Schabel, M.D.
Authenticated on: 22-Jul-97 3:59 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient: 04BR
Status: 1
MFID: 000971560

Sex: M
00071560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGE, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Siciliano, Mark MEDICAL UNIVERSITY OF SOUTH CAROLINA
1132281 23-Jul-97 4:59 AM Requested by: Jeff Marz, MD (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment: 0

EXAM DIAGNOSIS:
40% TBSA CHEMICAL BURNS
Alt. Bill Codes: 46740007

PORTABLE ABDOMEN: 07-23-97

COMPARISON: 07-22-97

INDICATION: Status post burns. Symptoms of ileus.

FINDINGS: A single frontal view of the upper abdomen, mostly cut off by collimation, reveals stomach full of air with NG tube and Dobhoff feeding tube in place in the fundus of the stomach. The small and large bowel cannot be evaluated as they are not included on this film.

IMPRESSION:

NG tube and feeding tube seen in the fundus of the stomach.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Stephen Schabel, M.D. (A)
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 23-Jul-97 9:28 AM by Stephen Schabel, M.D. (A)
Transcribed on: 23-Jul-97 12:44 PM by Donna Matlock
Finalized on: 23-Jul-97 1:22 PM by S. I. Schabel, M.D.
Authenticated on: 23-Jul-97 1:22 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR
Status: 1
MFID: 000971560

Sex: M
000 71560
JONES, ARCHIE E
NA

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BEARD, MANDY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1132406 23-Jul-97 9:15 AM Requested by: Jeff Merz, MD (R)
DIAG ANKLE, AP, LAT VIEWS /RIGHT/PORTABLE

Assessment:

EXAM DIAGNOSIS:
ANKLE FX
Alt. Bill Codes: 46736005

RIGHT ANKLE, 7/23/97

INDICATION: Burn patient; swollen ankle.

IMPRESSION:

AP, oblique, and lateral views of the ankle demonstrate multiple skin clips overlying the soft tissues of the distal leg and ankle. No definite acute abnormality is seen. Some degenerative change is noted in the tarsus, with early spur formation of the posterior aspect of the calcaneus.

Approved by:

Jeremy Young, M.D. (A) /signed by/ Jeremy Young, M.D. (A)

Dictated on: 23-Jul-97 10:41 AM by Jeremy Young, M.D. (A)

Transcribed on: 23-Jul-97 11:20 AM by Sharon Leviner

Finalized on: 23-Jul-97 2:41 PM by Jeremy Young, M.D.

Authenticated on: 23-Jul-97 2:41 PM by Jeremy Young, M.D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient ID: 04BR

Status: 1

MFID: 000071560

Sex: M
0 0 0 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: WAINWRIGHT, STANLEY MEDICAL UNIVERSITY OF SOUTH CAROLINA
1133530 25-Jul-97 7:50 AM Requested by: Jeff Merz, MD (R)
DIAG CHEST SINGLE VIEW FRONTAL /PORTABLE

Assessment: E

EXAM DIAGNOSIS:

PNEUMONIA

Alt. Bill Codes: 46710109

CHEST, 7/25/97

COMPARISON: 7/21/97

CLINICAL HISTORY: Burns

INDICATION: Fever spiked

FINDINGS: AP view of the chest again demonstrates a tracheostomy tube and nasogastric tube in position. The nasocenteric feeding catheter and right subclavian central venous catheter have been removed. There is persistent interstitial and air space disease and there is a small right pleural effusion.

IMPRESSION:

Persistently low lung volumes with bibasilar interstitial and air space disease as well as a small right pleural effusion.

Approved by:

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)

Dictated on: 25-Jul-97 10:15 AM by Lynn Coppage, M.D. (A)

Transcribed on: 25-Jul-97 12:27 PM by Sharon Leviner

Finalized on: 25-Jul-97 1:36 PM by Lynn Coppage, M.D. (A)

Authenticated on: 25-Jul-97 1:36 PM by Lynn Coppage, M.D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALPH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1136897 1-Aug-97 8:30 AM Requested by: Seugn Jun O
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
SUSPECY PTX/ILEUS
Alt. Bill Codes: 46740007

ABDOMEN, 8/1/97

COMPARISON: 7/23/97

INDICATION: Status post burn; clinical suspicion of ileus.

FINDINGS: Single frontal view of the abdomen with the diaphragms and right flank cut off by collimation reveal nasogastric tube in place in the stomach. There is a non-specific bowel gas pattern of gas seen in the small bowel and colon. There are multiple small calcifications seen in the lower pelvis consistent with phleboliths. No evidence of obstruction is noted.

IMPRESSION:

Nonspecific bowel gas pattern with no evidence of obstruction.

Approved by:

Richard Patrick, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)

Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)

Dictated on: 1-Aug-97 9:49 AM by Lynn Coppage, M.D. (A)

Transcribed on: 1-Aug-97 10:55 AM by Sharon Leviner

Last Edited on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)

Finalized on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)

Authenticated on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALPH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1136896 1-Aug-97 8:50 AM Requested by: Seugn Jun O
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
SUSPECT PTX/ILEUS
Alt. Bill Codes: 46710109

SINGLE PORTABLE CHEST, 8/1/97

COMPARISON: 7/25/97

INDICATION: Possible pneumonia

FINDINGS: A tracheostomy remains in place, tip overlying tracheal air shadow well above the carina. NG tube courses throughout the mediastinum in the expected location, however, the tip is not visible. There has been an interval increase in pulmonary edema but no evidence of consolidation, effusion or pneumothorax.

IMPRESSION:

Worsening pulmonary edema compared to prior film.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 1-Aug-97 9:50 AM by Lynn Coppage, M.D. (A)
Transcribed on: 1-Aug-97 10:54 AM by Carol-Ann Rhoads
Last Edited on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)
Finalized on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)
Authenticated on: 1-Aug-97 1:59 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALPH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1136963 1-Aug-97 11:18 AM Requested by: Seugn Jun O
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
SUSPEX PTX/ILEUS
Alt. Bill Codes: 46740007

ABDOMEN, 8/1/97.

COMPARISON: Earlier same day.

CLINICAL HISTORY: 53 year old with burns.

INDICATION: To evaluate nasogastric tube placement.

FINDINGS: AP view of the abdomen with the right flank and lower pelvis excluded by collimation shows that the nasogastric tube has been advanced with tip now in the region of the gastric antrum. The bowel gas pattern is nonspecific with nondilated loops of small and large bowel. Free intraperitoneal air cannot be excluded on this single AP radiograph.

IMPRESSION:

Interval advancement of the nasogastric tube with tip now in the region of the gastric antrum.

Approved by:
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 1-Aug-97 12:50 PM by Lynn Coppage, M.D. (A)
Transcribed on: 1-Aug-97 1:11 PM by Sharon Leviner
Finalized on: 1-Aug-97 2:01 PM by Lynn Coppage, M.D. (A)
Authenticated on: 1-Aug-97 2:01 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Electroencephalography Report

Patient: JONES, ARCHIE

MRN: 000971560

Date: 8/2/1997

Status: INITIAL

MEDICAL UNIVERSITY OF SOUTH CAROLINA
Clinical Neurophysiology Services
PAT COM#: 101451573

NAME: Jones, Archie
EEG Laboratory

MUH #: 971560

800-922-5250 (Meduline - state)

DATE: 08/02/97

803-792-2200 (Meduline - local)

STUDY #: Digital EEG #1

Disk#

803-792-3641 (EEG Scheduling)

REFER MD: Yarborough

ELECTROENCEPHALOGRAPHY REPORT

INTRODUCTION:

History: The patient is a 55 year old male with a history of chemical burn injury in June of this year and has been hospitalized since then. Recently, he became more confused, cyanotic and tachycardic. He also has episodes of shaking and shivering and this EEG was done to rule out epileptiform activity.

Medications: Dilantin, Versed, Dopamine.

Recording Conditions: Recording electrodes were applied according to the International 10-20

System,

An 20-channel EEG was obtained according to guidelines of the American Clinical Neurophysiology

society (J Clin Neurophysiol 1994; 11:2-115) in referential montages, reformatted to bipolar and Laplacian montages as necessary. Activating procedures included tactile and verbal stimulation. Recording was obtained during the waking, drowsy and asleep states.

EEG DESCRIPTION: During brief wakefulness, the record demonstrated a 7 Hz, 15-30 (?)V background rhythm. During drowsiness sleep there was attenuation of the background frequencies which gradually transcended into stage II sleep with K complexes, vertex waves and sleep spindles.

Activating procedures included tactile and verbal stimulation. Patient woke up with stimulation and sleep pattern changed to more drowsy and intermittently awake EEG for few seconds. No spikes, spike-wave complexes or periodic discharges were seen. Patient had mild trembling of the arms and

lips that did not have any EEG correlate. Minor muscular, eye movement, and EKG artifacts were noted.

IMPRESSION:

EEG Diagnosis: This is a mildly abnormal study due to slowing of the background. No epileptiform activity is noted. Mild trembling of the arms and lips did not have any EEG correlate.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed: 04/23/2007 9:40:04

Printed by: CANTRELL, EVELYN

Page: 1

Patient: JONES, ARCHIE

MRN: 000971560

Date: 8/2/1997

Status: INITIAL

Clinical Interpretation: The study shows a generalized abnormality in the form of diffuse slowing that points towards an encephalopathy. The causes could included metabolic, toxic, infectious or ischemic insults. No seizure activity was noted. Clinical correlation is suggested.

John Gross, M.D.
Assistant Professor
Department of Neurology.

Date dictated/transcribed: 08/02/97

Date signed: _____

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed: 04/23/2007 9:40:04

Page:

Printed by: CANTRELL, EVELYN

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E
LINA

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: DAVIS, JOHN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1137421 2-Aug-97 9:54 AM Requested by: Seugn Jun O
DIAG CHEST SINGLE VIEW FRONTAL /PORTABLE

Assessment:

EXAM DIAGNOSIS:
CHECK CENTRAL LINE PLACEMENT
Alt. Bill Codes: 4670109

CHEST: 08/02/97

INDICATION: Check central line placement.

EXAMINATION: Frontal chest.

COMPARISON: 08/01/97

FINDINGS: Tracheostomy tube 4 1/2 cm from the level of the carina.
Interval placement of a right subclavian line which terminates in the
superior vena cava without evidence of underlying pneumothorax. The
heart is not enlarged. There is slight prominence of the pulmonary
vasculature with mild prominence of the interstitium, diffuse and
bilateral suggesting minimal early pulmonary edema.

IMPRESSION:

1. Status post right subclavian line without pneumothorax.
2. Slight interstitial pattern.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Richard Patrick, M.D. (R)
W. Gene Phillips, II (I) /signed by/ W. Gene Phillips, II (I)
Dictated on: 3-Aug-97 10:50 AM by W. Gene Phillips, II (I)
Transcribed on: 3-Aug-97 12:04 PM by Lori O'Neal
Finalized on: 4-Aug-97 6:11 PM by W. Gene Phillips, II (I)
Authenticated on: 4-Aug-97 6:11 PM by W. Gene Phillips, II (I)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

Patient Loc: 04BR.
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: KURTZ, CARL MEDICAL UNIVERSITY OF SOUTH CAROLINA
1137472 2-Aug-97 3:15 PM Requested by: Ted M.D. (R) Johnson
PORTABLE CHEST 1 VIEW

Assessment: 60

EXAM DIAGNOSIS:
SWAN-GANZ PLACED
Alt. Bill Codes: 46710109

PORTABLE CHEST, 8/2/97 3:15 p.m.

INDICATION: Swan-Ganz placed.

COMPARISON: 8/2/97 at 9:59 a.m.

FINDINGS: Tracheostomy tube, NG tube, and right subclavian line all unchanged since the prior examination. There is interval placement of a left Swan-Ganz catheter the tip of which is seen within the main pulmonary artery directed toward the right pulmonary artery. There is slight prominence to the central pulmonary vascularity with evidence of minimal pulmonary edema. No gross lobar pneumonia, effusion, mass or pneumothorax demonstrated. Overall, no significant change regarding the heart and lungs since the prior examination earlier in the day.

IMPRESSION:

1. Status post placement left Swan-Ganz catheter without evidence of pneumothorax.
2. Minimal pulmonary edema.

Approved by:

Richard Patrick, M.D. (R) /signed by/ Richard Patrick, M.D. (R)
W. Gene Phillips, II(I) /signed by/ W. Gene Phillips, II(I)
Dictated on: 3-Aug-97 10:52 AM by W. Gene Phillips, II(I)
Transcribed on: 3-Aug-97 12:10 PM by Susi Gregg
Last Edited on: 4-Aug-97 8:05 AM by Carol-Ann Rhoads
Finalized on: 4-Aug-97 6:20 PM by W. Gene Phillips, II(I)
Authenticated on: 4-Aug-97 6:20 PM by W. Gene Phillips, II(I)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Karppinen, Margaret MEDICAL UNIVERSITY OF SOUTH CAROLINA
1137429 2-Aug-97 11:30 AM Requested by: Ted M.D. (R) Johnson M
CT POST FOSSA W/NO CONTRAST 6 0

Assessment: M E

EXAM DIAGNOSIS:
SEIZURE BLEED /STROKE
Alt. Bill Codes: 46704821

CT BRAIN, 8/2/97

INDICATION: Infarct, hemorrhage.

HISTORY: 54-year-old status post seizure and cardiac arrest.

TECHNIQUE: Pre and post-contrast axial CT scanning of the brain was performed.

COMPARISON: None.

FINDINGS: An NG tube is in place on the left side, and there are areas of fluid noted bilaterally in the ethmoid sinuses and in the right maxillary sinus. The sulci and ventricles are normal-appearing for age. No hemorrhage, edema, or mass effect is seen. No abnormal enhancement is noted. Post-contrast image #34 suggests an abnormal hypodensity in the central region of the entire pons; however, this is not noted at the same level on the non-contrast scans, and presumable represents a beam-hardening artifact.

IMPRESSION:

1. No acute-appearing intracranial abnormality such as hemorrhage or acute infarct. A follow-up CT or MR scan is recommended in one to two days if clinically indicated.

2. Sinusitis as described above.

Case discussed with Dr. Johnson by Dr. Durden at 11:46 AM on 8/2/97.

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: Karppinen, Margaret MEDICAL UNIVERSITY OF SOUTH CAROLINA
1137429 2-Aug-97 11:30 AM Requested by: Ted M.D. (R) Johnson
CT POST FOSSA W/NO CONTRAST

NA
M
6 0
E

NA
M
6 0
E

Approved by:
David Durden, M.D. (R) /signed by/ Pamela Vantassel, M.D. (A)
Pamela Vantassel, M.D. (A) /signed by/ Pamela Vantassel, M.D. (A)
Dictated on: 3-Aug-97 6:49 PM by Pamela Vantassel, M.D. (A)
Transcribed on: 3-Aug-97 8:22 PM by Cheryl Wiegner
Finalized on: 3-Aug-97 10:41 PM by Pamela Vantassel
Authenticated on: 3-Aug-97 10:41 PM by Pamela Vantassel, M.D. (A)
I have personally performed, and/or reviewed the above investigation
and report.

F I N A L

NA

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: GARMON, BUFORD MEDICAL UNIVERSITY OF SOUTH CAROLINA
1137786 4-Aug-97 5:01 AM Requested by: Tracy S. Harvey, M.D. (O)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
WM WITH ANOXIC EPISODE/TRACHEOSTOMY
Alt. Bill Codes: 46710109

SINGLE PORTABLE VIEW OF CHEST, 8/4/97

INDICATION: White male anoxic episode, tracheostomy, status post pneumonia.

FINDINGS: Single portable frontal film of the chest, compared to the prior examination dated 8/2/97 again reveals a permanent tracheostomy, tip overlying tracheal air column well above carina; flow-directed balloon tipped catheter from subclavian vein sheath left, tip overlying main pulmonary artery; subclavian vein catheter right, tip overlying superior vena cava. Do not see any evidence to suggest recurrence of pneumothorax. Blood vessels in the lung are more distended and less distinct than on the earlier film, the overall appearance suggests slight worsening heart failure. I do not see any focal evidence to suggest consolidation.

IMPRESSION:

Evidence of worsening heart failure. No focal evidence of pneumonia. No sign of recurrence of pneumothorax.

Approved by:
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A)
Dictated on: 4-Aug-97 7:44 AM by Stephen Schabel, M.D. (A)
Transcribed on: 4-Aug-97 9:58 AM by Carol-Ann Rhoads
Finalized on: 4-Aug-97 4:13 PM by S. I. Schabel, M.D.
Authenticated on: 4-Aug-97 4:13 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1139119 6-Aug-97 4:58 AM Requested by: Tracy S. Harvey, M.D. (O)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
40% 3RD BURNS W/INHALATION INJURY
HISTORY: EVAL RESP. STATUS
Alt. Bill Codes: 46710109

SINGLE PORTABLE VIEW OF CHEST, 8/6/97

INDICATION: Third degree burns, inhalational injury, respiratory status pneumonia.

FINDINGS: Single portable frontal film of the chest, compared to the prior examination dated 8/4/97 reveals a permanent tracheostomy, tip overlying tracheal air column well above carina; subclavian venous catheter right, tip overlying superior vena cava; flow-directed balloon tipped catheter and sheath removed from left side; nasogastric tube in place, distal tip not identified overlying upper abdomen. Generalized increase in density throughout the lungs, more marked in the bases and perihilar zones, predominately linear interstitial opacities compatible with interstitial edema. I do not see any evidence to suggest focal consolidation, in particular, nothing to suggest a new area of pneumonia or infarction is visible.

IMPRESSION:

Continued evidence of mild interstitial edema. No sign of pneumothorax following catheter removal. No new evidence of pneumonia.

Patient Loc: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: SMITH, RALPH MEDICAL UNIVERSITY OF SOUTH CAROLINA
1140502 8-Aug-97 8:45 AM Requested by: John Sutterlin, III (R) M
PORTABLE CHEST 1 VIEW 6-0
Assessment: 27 E

EXAM DIAGNOSIS:
PTX
Alt. Bill Codes: 46710109

SINGLE PORTABLE CHEST, 8/8/97

COMPARISON: 8/6/97

INDICATION: Worsening ventilatory status, evaluate pneumonia.

FINDINGS: Single frontal view of the chest shows that tracheostomy tube and right-sided subclavian central venous catheter unchanged in location from prior film. Nasogastric tube courses through the mediastinum, tip not visible on the is film. There is generalized increased in density throughout the lungs, more marked in the bases, with the right greater than left. This is worsened since the prior film. There is a small right-sided pleural effusion. No evidence of pneumothorax is seen.

IMPRESSION:

1. Worsening bilateral pneumonia.
2. Right-sided pleural effusion.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Stephen Schabel, M.D. (A) M
Stephen Schabel, M.D. (A) /signed by/ Stephen Schabel, M.D. (A) 6-0
Dictated on: 8-Aug-97 10:03 AM by Stephen Schabel, M.D. (A) 27 E
Transcribed on: 8-Aug-97 1:49 PM by Carol-Ann Rhoads
Finalized on: 8-Aug-97 5:15 PM by S. I. Schabel, M.D.
Authenticated on: 8-Aug-97 5:15 PM by Stephen Schabel, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG CHEST PORTABLE I VIEW
Accession #: 1141250

MRN: 000971560
Date Exam Completed: 08/10/1997 05:38
Last Update: 08/11/1997

CHEST, 8/10/97

INDICATION: Status post chemical burn, intubated; clinical suspicion of pneumonia.

COMPARISON: 8/8/97

FINDINGS: Single frontal radiograph of the chest reveals a tracheostomy tube, right sided subclavian venous catheter, and nasogastric tube - all seen and unchanged from prior film. There is bibasilar atelectasis which is seen on the prior film but improved. The bilateral basilar air space disease noted from the prior film is improved significantly with no evidence of pneumonia seen.

IMPRESSION:

Improved bilateral air space disease.

History: PTX

Technologist: GEORGE MCCUBBINS
Interpreter 1: CHARLES TUBBS
Interpreter 2:
Interpreter 3:
Date Dictated: 08/10/1997 10:02

Proxy Signer:

Authenticating Radiologist:
Date Authenticated:

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Printed: 04/23/2007 9:21 AM
Printed by: CANTRELL, EVELYN

Page:



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 1142069

MRN: 000971560
Date Exam Completed: 08/12/1997 05:00
Last Update: 08/12/1997

PORTABLE CHEST: 08/12/97

HISTORY: 40% total body area surface burns.

INDICATION: To evaluate for possible pneumonia.

FINDINGS: Nasogastric tube in position. The right subclavian central venous catheter has been removed. There is slight interval increase in the interstitial edema pattern. No definite pneumothorax is visualized. A tracheostomy cuff appears mildly overinflated and correlation with pressure readings is recommended.

IMPRESSION:

1. Interval worsening of the pulmonary edema pattern.

History: 40 YO TBSA CHEMICAL BURNCLINICAL SYMPTOMS PNEUMO

Technologist: GLEN SNIPE
Interpreter 1: LYNN COPPAGE
Interpreter 2:
Interpreter 3:
Date Dictated: 08/12/1997 08:21

Proxy Signer:
Authenticating Radiologist:
Date Authenticated:

Transcribed by: LORI O'NEAL

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Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG KNEE, AP/LAT VIEWS
Accession #: 1143024

MRN: 000971560
Date Exam Completed: 08/13/1997 13:50
Last Update: 08/14/1997

AP AND LATERAL VIEW OF THE RIGHT KNEE 8/13/97

INDICATION: 53 year old with history of chemical burn to 35% of total body surface area and a clinical suspicion of a septic joint.

IMPRESSION: AP and lateral view of the right joint shows a small joint effusion, but the bones are normal, there is no radiographic evidence of a definite septic joint. If clinical suspicion is high, would recommend arthrocentesis of the joint.

END OF IMPRESSION:

History: CHEMICAL BURN

Technologist: PHILLIP RAMSEY
Interpreter 1: WILLIAM CONWAY
Interpreter 2:
Interpreter 3:
Date Dictated: 08/13/1997 15:40

Proxy Signer:

Authenticating Radiologist:
Date Authenticated:

Transcribed by: BARBARA KNOX

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Printed: 04/23/2007 9:21 AM

Page:

Printed by: CANTRELL, EVELYN

Patient LSC: 04BR
Status: I
MFID: 000971560

Sex: M
000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: YARBROUGH, DABNEY R., M.D. (A) Visit number: IWX-101451573
Technologist: BRUNSON, GENE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1144766 17-Aug-97 6:54 AM Requested by: Dabney R. Yarbrough, M.D. (A)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
35% TBSA
HISTORY: PNEUMONIA
Alt. Bill Codes: 46710109

PORTABLE CHEST: 8/17/97

COMPARISON: 8/12/97

INDICATION: 35% total body surface area burn. Clinical suspicion of pneumonia.

FINDINGS: Single frontal radiograph of the chest reveals a tracheostomy tube, nasogastric tube in place and unchanged from prior film. There is perihilar fullness with bilateral edema noted. No evidence of consolidation, effusion is noted.

IMPRESSION:

Pulmonary edema.

Approved by:
Richard Patrick, M.D. (R) /signed by/ Lynn Coppage, M.D. (A)
Lynn Coppage, M.D. (A) /signed by/ Lynn Coppage, M.D. (A)
Dictated on: 17-Aug-97 8:55 AM by Lynn Coppage, M.D. (A)
Transcribed on: 17-Aug-97 1:08 PM by Mary Duc
Finalized on: 17-Aug-97 4:53 PM by Lynn Coppage, M.D. (A)
Authenticated on: 17-Aug-97 4:53 PM by Lynn Coppage, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

46r.

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 08/20/97

Drs. Harvey/O

PREOPERATIVE DIAGNOSIS: 60% Total body surface area burns.

POSTOPERATIVE DIAGNOSIS: 60% Total body surface area burns.

OPERATIVE PROCEDURES: 1. Tangential excision and split-thickness skin graft of right arm, abdomen wall, right leg, and right foot.
2. Amputation of left 5th toe.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, placed in supine position, general anesthesia induced through his tracheostomy. The patient's arms, legs, and chest wall were prepped with Hibiclens solution and draped in the usual sterile fashion.

The area on his right forearm, anterior abdominal wall, lateral upper thigh, and bilateral feet were excised using the Weck blade and a combination of blunt dissection. Hemostasis was achieved with cautery and phenylephrine lap pads.

Skin was harvested from the anterior abdominal wall and anterior chest wall using a Zimmer dermatome and then meshing in a 2:1 fashion. The total amount of skin harvested encompassed approximately 200 cm squared. The skin was then secured in place to the right arm, abdominal wall, right thigh, and bilateral feet using clips.

The right 5th toe was excised laterally where bone was exposed and a flap of skin and subcutaneous tissues left medially. Bone cutters were used to remove the metatarsal head. Rongeur was used to smooth out the bone fragments and remove cartilage pieces. Hemostasis achieved using cautery. The flap of subcutaneous tissue and skin left previously was then rotated laterally and secured in place using 2-0 chromic interrupted sutures.

The harvest sites were dressed with Biobrane, graft sites were dressed with interface, then burn dressing, and Kerlix. The right foot dressed with xeroform and Kerlix.

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

COMPLICATIONS: None.

DISPOSITION: The patient tolerated the procedure well.

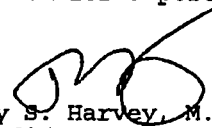
ESTIMATED BLOOD LOSS: 250.

FLUIDS: A liter.

BLOOD PRODUCTS: One unit of red cells.

NOTATION: Dr. Harvey scrubbed for a portion of the procedure.

Seung-Jun O, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

SJO:755/0814
DD: 08/20/97
DT: 08/21/97
Additional CC: _____

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171 Ashley Avenue
Charleston, SC 29425-0768

46R

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 08/20/97

Drs. Harvey/O

PREOPERATIVE DIAGNOSES:

Chemical burns to involve both extremities with open metatarsal joint of the right great toe, necrotic small toe with open bone exposure laterally of the small toe of the right foot with wounds of the right upper leg, abdomen, and arm.

POSTOPERATIVE DIAGNOSES:

Chemical burns to involve both extremities with open metatarsal joint of the right great toe, necrotic small toe with open bone exposure laterally of the small toe of the right foot with wounds of the right upper leg, abdomen, and arm.

OPERATIVE PROCEDURES:

1. Toe filet flap with coverage of fifth metatarsal with debridement of skin, subcutaneous tissue, muscle, and bone.
2. Open irrigation of open joint at the level of the metatarsal joint of the first great toe with debridement of tendon.
3. Placement of split-thickness skin graft to the great toe, approximately 50 square cm.
4. Placement of split-thickness skin graft to the right upper leg, abdomen, and right arm of 350 square cm.

ANESTHESIA:

General endotracheal anesthesia.

PREOPERATIVE INDICATIONS: The patient presents with multiple chemical burns and now presents for operative correction.

DESCRIPTION OF PROCEDURE: The patient was laid supine on the operating table. The area was all prepped and draped. The patient

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

underwent tangential excision and debridement of the upper burn wounds. Split-thickness skin grafts were harvested and meshed 1.5:1.0. These were placed on a recipient bed with surgical steel staples.

Open wound of the great toe joint was found. This was debrided and irrigated, K-wire fixation utilizing 4.5 K-wire was performed. A toe filet flap of the small toe was performed to cover exposed 5th metatarsal. This was sewn with 3-0 and 4-0 chromic sutures. The patient had large bulky dressing applied.

The patient tolerated the procedure well and went to the burn unit in guarded, but, stable condition.


Tracy S. Harvey, M.D.
Attending

TSH:755/0769
DD: 08/20/97
DT: 08/21/97
Additional CC: _____

Patient Loc: 04BR
Status: I
MRID: 000971560

704 Sex: M
0 0 0 9 7 1 5 6 0
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: HARVEY, TRACY S., M.D. (O) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1148186 23-Aug-97 5:02 AM Requested by: William J. (R) Edmiston
PORTABLE CHEST 1 VIEW

Assessment

EXAM DIAGNOSIS:

35% TBSA

HISTORY: EVAL RESP STATUS

Alt. Bill Codes: 46710109

PORTABLE CHEST: 8/23/97

COMPARISON: 8/17/96

INDICATION: 39% 3rd degree burns, evaluate respiratory status

FINDINGS: Single frontal radiograph of the chest reveals tracheostomy tube in place and unchanged from the prior film. Nasogastric tube courses through the mediastinum with tip not visible on this film. There continues to be bibasilar atelectasis with a new left base opacity consistent with atelectasis or pneumonia. No evidence of pneumothorax is seen.

IMPRESSION:

New left basilar opacity worrisome for pneumonia.

Case discussed with Dr. Edmiston on 08-23-97 at 10:15 a.m.

Approved by:

Richard Patrick, M.D. (R) /signed by/ Lisa Baron, M. D. (A)

Lisa Baron, M. D. (A) /signed by/ Lisa Baron, M. D. (A)

Dictated on: 23-Aug-97 9:26 AM by Lisa Baron, M. D. (A)

Transcribed on: 23-Aug-97 1:55 PM by Mary Duc

Last Edited on: 23-Aug-97 2:51 PM by Eileen Rogers

Finalized on: 23-Aug-97 4:28 PM by Lisa Baron, M. D. (A)

Authenticated on: 23-Aug-97 4:28 PM by Lisa Baron, M. D. (A)

I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: ~~IP~~
MFID: 000971560

Sex: M
DOB: 00971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radio logy Consultation

Physician: HARVEY, TRACY S. M.D. (O) Visit number: IWX-101451573
Technologist: MCCUBBINS, GEORGE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1150578 28-Aug-97 5:15 AM Requested by: William J. (R) Edmiston
PORTABLE CHEST, 1 VIEW

Assessment:

EXAM DIAGNOSIS:
CHEMICAL BURN AND INHALATION INJURY
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

PORTABLE CHEST, 08-28-97

INDICATION: Chemical inhalation injury

COMPARISON: 08-23-97

FINDINGS: AP portable view of the chest demonstrates tracheostomy tube overlying the tracheal shadow. The tip of the enteric feeding tube is not included on this film. The right costophrenic angle is not included on this film. Left lower lobe opacity persists, consistent with pneumonia. There is no evidence of pneumothorax. Well defined opacity projects over the left lower lobe. This was not seen on the previous film and likely represents something external to the patient.

IMPRESSION:

Persistent, left lower lobe opacity, unchanged from 08-23-97.

Approved by:
Susan Ackerman, M.D. (A) /signed by/ Susan Ackerman, M.D. (A)
Dictated on: 28-Aug-97 9:12 AM by Susan Ackerman, M.D. (A)
Transcribed on: 28-Aug-97 10:25 AM by Eileen Rogers
Finalized on: 28-Aug-97 2:28 PM by Susan Ackerman, M.D. (A)
Authenticated on: 28-Aug-97 2:28 PM by Susan Ackerman, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 04BR
Status: I
MEID: 000971560

Sex: M
01000971560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: HARVEY, TRACY S., M.D. (O) Visit number: IWX-101451573
Technologist: BRUNSON, GENE MEDICAL UNIVERSITY OF SOUTH CAROLINA
1152105 31-Aug-97 4:30 AM Requested by: William J. (R) Edmiston
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
CHEMICAL BURN AND INHALATION INJURY
HISTORY: PNEUMO
Alt. Bill Codes: 46710109

PORTABLE CHEST, 8/31/97

INDICATION: 54 year old male with inhalation injury from chemical burns.

COMPARISON: Chest film dated 8/28/97

FINDINGS: There are bilateral increased interstitial markings creating central pulmonary vessel enlargement, consistent with mild pulmonary edema. There is no significant interval change from prior study. The right costophrenic angle was excluded from this single AP portable view of chest. No repeat film was obtained per the requesting physician, Dr. Edmiston.

IMPRESSION:

No significant interval change with continued signs of mild pulmonary edema.

Approved by:
Bernard Masters III, M.D. (F) /signed by/ Jeanne Stryker, M.D. (A)
Jeanne Stryker, M.D. (A) /signed by/ Jeanne Stryker, M.D. (A)
Dictated on: 31-Aug-97 10:56 AM by Jeanne Stryker, M.D. (A)
Transcribed on: 31-Aug-97 12:00 PM by Nancy Nazer
Last Edited on: 31-Aug-97 12:34 PM by Nancy Nazer
Finalized on: 2-Sep-97 5:58 PM by Jeanne Stryker, M.D. (A)
Authenticated on: 2-Sep-97 5:58 PM by Jeanne Stryker, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient LOC: 006W
Status: I
MFID: 000971560

Sex: M
00091560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: HARVEY, TRACY S., M.D. (O) Visit number: IWX-101451573
Technologist: RAMSEY, PHILLIP MEDICAL UNIVERSITY OF SOUTH CAROLINA
1152259 31-Aug-97 3:00 PM Requested by: Patrick J. Oneill, M.D. (R)
DIAG ABDOMEN, SINGLE AP VIEW /PORTABLE

Assessment:

EXAM DIAGNOSIS:
40% BURNS
Alt. Bill Codes: 46740007

EXAMINATION: Single portable view of the abdomen on 8/31/97 at 1510.

FINDINGS: A nasogastric tube is within the distal aspect of the stomach. A non-specific bowel gas pattern is identified. There is no evidence of free intraperitoneal air on this study. The visualized portions of the lungs are clear.

IMPRESSION:

1. Non-specific bowel gas pattern with a Dobhoff catheter in the distal aspect of the stomach.

Approved by:
Jeanne Stryker, M.D. (A) /signed by/ Jeanne Stryker, M.D. (A)
Dictated on: 31-Aug-97 4:16 PM by Jeanne Stryker, M.D. (A)
Transcribed on: 31-Aug-97 5:11 PM by Susi Gregg
Finalized on: 2-Sep-97 6:13 PM by Jeanne Stryker, M.D. (A)
Authenticated on: 2-Sep-97 6:13 PM by Jeanne Stryker, M.D. (A)
I have personally performed, and/or reviewed the above investigation and report.

F I N A L

Patient Loc: 006W
Status: I
MFID: 000971560

Sex: M
0009 1560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

R a d i o l o g y C o n s u l t a t i o n

Physician: HARVEY, TRACY S., M.D. (O) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1152431 1-Sep-97 6:30 AM Requested by: Cassandra Joffs, MD (R)
PORTABLE CHEST 1 VIEW

Assessment:

EXAM DIAGNOSIS:
40% BURNS
Alt. Bill Codes: 46710109

CHEST, 9/1/97

COMPARISON: 8/31/97

HISTORY: 54 year old male with 40% total body surface area,
inhalation injury.

INDICATION: Clinical evidence of shortness of breath.

FINDINGS: Portable frontal view of the chest demonstrates
tracheostomy tube in place with distal tip well above the carina. The
enteric tube has been withdrawn and a Dobhoff tube seen coursing
through the mediastinum. The Dobhoff tip is not well seen, and is
difficult to visualize beyond the mid esophagus. The
cardiomediastinal silhouette is unchanged. There is bilateral
interstitial prominence. The pulmonary arteries also remain
prominent. The right costophrenic angle is excluded but there is no
evidence of pleural effusion.

IMPRESSION:

Bilateral interstitial disease and central pulmonary vascular
congestion suggestive of pulmonary edema. No significant interval
change.

Patient Loc. 006W
Status: I
MFID: 000971560

Sex: M
00091560
JONES, ARCHIE E

MEDICAL UNIV OF SOUTH CAROLINA
Charleston, SC 29425

Radiology Consultation

Physician: HARVEY, TRACY S. M.D. (O) Visit number: IWX-101451573
Technologist: SNIPE, GLEN MEDICAL UNIVERSITY OF SOUTH CAROLINA
1152431 1-Sep-97 6:30 AM Requested by: Cassandra Joffs, MD (R)
PORTABLE CHEST 1 VIEW

Approved by:
Glenn Blackwood, M.D. (R) /signed by/ Susan Ackerman, M.D. (A)
Susan Ackerman, M.D. (A) /signed by/ Susan Ackerman, M.D. (A)
Dictated on: 1-Sep-97 2:17 PM by Susan Ackerman, M.D. (A)
Transcribed on: 1-Sep-97 5:06 PM by Sharon Leviner
Finalized on: 1-Sep-97 8:37 PM by Susan Ackerman, M.D. (A)
Authenticated on: 1-Sep-97 8:37 PM by Susan Ackerman, M.D. (A)
I have personally performed and/or reviewed the above investigation
and report.
Copy to: NORCROSS, E. D., M.D. (A)
F I N A L

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

6W D6 76A

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 09/12/97

Drs. Harven/O/Kaufman

PREOPERATIVE DIAGNOSIS: Burns.

POSTOPERATIVE DIAGNOSIS: Burns.

PROCEDURE: Tangential excision and
split-thickness skin grafting to right
foot and abdominal wall as well as
removal of K-wire from left great toe.

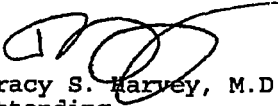
DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, placed in a supine position, and general endotracheal anesthesia established through his tracheostomy tube. The patient's leg and abdominal wall were prepped with Hibiclens solution and draped in the usual sterile fashion. Blunt and sharp debridement was performed over the first metatarsal joint as well as the abdominal wall until good healthy bleeding tissues were encountered. Hemostasis was achieved with cautery and lap pads. Skin grafts were harvested from the anterior abdominal wall totalling 50 cm squared. The skin graft was harvested with a Zimmer dermatome and meshed in a 1 x 1 1/2 fashion. The skin was secured to the abdominal wall with clips and reinforced with 5-0 chromic sutures. The skin graft was also applied to the defect over the right forefoot at the first metatarsal joint and this was secured in place with interrupted 5-0 chromic sutures. The abdominal wall wound was dressed with interface and burn dressing. The donor sites were dressed with Xeroform. The right foot wound was dressed with Xeroform followed by a Xeroform with cotton ball impregnated with Bacitracin bolster, dry dressings, and then an ACE wrap. The patient was awakened in the operating room and transported to recovery still with his tracheostomy tube in place. The patient tolerated the procedure well. There were no complications. Counts were correct.

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

Dr. Harvey was present for a brief portion of the case.

Seung-Jun O, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

SJO:752/3632
DD: 09/12/97
DT: 09/13/97
Additional CC: _____

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MEDICAL UNIVERSITY OF SC
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Charleston, SC 29425-0768

See 6762

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 09/12/97

Drs. Harvey/O

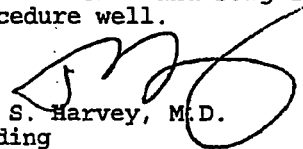
PREOPERATIVE DIAGNOSIS: Chemical burn involving the foot and abdomen with associated open wounds.

POSTOPERATIVE DIAGNOSIS: Chemical burn involving the foot and abdomen with associated open wounds.

OPERATION: Debridement of burn wounds over the abdomen and right great toe with potential exposure of the metatarsal phalangeal joint with placement of split thickness skin graft approximately 30 square cm to the right great toe and 80 square cm to the abdomen.

ANESTHESIA: General endotracheal.

PROCEDURES: The patient was laid supine on the operating table and the areas were prepped and draped in the usual sterile fashion. Granulation tissue was excised. The wound was irrigated copiously with antibiotic irrigation. Split thickness skin graft was harvested with a dermatome. Skin graft meshed at 1.5:1 was placed on the recipient bed and sewn in with 5-0 chromic and surgical steel staples. The patient tolerated the procedure well.


Tracy S. Harvey, M.D.
Attending

TSH:731/3626
DD: 09/12/97
DT: 09/13/97
Additional CC: _____

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE E. JR.
MRN: 000971560
Admitted: 06/03/97
Discharged: 09/25/97
Service: Burn Trauma
Attending: Tracy S. Harvey, M.D.

Referring:

ADMISSION DIAGNOSIS: 40% total body surface area burn.

HISTORY OF PRESENT ILLNESS: The patient is a 53-year-old white male who was working at the 3M factory on 6/3/97 when he suffered a hot chemical spill burn of thermal 66 which was reported to be greater than 300 degrees Fahrenheit. The patient was initially evaluated at Greenville Memorial Hospital. He was awake and alert initially but had some respiratory distress and was noted to have swelling in the posterior oropharynx. Subsequently, elective intubation was performed. Resuscitation was begun with lactated Ringer's and the patient was reported to have stable vital signs and good urine output. He was flown to MUSC on 6/3/97. On arrival to MUSC, the patient was sedated.

PERTINENT FINDINGS ON ADMISSION PHYSICAL EXAMINATION: The patient had second and third degree burns, the majority of which were on his anterior thighs, lower legs and dorsum of feet bilaterally, posterior calves, dorsum and palmar aspect of fingers, dorsal aspect of forearms, and some small places on the ventral aspect of forearms bilaterally, and the superior aspect of the nasal bridge and forehead on the left. Eyes: The patient was noted to have conjunctival chemosis bilaterally. An ET tube was in place. Lungs were clear to auscultation bilaterally with equal breath sounds bilaterally. The patient had palpable distal pulses in all extremities and was noted to be tachycardic with a regular rhythm.

HOSPITAL COURSE: He was admitted to the burn unit with ET tube in place, resuscitation was continued, urine output monitored, and the patient was initiated on the ventilator. On 6/4/97, the patient's PO2 was noted to be low on 85% FIO2. Bronchoscopy was performed with findings as follows: Intense erythematous tracheobronchial mucosa, marked thick whitish secretions, and no ulcerations. Necrotic mucosa was noted on bronchoscopy as well. Escharotomy was also performed on 6/4/97 to both lower legs and feet with good results. On 6/5/97, the patient's respiratory status remained critical with a PO2 of 89 on FIO2 of 85%. The patient had a repeat bronchoscopy performed which showed slightly improved erythema and

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE E. JR.

MRN: 000971560

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slightly less secretions. On 6/6/97, post burn day #3, the patient's respiratory status continued to be his major problem and he again underwent repeat bronchoscopy; this time showing slightly less erythema of mucosa with clearer and thinner secretions. His arterial blood gas began to improve at that time. The patient slowly began to improve his respiratory status and on 6/9/97, post burn day #6, he was noted to have a low-grade fever with a cellulitis and was started on nafcillin initially which was changed to Timentin and vancomycin on 6/13/97. On 6/11/97, the patient was taken to the operating room for debridement of his lower legs bilaterally and feet, and was subsequently grafted with 23 pieces of 100 sq cm of homograft. There were no complications for this operation. On post burn day #9, 6/12/97, the patient was noted to have his endotracheal tube out. Anesthesia was called and the patient was eventually reintubated with saturations in the 96-98 range. On 6/14/97, the patient's sputum grew out E. coli and his urine grew out E. coli, and he was changed from Timentin to Cipro. On 6/16/97, the patient was again taken to the operating room for homograft of his lower extremities bilaterally. There were no complications for this procedure. The patient continued to have fevers spiking through Cipro and vancomycin, and continued to remain on the ventilator via the endotracheal tube. On 6/25/97, the patient was again taken to the operating room for homograft skin grafting to his bilateral lower extremities and abdomen. During the procedure, a #8 cuffed Shiley tracheostomy tube was placed and 45 homografts were used during this procedure. On 6/27/97, post burn day #24, the patient's Cipro was discontinued and he was started on Diflucan for yeast in his sputum. On 7/2/97, the patient was again taken to the operating room for tangential excision and split-thickness skin graft to his bilateral lower extremities. That same day, vancomycin was discontinued and ampicillin was started for presumptive enterococcal bacteremia. Ampicillin was discontinued on 7/7/97 and vancomycin was again restarted for unresponsive fever to the ampicillin. On 7/10/97, the patient was again taken to the operating room for split-thickness skin graft to his bilateral thighs, legs, and feet. 1200 sq cm were covered during this procedure. The patient continued to be slow to wean from his ventilator, requiring alternating PRVC and SIMV. Then, on 7/13/97, CPAP trials were initiated. Speech was consulted and Passy-Muir valve was placed in-line on ventilator. On 7/18/97, the patient was again taken to the operating room for a full-thickness skin graft to his right forehead and split-thickness skin graft to his left foot, right leg, right foot, and abdomen. Total split-thickness skin graft was 1850 sq cm. On 7/21/97, post burn day #48, the patient was started on a pureed diet as tolerated, although tube feeds via Dobhoff tube were continued as they had been since post burn day #2. On 7/25/97, post burn day #51, the patient was noted to have a metabolic alkalosis of unknown etiology and was started on tracheostomy collar trials alternating with SIMV rest. On 7/26/97, post burn day #52, vancomycin and ciprofloxacin were again started

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE E. JR.

MRN: 000971560

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for sputum cultures of gram-positive cocci and gram-negative bacilli; however, on 8/1/97, the patient had been afebrile for five days and antibiotics were discontinued at that time. Then on 8/2/97, post burn day #59, the patient was noted to be cyanotic with apparent seizure-like activity and neurology was consulted. EEG at that time was negative. CT scan was negative as well. On 8/12/97, the patient was still on tube feeds supplemented with small amounts of p.o. intake. His prealbumin, which had been low, began to improve. He continued to wean from his ventilator with tracheostomy collar trials and SIMV rest. On 8/15/97, Cipro was restarted for an E. coli urinary tract infection. On 8/20/97, post burn day #76, the patient was again taken to the operating room for split-thickness skin graft to his right arm, right leg, and abdominal wall; 200 sq cm were covered. In addition, the patient had a right 5th toe amputation during this procedure. The patient continued to improve with skin graft sites looking good, weaning fairly well from the ventilator, and remaining afebrile until 8/25/97 at which time a new chest x-ray finding showed a left lower lobe pneumonia. Staph aureus grew out of his sputum and the patient was started on vancomycin and Timentin for presumed nosocomial versus aspiration pneumonia. On 8/31/97, all antibiotics were discontinued and the patient was sent to step-down. The patient's respiratory status continued to remain a problem with very thick tenacious sputum and secretions. He continued to have a mixed respiratory acidosis and metabolic alkalosis with a PCO2 in the 70s and a pH of 7.37. He continued on tracheostomy collar trials from 6 a.m. to 6 p.m. and then SIMV rest at night. The SIMV rest was initiated to see if the metabolic alkalosis might improve on ventilator rest; however, the metabolic alkalosis continued. On 9/3/97, post burn day #90, the patient was started on aggressive respiratory therapy with q.4h. albuterol and Atrovent and b.i.d. Azmacort treatments. Normal saline was initiated in an attempt to correct metabolic alkalosis. The patient's nutritional status continued to improve with prealbumins reaching into the 20s. On 9/12/97, the patient was again taken to the operating room for split-thickness skin graft to this right great toe and his anterior abdominal wall with removal of a K wire. There were no complications to this procedure. On 9/17/97, the patient's nutritional status and p.o. intake were superb and his Dobbhoff was discontinued at that time. The patient continued to improve every day including his respiratory status and on 9/20/97 the #8 Shiley was removed and a #6 cuffless Shiley was placed. The #6 Shiley was removed on 9/22/97 and a #4 Shiley was placed. Then, on 9/23/97, post burn #111, the patient's tracheostomy tube was discontinued altogether.

CURRENT PHYSICAL EXAMINATION: HEENT: Unremarkable except some mild presbycusis on the right per ENT. Mouth is clear. Lungs: Clear to auscultation bilaterally with occasional wheeze at times during sleep. Heart: Regular rate and rhythm without murmurs, rubs, or gallops. Abdomen: Benign. Extremities: Good strength in all

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE E. JR.

MRN: 000971560

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extremities with 2+ pulses throughout. Skin: The patient's graft sites on his forehead, anterior abdominal wall, arms, legs, and feet are all taking 95% or greater. There are still a few areas behind the patient's left ear, on his right thigh, and anterior abdominal wall that are exposed granulating tissue. These areas are being treated by thin coat burn cream and Xeroform.

PROGRESS IN THERAPIES: In terms of the patient's physical therapy advances, he is ambulating very well (approximately 100 feet on flat ground and 3-4 steps at a time).

Speech and swallowing: The patient has advanced to approximately 95% of his pre-burn ability.

Occupational therapy: The patient continues to have some difficulty with contractions in his hands, particularly the right 5th digit.

DISPOSITION: The patient is scheduled to be discharged on Thursday, 9/25/97, and admitted to rehab. He is very excited about his progress.

MEDICATIONS ON DISCHARGE:

1. Albuterol MDI 8 puffs q.4h.
2. Atrovent MDI 8 puffs q.4h.
3. Azmacort 4 puffs b.i.d.
4. Vitamin C 1 g daily.
5. Bacitracin ointment apply twice daily behind left ear.
6. Burn ointment applied to his affected areas twice daily.
7. Klonopin 1 mg p.o. q.h.s.
8. Colace 100 mg p.o. b.i.d.
9. Heparin 5000 units subcu b.i.d.
10. Lopressor 25 mg p.o. b.i.d.
11. Multivitamin 1 p.o. q.d.
12. Paxil 10 mg 1 p.o. q.a.m. The Paxil is to be increased to 20 mg when the patient can tolerate it.
13. Zinc sulfate 220 mg p.o. q.d.
14. Atarax 25 mg p.o. t.i.d. p.r.n. itching.
15. Ibuprofen 600 mg p.o. q.8h. p.r.n.
16. Morphine sulfate 1 mg q.2-4h. as needed prior to dressing changes.

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE E. JR.
MRN: 000971560
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- 17. Chloraseptic spray p.r.n. at bedside.
- 18. Phenergan 25 mg q.6-8h. p.r.n. p.o./IM.

Paul L. Kaufman, M.D.
Resident

Tracy S. Harvey, M.D.
Attending

PLK:669/4968
DD: 09/24/97
DT: 09/25/97

Additional CC: _____

MUSC Medical Center - Occupational Therapy/CNS

CHARTING REPORT

PAGE 1

NAME: JONES, ARCHIE E MUH. # 000971560 RM#: B229-APatcom # 10150471-0

DATE: 09/26/97 TIME: 08:44

BURN
INITIAL EVALUATION

DIAGNOSIS: Pt is a 53 yr old WM employee of 3M factory. On 6-3-97 suffered hot chemical spill burn of thermal 66 (> 300 F). He also suffered inhalation burn injury with post oropharynx swelling upon initial eval. at Greenville Memorial Hospital. Pt found to have 2nd and 3rd degree burns involving ant thighs, B LES, dorsum of B feet, dorsum/palms of hands, forearms (dorsal 1, small areas ventral), nose and forehead. Pt currently has MRSA.

HISTORY:

TREATMENT LOCATION:
Department

PRECAUTIONS:
Sun precautions
Fragile skin/blisters
MRSA

AMBULATORY STATUS:
Assisted ambulation
Wheelchair

BARRIERS TO LEARNING:
No limitations
Hearing Impaired

APPEARANCE/BEHAVIOR:
- alert x oriented
- confused - combative
- unresponsive x cooperative
- lethargic

BURNS LOCATION/DEPTH: SEE HX

EDEMA:
Mild

HAND DOMINANCE:
Right

RANGE OF MOTION LIMITATIONS/CAUSE: ROM WFL with the exception of the following:

	RANGE	CAUSE
Facial mobility:	WFL	
Neck:	WFL	
Shoulder: right	WFL	
left	WFL	

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE
MRN: 000971560
Admitted: 09/25/97
Discharged: 10/03/97
Service: Physical Medicine & Rehab
Attending: Tracy L. McFall, M.D.

Referring: Tracy Harvey, M.D.

DIAGNOSES: 1. Forty percent total body surface area burn.
2. Malaise and fatigue.

HISTORY OF PRESENT ILLNESS: Briefly, the patient is a 53-year-old male who was working at the 3-M factory on 6/3/97 when he suffered a hot chemical spill burn of therminal 66 which was reported to be greater than 300 degrees Fahrenheit. The patient was initially evaluated at Greenville Memorial Hospital and transferred to MUSC. For further information on the patient's hospital course from 6/3/97 till he was transferred to the rehabilitation unit on 9/25/97, please see that discharge summary from the burn trauma team.

PAST MEDICAL HISTORY: Is significant for hypertension.

PAST SURGICAL HISTORY: Is not recorded.

MEDICATIONS ON ADMISSION TO REHABILITATION ARE:

1. Albuterol MDI 8 puffs q.4h.
2. Atrovent MDI 8 puffs q.4h.
3. Azmacort MDI 4 puffs b.i.d.
4. Vitamin C 1 gram q.d.
5. Bacitracin Ointment, apply behind the left ear.
6. Klonopin 1 mg p.o. q.h.s.
7. Colace 100 mg p.o. b.i.d.
8. Heparin 5000 units subcutaneous b.i.d.
9. Lopressor 25 mg b.i.d.
10. Multivitamin q.d.
11. Paxil 10 mg q.a.m.
12. Zinc sulfate 220 mg q.d.
13. Atarax 25 mg t.i.d.
14. Darvocet-N 100 p.o. q.4h. p.r.n. pain.
15. Ibuprofen 600 mg p.o. q.8h. p.r.n. pain.
16. Morphine sulfate immediate release 1 mg p.o. 30 minutes prior to any dressing changes.

ALLERGIES: No known drug allergies.

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE

MRN: 000971560

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PHYSICAL EXAMINATION: On admission, the patient is a well-developed, well-nourished pleasant male in no apparent distress. **HEENT:** Healing scars the bridge of the nose and the mid-forehead and behind the left ear, otherwise benign. **Neck:** A tracheostomy opening about 2-3 mm in diameter. It was clean with no drainage. **Cardiovascular:** Regular rate and rhythm, negative murmurs, rubs or gallops. **Lungs:** A few crackles at the left base and some expiratory wheezes. **Abdomen:** Nondistended, nontender, no masses. **Skin:** Upper abdomen donor sites are healed, low abdominal burns are healing. Forearms are healing. Right fifth digit with decreased range of motion of flexion. There are a few scars on the dorsum of the hands that are healing well. The anterior thighs have a split thickness skin graft which is healing well. Lower extremities below the knees show good take of skin graft foot. The left foot with great toe has an open area. The right foot great toe and lateral aspect of that foot has opening draining areas. The right fifth toe has been amputated. **Neuromuscular:** Strength and range of motion are within functional limits in all extremities. Sensation is decreased to pinprick/hot/cold in lower extremity feet and patchy below the knees and especially around the burned areas. His hyperesthesia is pronounced in the feet.

HOSPITAL COURSE:

Problem 1. Functional status at discharge: The patient is independent in all his activities of daily living and self-care. He is independent with his transfers to the toilet and shower seat. He is independent with ambulation over 1000 feet on a level surface without any assistive devices. He has decreased hip flexion and his gait is shuffling.

Problem 2. Pulmonary: The patient's pulmonary status continued to improve while on the rehabilitation unit and his MDIs were dropped except for the albuterol inhaler, which he is to use on a p.r.n. basis.

Problem 3. Skin: The skin continued to heal while on the unit. His wife was knowledgeable and independent with applying all medications to the areas and with dressing changes.

Problem 4. Hypertension: The patient's blood pressure was well-controlled on his current antihypertensive medications and no further medication changes were needed.

DISPOSITION: The patient was discharged in stable condition on October 3, 1997.

FOLLOW-UP: His follow up includes:

1. A burn clinic appointment on October 14, 1997.
2. The dressing changes, which his wife is independent and

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE

MRN: 000971560

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knowledgeable in performing.

DISCHARGE MEDICATIONS:

1. Albuterol MDI 4 puffs p.r.n.
2. Multivitamin 1 p.o. q.d.
3. Elavil 50 mg p.o. q.h.s.
4. Paxil 5 mg p.o. q.d.
5. Lopressor 25 mg p.o. b.i.d.
6. Klonopin 1 mg p.o. q.h.s.
7. Preparation H ointment as directed b.i.d.
8. Bacitracin ointment behind the left ear b.i.d.
9. Cocoa butter to the affected areas q.d.
10. Atarax 25 mg p.o. q.4h. p.r.n. itching.
11. Darvocet-N 100 1 q.4h. p.r.n. pain.

Kerri A. Kolehma, M.D.
Resident

Gracy McFall
Tracy L. McFall, M.D.
Attending

KAK:673/8494
DD: 10/22/97
DT: 10/23/97
cc: Tracy Harvey, M.D.
Tracy L. McFall, M.D.
Additional CC: Dr Harvey

Patient Name: JONES, Archie

MR# 597 000971560

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PATIENT CARE DISCHARGE FORM

Patient/Family Instruction Sheet

INPATIENT
P/T R

The following information is for you and your family regarding how to care for yourself after you leave the hospital. Thank you for choosing MUSC Medical Center for your care.

Activity restrictions: as tolerated

Food/Meals: Regular diet

Special Instructions (wound care, bowel & bladder, isolation requirements etc...)

change your dog as taught

Your Medicines: ☐ None How will you pay for your medicines? ☐ Don't know (page SH)

Drug	Dose	How taken	Schedule	Next dose due	Special instructions	Prescriptions given
gabapentin	25mg	mouth	1 q 4 ^o as needed		you itching	(Y) N
Dorivector N	100mg	1 mg	every 4 hours	as needed	for pain	(Y) N
Albuterol MDI	4 puffs	every 12 hrs.	prn			(Y) N
MVI	1 pill	mouth	every day	10/4		(Y) N
Elavil	50mg		every night	10/3		(Y) N
Paxil	10mg	10mg	1/2 tablet q (every) AM	10/4		(Y) N
Lopressor	50mg	25mg	1 tablet 2 times daily	10/3	supper	(Y) N
Klonopin	1mg	1 tablet	every night	10/3		(Y) N
prep. H ointment			to return twice daily and to burn sites			(Y) N
Vaccitacin	ointment		behind ears, BID		twice a day	(Y) N
cocoa butter			to soled burn areas as needed			(Y) N
Kerlex	30 rolls		to be used for burn dressing changes as needed			(Y) N
Tierofom	1 pkg		to be used for burn dressing changes as needed			(Y) N
						Y N
						Y N

How will you get to your appointment(s)? my wife ☐ Don't know" page social worker

Return Appointment(s)	Date	Time	Phone	Location of appointment	Made by:
Burn clinic	10.14.97	1200	792-3137	Module 12	apt. + wife

Call for following problems:

Name	Phone number	Name	Phone number
Doctor: <u>Dr. H McFall</u>	792-1591	Social Worker: <u>Don Davis</u>	792-0692
Nurse: <u>Shirley McNeal</u>	792-8832	Other:	

Nurse discharging patient: Shirley McNeal, RN RN reviewing form:

Photo copy of patient care discharge forms sent to: ☐ Referring Physician ☐ Clinic ☐ Home Health Agency

I have reviewed this form with the nurse, understand the information, and have received a complete copy.

Patient or Care giver: Archie Jones Date: 10/3/97

11/10/97 Rev. 5/97

PATIENT CARE DISCHARGE FORM
(Information for referring physicians,
clinics, and agencies)

Page 5

Admission Date: 9/25/97 Admitting Physician: DR. J. R. B. J. 40% TBSA Burn
Discharge Date: 10/03/97 Discharge Diagnosis: S/P Burn 3/40% TBSA
Discharged to: Person Darrell Jones Place: 101504717 Anderson, SC
Address: See below
Mode of transportation (circle one): Ambulance ☒ Taxi ☐ DSS transport ☐
How was patient discharged (circle one): Carried ☐ Walking ☐ Stretcher ☐ Wheelchair ☐
Caregiver: Darrell Jones Phone number: (864) 224-2669
Address: 1229 SALEM CHURCH RD. ANDERSON, SC 29625
Primary Insurance: Workman's Comp. Policy #: Liberty Mutual claim # 510-171-941
Secondary Insurance: Policy #:

Indicate below major diagnostic tests/procedures performed during patient's hospitalization:

Date	Test/Procedure	Date	Test/Procedure

Community Services: ☐ None ordered

Name of Agency	Services	Contact Person	Phone number	Contact made by/date	New Referral?
	PT - 3X/week				☒ Y ☐ N
Home Health Nursing	x 1 wk. and as needed for assessment of infection				☒ Y ☐ N
INTERIM Home Health	Delbie Summ	1-800-773-6638			☒ Y ☐ N
in Anderson					☒ Y ☐ N

Durable Medical Equipment Ordered: ☐ None ordered

Name of Agency	Equipment	Contact Person	Phone number	Contact made by/date	New Referral?
Liberty Mutual	long handled bath sponge		1-800-922-3305 ext. 226		☒ Y ☐ N
Workman's comp.	shower bench		02762-0094 (charleston)	Sandi Rogers	☒ Y ☐ N
claim # 510-171-941	hand held shower mech.			of Liberty Mutual	☒ Y ☐ N
	w/c rental for distance mobility				☒ Y ☐ N

NEW PATIENT NOTE

Jones, Archie
MR# 971560

October 28, 1997

Chief Complaint: Urethral erosion, status post catheter placement.

History of Present Illness: The patient is a 54 year-old white male who sustained a forty percent total body surface area burn in June, 1997. Due to his prolonged hospitalization and catheter placement with this, he had erosion of his urethral meatus. He is being seen for follow-up at this time by ENT for closure of his tracheostomy and we were asked to see him for his urethral erosion. On questioning he states that his only voiding difficulty is with control. By report, he had a PSA done in the recent past which was 0.45.

Past Medical History: The patient's past medical history is significant for his burns as listed above, hypertension, sinusitis, and erectile dysfunction.

Past Surgical History: The patient's past surgical history is significant for multiple procedures related to his burn including complete body split thickness skin grafts and tracheotomy.

Social History: The patient lives in Aiken, SC. He denies smoking or alcohol use. He is currently disabled secondary to his burns.

Medications: The patient is on a multitude of medications related to his burn. We do not have a complete list of these at this time.

Allergies: There are no known drug allergies.

Review of Systems: The patient's review of systems is significant for some parenchymal disease of his lungs from smoke inhalation. He denies any heart disease, lung disease, kidney disease or liver disease.

Physical Examination: Physical examination is limited to the GU tract. The patient is an uncircumcised male. There is erosion of the glans of the penis, which is in appearance, meatus. This extends down to the coronal sulcus, but not onto the shaft of the

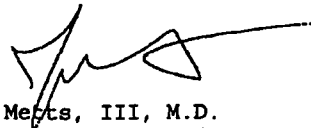
RE: ARCHIE JONES

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penis. The testes are bilaterally descended. There are sebaceous cysts over the scrotum. Rectal exam was not done at this time secondary to patient comfort with movement.

Impression: Mild urethra erosion, secondary to Foley catheter placement.

Plan: I had a long discussion with patient concerning the situation. He is going to undergo revision of his tracheostomy and possibly revision of some facial scarring. I am going to see him when he is admitted to the hospital. At that time, we will discuss the treatment options further. I did discuss with him a "MAGPI image" type procedure for repair. We did specifically discuss the risks of break down and subsequent fistula formation. He is going to think further about this and decided whether he wishes to go ahead with repair. For his erectile dysfunction, he has previously tried injection therapy, although this seems to have met with some resistance. He thinks that this may be related to some painful ejaculation he had in the past. I told him we could try MUSE urethral suppositories following repair and healing. I did give him precautions concerning this including orthostatic hypertension, pain, and pain to the partner. We are going to discuss this further when he follows-up with me after the decision is made about the repair. I spent approximately 25 minutes discussing the situation with this patient.



Jobe C. Meets, III, M.D.
Assistant Professor of Urology

JCM:smt-65

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MEDICAL UNIVERSITY OF SC
171 Ashley Avenue
Charleston, SC 29425-0768

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 00971560
Date of Surgery: 11/06/97

Drs. Harvey/Rast/O'Neill

PREOPERATIVE DIAGNOSIS: Tracheocutaneous fistula following tracheostomy removal.

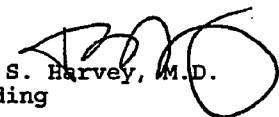
POSTOPERATIVE DIAGNOSIS: Tracheocutaneous fistula following tracheostomy removal.

PROCEDURE PERFORMED: Closure of persistent tracheal fistula with exposure, primary suture of trachea, and plastic closure with rotation of strap muscles.

ANESTHESIA: General endotracheal anesthesia.

INDICATIONS: The patient presents upon removal of tracheostomy. He was noted to have a persistent tracheal fistula, and he now presents for operative closure.

DESCRIPTION OF PROCEDURE: The patient was placed supine on the operating room table. The area was all prepped and draped. Undermining scar was excised. The patient had dissection carried to the trachea wall. The trachea was exposed. A plain Monocryl suture was placed. Strap muscles were mobilized. These were closed in a layer closure underneath the trachea. The skin was then closed in a layer closure utilizing 4-0 Monocryl and 5-0 Prolene. The patient tolerated the procedure well and went to the recovery room in stable condition.


Tracy S. Harvey, M.D.
Attending

TSH:753/0474
DD: 11/06/97
DT: 11/07/97
Additional CC: _____



MEDICAL UNIVERSITY OF SOUTH CAROLINA
171 Ashley Avenue
Charleston, South Carolina 29425

June Souviron, M.D.
2405 N. Main Street
Anderson, SC 29621

Dear Dr. Souviron:

This preliminary discharge report on your patient is being sent to you as promptly as possible for your information and convenience. If you need additional information please contact the MUSC attending physician or me through MEDULINE (1-800-922-5250 or in the Charleston area 792-2200).

Diagnosis: Tracheocutaneous fistula

Procedures/
Operations: Closure of tracheocutaneous fistula

Discharge activity: As instructed

Discharge diet: Regular

Discharge meds: Tylox 1-2 capsules po q4-6h prn pain

Special Instructions: Call 911 if patient develops difficulty breathing

Follow-up: With Dr. Harvey on 20 Nov 97 at 2:20 p.m.

We appreciate the opportunity to share in the care of your patients.

Thomas A. Willman
Physician Liaison

MEDULINE 1-800-922-5250

PRELIMINARY DISCHARGE REPORT

Patient: Eddie Jones Archie
Address: 1229 Salem Church Road
Anderson, SC 29625

DOB: [REDACTED]
MUH#: 971560
Admitted: 11/6/97
Discharged: 11/6/97
MUSC Attending: Tracy Harvey, M.D.



Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29425-0768

SHORT-STAY RECORD
(Length of Stay 48 Hours or Less)

Referring Physician: _____

Address/City/Zip: _____

HRN 000971560 P/T 1
JONES ARCHIE E
PAT 101524312 PLA
HARVEY, T
WX WORK COMP
EXP. ADH. 11/06/97

PATIENT HISTORY

HISTORY/REASON FOR ADMISSION:

Sty was sp chemical Burns while
requires tracheostomy. Pl. 2 tracheostomy
fistula

Adverse Reactions No ☒ Yes ☐ Specify:

Allergies, Hayfever, No ☐ Yes ☒ Specify: *allergic*
Hives, Rash, Wheezing?

Current Medications? No ☐ Yes ☒ Specify: *Ativan 25mg q4 as needed for itch*
Albuterol-MNI 4mg q6 *Darvocet 100mg T q4 for pain*
MVI 1 BID
E-Lav 15mg qhs *Percil 10mg V2 TID* *Lopressor 25mg 1 BID* *Klonopin 1mg T qhs*
Albuterol 2mg BID *Albuterol 2mg BID*

PHYSICAL EXAMINATION
T 98.5 P 76 R 20 BP 145/94 WT 210 HT 5'10"

AREA	NORM	AB-NORM	EXPLANATION OF ABNORMAL FINDINGS
General Appearance			
Head, Neck			
Ears, Nose, Throat			
Eyes			
Cardiovascular			
Lungs			
Breasts			
Abdomen			
Genitalia/Rectum			
Extremities			
Skin			
Lymphatics			
Neurologic			

ADDITIONAL COMMENTS:

ADMITTING DIAGNOSIS:

Tracheostomy fistula

DATE: 11, 6, 97

RESIDENT'S SIGNATURE: *[Signature]*

DATE: 11, 6, 97

ATTENDING'S SIGNATURE: *[Signature]*



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: JONES, ARCHIE
Procedure: DIAG FOOT AP/LAT VIEWS
Accession #: 1202444

MRN: 000971560
Date Exam Completed: 12/04/1997 15:14
Last Update: 12/04/1997

AP LATERAL AND OBLIQUE VIEWS OF RIGHT FOOT 12/4/97

INDICATION: Prior surgery.

COMPARISON: None.

FINDINGS: The little toe has been amputated through the distal fifth metatarsal. The medial four toes appear unremarkable. There are some subchondral cysts and asymmetric narrowing of metatarso phalangeal joint of big toe is appreciated. Further surgical clips are also visualized along the medial aspect of the ankle. There are no fractures. There is no definite evidence of osteomyelitis.

IMPRESSION:

1. The little toe has been amputated through the distal fifth metatarsal.
2. There is no radiographic evidence of osteomyelitis. There are no stress fractures or other signs of arthropathy. If clinical concern exists an MRI examination of the foot might be of value.

History: RIGHT FOOT

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed: 04/23/2007 9:18 AM
Printed by: CANTRELL, EVELYN

Page: 1



PATIENT

REGISTRATION

☒ INPATIENT☐ OUTPATIENT☐ EMERGENCY

REG. DATE	REG. TIME	MEDICAL RECORDS #	SOURCE #	EPISODE #	PAT. COM #	DISCHARGE DATE	SEX	RACE	BIRTH DATE	AGE
12/26/97	12:23	000971560	809	014	101546554	1-9-98	M	W	7/24/70	27
NAME LAST		FIRST		M		MARRIAGE STATUS		JMD. IPR		PED. IPR
JONES		ARCHIE		M		M		JMD. IPR		PED. IPR
ADDRESS		CITY		STATE		ZIP		COUNTY		FIN. CLAS
1229 SALEM CHURCH RD		ANDERSON		SC		29625		A		6
SS NUMBER		HOME TELEPHONE		RELIGION		REFERENCE NAME		EMPLOYER NAME		
[REDACTED]		(864) 224-2669		BAPTIST		GAINES/MMN				
EMPLOYER PHONE		EMPLOYER ADDRESS STREET		CITY		ST		ZIP		
PAT. TYPE		NURSING STATION		ROOM		BED		ATTENDING DOCTOR		MED. SERV.
I		004E		B40J		A		HARVEY, TRACY		PLA
ADV. DIR.		ON FILE		INFO. PROV.		ADMITTING DOCTOR		LOS		PREV. ADMIT DATE
N		N		Y		HARVEY, TRACY				5
DIAGNOSIS										
DRAINAGE RT 1ST TOE, S/P BURNS										
PROCEDURE										
120 RT 1ST METATARSAL, FREE FLAP TO FOLLOW ON LATER DATE										
PRECERT #		PRECERT PHONE		PRECERT LOS		PRECERT DATE				
510171941		(800) 922-3305		0000		12/23				
EMERGENCY NOTIFICATION		LAST		FIRST		M		RELATIONSHIP		HOME TELEPHONE
JONES		JONES		DERRELL		M		02 - SPOUSE		(864) 224-2669
ADDRESS		CITY		STATE		ZIP		WORK TELEPHONE		
1229 SALEM CHURCH		ANDERSON		SC		29625				
REFERRING DOCTOR		PHONE		ADDRESS		CITY		ANDERSON		
SOUVIRON, JUNE		8032317003		2405 N MAIN ST		ANDERSON				
STATE / ZIP		REFERRING INSTITUTION		EMERGENCY REFERRAL						
SC 29621				N						
FAMILY DOCTOR		PHONE		ADDRESS		CITY		ST		ZIP
SOUVIRON, JUNE		8032317003		2405 N MAIN ST		ANDERSON		SC		29621
PRIMARY INSURANCE COMPANY		ADDRESS		CITY / STATE						
WU/0 WORKMENS COMP		PO BOX 100154		COLUMBIA		SC				
ZIP		TELEPHONE		PT. REL. / SUB		POLICY # / GROUP NAME		GROUP NAME		
29202 (800) 922-3305				01		[REDACTED]		3M COMP		
SUBSCRIBER NAME		ARCHIE		PRECERT #		EFFECTIVE DATE OF COVERAGE		SUBSCRIBER SSN		
JONES				510171941				250-70-5111		

PRINCIPAL DIAGNOSIS	CODE NUMBER
chronic wound - foot	
SECONDARY DIAGNOSIS	
ingrown toenail	
epidermolysis - flap	
toe cellulitis	
OPERATION OR SPECIAL PROCEDURE	
12/30/97 86:22 STSG, fasciocutaneous flap	
12/26/97 86:22 arthroscopy, 96:59 correction - nail	

DISCHARGE SUMMARY
OR NOTE

- ☐ DICTATED DATE
☐ DICTATED DATE
☐ MAILED DATE

HEALTH INFORMATION SERVICES

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MEDICAL UNIVERSITY OF SC
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Charleston, SC 29425-0768

144 767

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 12/26/97

Drs. Harvey/Gayoso/Rast

PREOPERATIVE DIAGNOSIS: Right metacarpophalangeal joint infection with associated open draining wound and left ingrown toenail secondary to compression hose.

POSTOPERATIVE DIAGNOSIS: Right metacarpophalangeal joint infection with associated open draining wound and left ingrown toenail secondary to compression hose.

PROCEDURE PERFORMED: Debridement of skin, subcutaneous tissue, muscle, and bone of the right foot with arthrotomy and irrigation of metacarpophalangeal joint of right foot and associated correction of left ingrown toenail utilizing wedge takeout technique.

OPERATIVE INDICATIONS: The patient is status post multiple chemical burns and now presents with open draining right MCP joint with also associated wound of the left great toe. He now presents for operative correction.

OPERATIVE DESCRIPTION: The patient was laid supine on the OR table. Areas were all prepped and draped. One percent plain lidocaine was injected in the left great toe. Ankle block was performed of the right toe. The patient then had the open wound of the right foot all debrided including the underlying bone. The MCP joint was irrigated copiously with saline irrigation. The wound was left open with packing. Cultures were obtained. Attention was then turned to the left ingrown toenail. This had a wedge section of the nail as well as associated skin on the lateral aspect of the foot removed. This was then closed with 4-0 nylon. The patient tolerated the

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

procedure well. A bulky dressing was applied and the patient went to the recovery room in stable condition.

Antonio Julio Gayoso, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

TSH: 754/6111
DD: 12/26/97
DT: 12/29/97
Additional CC: _____



Medical University of South Carolina
171 Ashley Avenue
Charleston, South Carolina 29425-0768

SHORT-STAY RECORD
(Length of Stay 48 Hours or Less)

Referring Physician: _____

Address/City/Zip: _____

122297

4550

INPATIENT
HRR 000971560 P/T I
JONES ARCHIE E
PAT 101546554 PLA
W/H D 000971560 HARVEY, T
WX WORK COMP EFF 12/26/97

7:7
40
59

PATIENT HISTORY

HISTORY/REASON FOR ADMISSION:

54y.o. WM s/p hot oil burn 40% 3° from head down
June 3, 97 s/p multiple debridement & grafting.
here for ① toe ingrown nail removal + debridement & ② bite
PMHx

P Surg Hx multiple debridement track
② Ankle Tonsil removed

Adverse Reactions to Medications? No ☒ Yes ☐ Specify: _____

Allergies, Hayfever, No ☒ Yes ☐ Specify: _____
Hives, Rash, Wheezing?

Current Medications? No ☐ Yes ☒ Specify: _____

See data base

PHYSICAL EXAMINATION

T	P	R	BP	WT	HT
				210	5'10"
AREA	NORM	AB-NORM	EXPLANATION OF ABNORMAL FINDINGS		
General Appearance	☒		54y.o. WM WD NAD		
Head, Neck	☒		HEENT PERILIA oral mucosa pink moist		
Ears, Nose, Throat	☒		Imp CTA ① Ant S, H, RHR		
Eyes	☒		ALL P/O EXTANT IND		
Cardiovascular	☒		Ext 2 @ pulse swelling UE + LE ①		
Lungs	☒		See above T + J		
Breasts	☒		Skin - Abd / ① + ② UE + ③ LE purple red discoloration		
Abdomen	☒		AADX 3		
Genitals/Rectum	☒				
Extremities		☒			
Skin		☒			
Lymphatics	☒				
Neurologic	☒				

ADDITIONAL COMMENTS:

ADMITTING DIAGNOSIS:

s/p 40% TBSA 3° degree

DATE: ____/____/____

RESIDENT'S SIGNATURE: _____

L. Ueb MD 5064

DATE: ____/____/____

ATTENDING'S SIGNATURE: _____

[Signature]

DATE M/D/Y	Hour	PHYSICIAN' ORDER
DATE M/D/Y	Hour	PROGRESS AND PROCEDURE NOTES
12/26		Inguinal (L) great toe nail; chronic wound mp (L) great toe Hemorrhoid / Gynec / Part (R) Ankle block / (L) great toe Digital block <i>[Signature]</i>
DATE M/D/Y	Hour	NURSING NOTES
DISCHARGE SUMMARY If applicable include diet, meds, activity, condition of patient and follow-up.		
FINAL DIAGNOSIS: <i>Rt c low Rt foot and</i> <i>uln pt in hand</i>		
Date: ___/___/___ RESIDENT'S SIGNATURE: <i>[Signature]</i> Date: ___/___/___ ATTENDING'S SIGNATURE: _____		

T555dJ

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HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 0971560
Date of Surgery: 12/30/97

Drs. Harvey/Cannova/O'Neill

PREOPERATIVE DIAGNOSIS: Open joint, right first metatarsal.

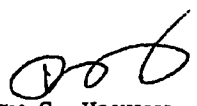
POSTOPERATIVE DIAGNOSIS: Open joint, right first metatarsal.

PROCEDURE: Axial pattern rotational flap with
split-thickness skin graft.

ANESTHESIA: Spinal. }

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed in a supine position. Spinal anesthesia was then induced in a routine fashion. The right foot and to the knee was prepped and draped in the usual sterile fashion as was the left thigh region. The original wound was then debrided circumferentially of the surrounding tissue and simple lavaged with three liters of antibiotic saline solution. The wound was also curetted. Bovie cautery was used to maintain meticulous coagulation of soft tissue and bone. Next axial random rotational flap was then elevated from the dorsum of the foot and brought down into the area of the wound. This was sutured into position over a mini-flap drain using 4-0 nylon suture and 5-0 chromic suture. Once this was performed a split-thickness skin graft was taken from the left thigh and meshed in a one-and-a-half to one pattern. This was placed into the remaining defect over the dorsum of the foot. Staples were then placed into the skin graft 35 wide. The wound was then dressed in a routine fashion and a bulky volar splint was then placed to prevent foot drop. The mini flap drain was then sutured into position. The skin graft donor site was then dressed in a routine fashion and the patient was taken to the recovery room in good condition where he did well postoperatively.

Joseph V. Cannova, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

JVC:648/6387
DD: 12/30/97
DT: 12/31/97
Additional CC: _____

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171 Ashley Avenue
Charleston, SC 29425-0768

767

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 0010971560
Date of Surgery: 12/30/97

Drs. Harvey/Cannova/O'Neill

ADMISSION DIAGNOSIS: Right slit open wound with
osteomyelitis of the first metatarsal.

POSTOPERATIVE DIAGNOSIS: Right slit open wound with
osteomyelitis of the first metatarsal.

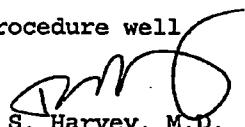
PROCEDURE PERFORMED: Debridement of skin and subcutaneous
tissue, muscle and bone with
irrigation and fasciocutaneous flap
closure with placement of split
thickness skin graft to 5 x 6 cm
defect.

ANESTHESIA: General endotracheal anesthesia.

OPERATIVE INDICATIONS: The patient is status post a burn with third
degree skin loss over the dorsum of the foot. The patient now
presents for operative debridement and closure.

OPERATIVE DESCRIPTION: The patient was laid supine on the OR table.
The right foot and left upper groin were all prepped and draped in
the usual sterile fashion. The patient had debridement performed.
It included portion of the bone. The wound was then irrigated with
5 liters of antibiotic irrigation. The patient then had the
fasciocutaneous flap rotated into the defect. The split thickness
skin graft was harvested from the left upper thigh. This was sewn
to the recipient bed with #5-0 chromic. A closed suction drain was
placed. A large bulky dressing was applied.

CONDITION: The patient tolerated the procedure well


Tracy S. Harvey, M.D.
Attending

TSH: 673/6386
DD: 12/30/97
DT: 12/31/97
Additional CC: _____

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HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCH
MRN: 000971660
Admitted: 12/26/97
Discharged: 01/09/98
Service: Plastic Surgery
Attending: Tracy S. Harvey, M.D.

Referring:

ADMISSION DIAGNOSIS: Chronic wound, right foot.

DISCHARGE DIAGNOSIS: Chronic wound, right foot, status post flap coverage.

HISTORY OF PRESENT ILLNESS: The patient is a 54-year-old man who suffered 40% total body surface area thermal burn secondary to hot oil in June of 1997. The patient has recovered well except for a chronic draining wound on the right foot overlying the superomedial aspect of the head of the first metatarsal. The patient presents for flap coverage of this wound.

PAST MEDICAL HISTORY: Healthy except for 40% TBSA burn.

PAST SURGICAL HISTORY: Multiple debridements and skin grafting of burn as well as tracheostomy at that time and tonsillectomy as a child.

ALLERGIES: No known drug allergies.

ADMISSION MEDICATIONS:

1. Albuterol 2 puffs b.i.d.
2. Elavil 50 mg p.o. q.h.s.
3. Vantin 200 mg p.o. b.i.d.
4. Zyrtec 10 mg p.o. q.h.s.
5. Colace 100 mg p.o. b.i.d.
6. Cardura 1 mg p.o. q.h.s.
7. Duratuss 1200 mg p.o. b.i.d.
8. Paxil 5 mg p.o. q.d.
9. Azmacort inhaler 2 puffs b.i.d.
10. Sudafed 60 mg p.o. q.4h. p.r.n.

HOSPITAL COURSE: The patient was admitted to the hospital and was taken to the operating room where a debridement and a local skin flap coverage along with split thickness skin grafting of the donor site were performed. The patient tolerated the procedure well but subsequently suffered superficial epidermolysis of the flap. This

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCH
MRN: 000971560
PAGE 2

required a prolonged hospital stay with observation and elevation of the right lower extremity. The flap has begun to reepithelialize and is completely viable; however, there is some concern of the distal tip of the flap becoming necrotic. This does not seem likely; however, it is a possibility. The patient is subsequently discharged to home.

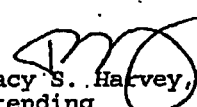
DISCHARGE INSTRUCTIONS: Dressing changes will be to wash and dry the wound carefully daily with water and mild soap. Bacitracin ointment should be applied to the skin graft and Xeroform to the skin graft and flap. All this will be covered by Kerlix. The patient was instructed to keep his right lower extremity elevated at all times.

FOLLOWUP: Followup is with Dr. Harvey one week's time.

DISCHARGE MEDICATIONS:

1. Albuterol 2 puffs b.i.d.
2. Elavil 50 mg p.o. q.h.s.
3. Vantin 200 mg p.o. b.i.d.
4. Zyrtec 10 mg p.o. q.h.s.
5. Colace 100 mg p.o. b.i.d.
6. Cardura 1 mg p.o. q.h.s.
7. Duratuss 1200 mg p.o. b.i.d.
8. Paxil 5 mg p.o. q.d.
9. Azmacort inhaler 2 puffs b.i.d.
10. Sudafed 60 mg p.o. q.4h. p.r.n.

Patrick J. O'Neill, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

PJO:754/7303
DD: 01/09/98
DT: 01/09/98
Additional CC: _____

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HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE
MRN: 000971560
Admitted: 01/12/98
Discharged: 01/19/98
Service: Plastic Surgery Service
Attending: Tracy S. Harvey, M.D.

Referring: June Souvione, M.D.

HISTORY OF PRESENT ILLNESS: This is a white male who is status post a chemical burn with open extensor tendon of the right great toe. The patient also sent for extensive burns that are dictated in the previous H&P. The patient recently underwent local flap coverage of the right open extensor tendon, was discharged to home, and shortly after being discharged has experienced trauma to the right toe with an opening of the distal aspect of the local flap. He was admitted for evaluation of this wound. For further details, please see H&P.

HOSPITAL COURSE: He was admitted to the plastic surgery service and placed on bedrest with elevation of the right great toe. He also had a splint created by occupational therapy for a right great toe drop, which was developing. The patient was also given pulsed lavage therapy by physical therapy each day with continued improvement in granulation tissue, in this open area, of his right great toe.

He remained afebrile with stable vital signs throughout his hospital stay and was discharged to home in stable condition on January 19, 1998.

DISCHARGE SPECIAL INSTRUCTIONS:

1. Continue to do wet-to-dry dressing changes to his open area of his right great toe, twice-a-day.
2. He should continue to wear his Jobst garments on his upper extremity burns, as well as wrapping his left foot to prevent hypertrophic scarring.
3. He is to be on bedrest with only bathroom privileges, as for times he is out of bed.
4. He can do his physical therapy exercises, in the bed, but should not be allowed out-of-bed for these exercises.

DISCHARGE FOLLOW-UP: To follow up with Dr. Harvey on Thursday, January 22, 1998 in Module #12.

HOSPITAL DISCHARGE SUMMARY

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

DISCHARGE MEDICATIONS: He has all of his medications, with which he was admitted, and should remain on the same.

Jack Otteni, M.D.
Resident


Tracy S. Harvey, M.D.
Attending

JO:755/8549
DD: 01/19/98
DT: 01/21/98
cc: June Souvirone, M.D., North Main Street, Anderson, SC 29621.
Additional CC: _____

MUSC MEDICAL CENTER - Physical Therapy
Physical Therapy Department
CHARTING REPORT

PAGE 1

NAME: JONES, ARCHIE E MRN 000971560 RM#: B615-A Current PAT 43436114-3

DATE: 01/14/98 TIME: 08:17

PHYSICAL THERAPY HYDROTHERAPY EVALUATION
INITIAL EVALUATION

DIAGNOSIS: s/p trauma to the right foot flap
HISTORY OF SKIN BREAKDOWN: Mr. Jones is a 54 yowm well known to this therapist who was readmitted on 1/12/98 after injuring a recent flap on his right great toe by hitting it on the coffee table. He caused a opening in the flap. He was referred to PT for Pulsatile lavage and dressing changes.
PMH: 60% TBSA thermal/chemical injury, multiple skin grafting and surgical procedures, depression, little toe amputation on the right foot.

HOME ENVIRONMENT: Mr. Jones lives with his wife in Anderson SC he has many pieces of medical equipment including a wheelchair.
SUBJECTIVE: PATIENT GOAL: "to get back on my feet again"

OBJECTIVE:

LEARNING BARRIERS

NO BARRIERS OR LIMITATIONS

MENTAL STATUS:

Alert and oriented x 3

SPECIAL CONDITIONS:

Patient wear Jobst garments for scar management on the arms, hands and left foot.

ROM:

WFL in all 4 extremities

Except:

Involved joint not assessed at this time.

STRENGTH:

WNL in all 4 extremities

WOUND CONDITIONS:

1. LOCATION: right great toe

Size (CM)

Width - 2.0 cm

Length - .3 cm

Depth - .2 cm

75% of granulation tissue present

25% of avascular tissue present

Erythema noted around periphery of wound.

Exudate:

Minimal

Yellow

DRESSING CHANGE EDUCATION:

Patient & wife are independent with dressing changes.

EDEMA:

MUSC MEDICAL CENTER - Physical Therapy
Physical Therapy Department
CHARTING REPORT

PAGE 2

NAME: JONES, ARCHIE E MRN 000971560 RM#: B615-A Current PAT 43436114-3

Location: none

FUNCTIONAL ACTIVITIES:

(*KEY- TA (TOTAL ASSIST): subject expends <25% of effort,
MAX (MAX ASSIST): 25% to 49% of task, MOD (MOD ASSIST): 50% to
74% of task, MIN (MIN ASSIST): subject performs 75% or more of task,
S (SUPERVISION): standby, cue, or coaxing, MI (MODIFIED
INDEPENDENCE): requires assistive device, extra time, or
there is a safety risk, I (COMPLETE INDEPENDENCE).

Wheelchair propulsion: I
Ambulation:
Non-ambulatory at this time.

TREATMENT:

Patient received pulsavac to the right great toe for irrigation and
debridement using 1000ml NS at 8 PSI with 100 mmHg suction. Followed by
dressing with Xeroform covered with dry gauze and secured with tape.

ASSESSMENT: Mr. Jones is cooperative with PT. He will benefit from daily
pulsavac to increase granulation tissue formation and promote
epithelialization.

Short term goals: (As discussed with patient and/or family)
to be met within 2 weeks.

#1 Increase granulation tissue to 90% to increase epithelialization of the
wound bed.

Long term goals: (As discussed with patient and/or family)
to be met within 4 weeks.

#1 Patient will have complete wound closure to allow patient to return to
functional ambulation.

PLAN:

Progress as patient tolerates.
Treat patient QD for pulsavac and dressing changes.

MUSC MEDICAL CENTER - Physical Therapy
Physical Therapy Department
CHARTING REPORT

PAGE 2

NAME: JONES, ARCHIE E MRN 000971560 RM#: PLASTIC Current PAT 434504940

DATE: 01/19/98 TIME: 17:20

PHYSICAL THERAPY HYDROTHERAPY EVALUATION
DISCHARGE SUMMARY

DIAGNOSIS: s/p trauma to the right foot flap
HISTORY OF SKIN BREAKDOWN: Mr. Jones is a 54 yowm well known to this therapist who was readmitted on 1/12/98 after injuring a recent flap on his right great toe by hitting it on the coffee table. He caused a opening in the flap. He was referred to PT for Pulsatile lavage and dressing changes. Mr. Jones was followed Qd by PT until his discharge on 1/19/98.
PMH: 60% TBSA thermal/chemical injury, multiple skin grafting and surgical procedures, depression, little toe amputation on the right foot.

HOME ENVIRONMENT: Mr. Jones lives with his wife in Anderson SC he has many pieces of medical equipment including a wheelchair.

SUBJECTIVE: PATIENT GOAL: "to get back on my feet again"

OBJECTIVE:

LEARNING BARRIERS

NO BARRIERS OR LIMITATIONS

MENTAL STATUS:

Alert and oriented x 3

SPECIAL CONDITIONS:

Patient wear Jobst garments for scar management on the arms, hands and left foot.

ROM:

WFL in all 4 extremities

Except:

Involved joint not assessed at this time.

STRENGTH:

WNL in all 4 extremities

WOUND CONDITIONS:

1. LOCATION: right great toe

Size (CM)

Width - 1.5 cm

Length - .3 cm

Depth - .2 cm

90% of granulation tissue present

10% of avascular tissue present

Erythema noted around periphery of wound.

Exudate:

Minimal

Yellow

DRESSING CHANGE EDUCATION:

Patient & wife are independent with dressing changes.

MUSC MEDICAL CENTER - Physical Therapy
Physical Therapy Department
CHARTING REPORT
PAGE 3

NAME: JONES, ARCHIE E MRN 000971560 RM#: PLASTIC Current PAT 434504940

EDEMA:

Location: none

FUNCTIONAL ACTIVITIES:

(*KEY- TA (TOTAL ASSIST): subject expends <25% of effort,
MAX (MAX ASSIST): 25% to 49% of task, MOD (MOD ASSIST): 50% to
74% of task, MIN (MIN ASSIST): subject performs 75% or more of task,
S (SUPERVISION): standby, cue, or coaxing, MI (MODIFIED
INDEPENDENCE): requires assistive device, extra time, or
there is a safety risk, I (COMPLETE INDEPENDENCE).

Wheelchair propulsion: I

Ambulation:

Non-ambulatory at this time.

TREATMENT:

Patient received pulsavac to the right great toe for irrigation and
debridement using 1000ml NS at 8 PSI with 100 mmHg suction. Followed by
dressing with saline soaked gauze covered with dry gauze and secured with
tape.

ASSESSMENT: Mr. Jones is cooperative with PT. He will benefit from daily
pulsavac to increase granulation tissue formation and promote
epithelialization. He would benefit from continued pulsatile lavage in the
home environment.

Short term goals: (As discussed with patient and/or family)
to be met within 2 weeks.

#1 Increase granulation tissue to 90% to increase epithelialization of the
wound bed.- met

Long term goals: (As discussed with patient and/or family)
to be met within 4 weeks.

#1 Patient will have complete wound closure to allow patient to return to
functional ambulation.- continue to address via home health wound care.

PLAN:

Discharge patient to home with home health wound care.

MUSC MEDICAL CENTER - Physical Therapy
Physical Therapy Department

CHARTING REPORT

PAGE 4

NAME: JONES, ARCHIE E MRN 000971560 RM#: PLASTIC Current PAT 434504940

CHARTED BY: BEVERLY A. SMITH, PT

Beverly A. Smith PT

☐ INPATIENT☐ OUTPATIENT

EMERGENCY

FOR YOUR COPY

☐ DICTATED DATE
☐ DICTATED DATE
☐ MAILED DATE

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171 Ashley Avenue
Charleston, SC 29425-0768

6

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 08/13/98

Drs. Harvey

PREOPERATIVE DIAGNOSIS:

Burn contractures involving the left nose, left upper eyebrow, left posterior ear and neck, as well as trunk and right arm.

POSTOPERATIVE DIAGNOSIS:

Burn contractures involving the left nose, left upper eyebrow, left posterior ear and neck, as well as trunk and right arm.

PROCEDURES PERFORMED:

1. Release of burn contracture of the nose with Z-plasty.
2. Excision of hypotrophic scar measuring 1 x 3 cm of the left upper eyebrow with 3.5 cm intermediate closure.
3. Excision of hypertrophic scar of the left posterior ear measuring 1 x 4 cm with 4.5 cm intermediate closure.
4. Excision and associated steroid injection of multiple hypertrophic scars of the abdomen, right arm, wrist with Kenalog 10 dilute.

OPERATIVE DESCRIPTION: The patient was laid supine on the table. Areas were all prepped and draped.

Attention was first turned to the contracture involving the left nasal rim. Z-plasty was performed, elevated and sewn with 6-0 Prolene suture. Additional hypertrophic scar of the left upper eyebrow was excised and closed with 6-0 Prolene and 5-0 Monocryl.

Attention was then turned to the left posterior where this was also excised and closed, after being undermined with 5-0 Monocryl and 5-0 Prolene.

Attention was then turned to the truncal areas, as well as right abdomen where multiple steroid injections were performed over the

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
PAGE 2

hypertrophic scars.

The patient tolerated the procedure well. He went to the recovery room in stable condition.


Tracy S. Harvey, M.D.
Attending

TSH:731/3442
DD: 08/13/98
DT: 08/13/98
Additional CC: _____

Jones, Archie E.
MUH#971560
10/15/98

Archie comes in today for evaluation. He is noted to be doing relatively well. He has some areas of increased burn sensitivity from thinning of the skin along the upper portion of his abdomen, the suprapubic area, as well as additional burns on the right shoulder, neck, and right arm. I feel that this patient would benefit from excision with complex closure of right upper quadrant burns measuring 3 X 12 cm with 14 cm complex closure as well as excision of hypertrophic burns of the lower abdomen with flap advancement utilizing adjacent tissue transfer flap measuring 3 X 14 cm. The patient will also undergo steroid injections. This will be done as a 23 hour admission and will take approximately 1 1/2 hours. We have enclosed photographs for your approval. If any further information is needed, please don't hesitate to call.

Sincerely,

Tracy S. Harvey, M.D.
Assistant Professor
Interim Head, Division of Plastic Surgery

TSH/kab



PATIENT
REGISTRATION

☐ INPATIENT

☒ OUTPATIENT

☐ EMERGENCY

REG. DATE 12/17/98	REG. TIME 11:26	MEDICAL RECORDS # 000971560	SOURCE # 023	EPISODE # 028	PAT COM # 440674455	DISCHARGE DATE 12-17-98	SEX M	RACE W	BIRTH DATE 12-17-1941	AGE 57Y
NAME JONES		LAST ARCHIE		FIRST M	MARITAL STATUS NFS.IPR	JAB.IPR				
ADDRESS 1229 SALEM CHURCH RD		CITY ANDERSON		ST SC	ZIP 29625	COUNTY 4	VIP CODE	ENGLAB WX		
SS NUMBER 200-70-5417		HOME TELEPHONE (864)224-2669		RELIGION BAPTIST	REFERENCE NAME GAINES/MMN	EMPLOYER NAME				
EMPLOYER PHONE		EMPLOYER ADDRESS STREET		CITY	ST	ZIP				
PAT TYPE K	NURSING STATION	ROOM	BED	ATTENDING DOCTOR HARVEY, TRACY				MED SERV FLA		
ADV DIR N	ON FILE N	INFO PROV Y	ADMITTING DOCTOR HARVEY, TRACY				LOS L	PREV. ADMIT DATE		
DIAGNOSIS EXCISION OF UPPER BURNS										
PROCEDURE INCREASED SENSITIVITY FROM THINNING OF SKIN										
PRECERT # 510171941		PRECERT PHONE (800)922-3305				PRECERT LOS 0000	PRECERT DATE 12/16/98			
EMERGENCY NOTIFICATION SCOTT, SISTER		LAST FAM	FIRST M	RELATIONSHIP 09 - UNKNOWN	HOME TELEPHONE (864)225-9713					
ADDRESS STREET		CITY		STATE	ZIP	WORK TELEPHONE				
REFERRING DOCTOR YARBROUGH, DABNEY		PHONE	ADDRESS			CITY				
STATE/ZIP		REFERRING INSTITUTION			EMERGENCY REFERRAL N					
FAMILY DOCTOR SOUVIRON, JUNE		PHONE 8642317003	ADDRESS 2405 N MAIN STREET			CITY ANDERSON	ST SC	ZIP 29621		
PRIMARY INSURANCE COMPANY W070 LIBERTY MUTUAL INSURANCE		ADDRESS PO BOX 100154			CITY/STATE COLUMBIA SC					
ZIP 29202	TELEPHONE 800-922-3305	PT REL/SUB 01	POLICY #/SUBSCRIBER # 300000000	GROUP NAME 3M CONFA						
SUBSCRIBER NAME JONES		ARCHIE	PRECERT # 510171941	EFFECTIVE DATE OF COVERAGE 220-70-5119						
PRINCIPAL DIAGNOSIS <i>scar hypertrophy</i>										
SECONDARY DIAGNOSIS <i>steroid ingestion</i>										
OPERATION OR SPECIAL PROCEDURES <i>excision / hypertrophic scar (complex closure)</i>										
<i>90714</i>										
<i>1300</i>										
<i>90714</i>										

CS-C03D REV 8

DISCHARGE SUMMARY
OF NOTE

- ☐ DICTATED DATE
☐ DICTATED DATE
☐ MAILED DATE

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HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE
MRN: 000971560
Date of Surgery: 12/17/98
Surgeon: Tracy S. Harvey, M.D.
Assistant(s): Rast, Arabitg

PREOPERATIVE DIAGNOSIS:

Hypertrophic and painful burn scars along the lower abdomen, right upper chest wall, as well as scars on the neck and chest.

POSTOPERATIVE DIAGNOSIS:

Hypertrophic and painful burn scars along the lower abdominal, right upper chest wall, as well as scars on the neck and chest.

OPERATIVE PROCEDURES:

Excision of hypertrophic scars of the lower abdomen with adjacent tissue transfer advancement flap, measuring 3 x 14 cm, with excision of 4 x 10 cm hypertrophic scar of the right upper chest wall with complex closure, 12 cm; steroid injections of multiple abdominal, as well as neck and facial scars with Kenalog 10.

ANESTHESIA:

General oral endotracheal anesthesia.

DESCRIPTION OF PROCEDURE: The patient was laid supine on the operating room table/ and the area was well-prepped and draped. The hypertrophic scars in the lower abdomen were excised. The skin flap was undermined, and rotated down, covering the defect with layered closure of 2-0 Monocryl, 3-0 Monocryl, and 4-0 Monocryl subcuticular was performed.

Attention was then turned to the right chest wall, where additional excision was performed. This did not require undermining and was closed with 3-0 Monocryl and 4-0 Monocryl subcuticular.

Dilute steroid 10 was then injected in the all scars and the patient

HOSPITAL OPERATIVE REPORT

Patient Name: JONES, ARCHIE

MRN: 000971560

PAGE 2

tolerated the procedure well and went to the recovery room in stable condition.


Tracy S. Harvey, M.D.
Surgeon

TSH: 755/3963

DD: 12/17/98

DT: 12/19/98

Attn: Page

Jones, Archie
MUH#971560
March 11, 1999

Archie comes in today for evaluation of his multiple burns. He is still noted to have alot of symptomatic burn contractures over his chest, left arm, neck. He is otherwise doing well. We will need to schedule him in one month for a steroid injection of multiple hypertrophic scars.

Tracy S. Harvey, M.D.
Assistant Professor

TSH/gal

** arrange time in one month.

Procedure Note

Archie Jones

MUH#

April 22, 1999

Pre-operative diagnosis:

Multiple hypertrophic scars of the trunk, arms, neck

Post Operative diagnosis:

Same

Procedure:

Injection of approximately 25 areas of hypertrophic scarring utilizing Kenalog 10 diluted with 1% Lidocaine

Surgeon:

Tracy S. Harvey, M.D.

Anesthesia:

1% Lidocaine with epi and bicarb

Procedure description:

The patient was laid supine on the operating table. Areas were all prepped with Betadine and alcohol. Areas were injected. She tolerated the procedure well.

Tracy S. Harvey, M.D.
Assistant Professor

TSH/gal

Jones, Archie E.
MUH#971560

MUSC
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• Plastic Surgery

John H. Roberts, M.D., FACS
Residency Program Director
Diplomate,
American Board of Surgery
• Plastic Surgery

Rodney B. Young, M.D., FACS
Diplomate,
American Board of Surgery
• Plastic Surgery



April 6, 2007

RE: ARCHIE JONES
MRN: 971560

To Whom It May Concern:

We were unable to locate the above patient's private
plastic surgery records from 10/14/97 through 8/20/1998.
We do apologize for any inconvenience this may cause.

Sincerely,

Tracy C. Buras
Administrative Assistant
Plastic Surgery

"An equal opportunity employer,
promoting workplace diversity."

<http://www.musc.edu>

Date 10/20/97 Allergy _____
Name Oddie Jones Age 54 Race W Sex M
CC/HPI here formed deficits - burned on 6/3/97
↑ BRS upst & previously
APT BRS! occ SOB even @ MRI
ROS anxiety type symptoms - at times overwhelming
PMH s/p extensive chemical burns trunk face Social: Tobacco _____
s/pice - spent 3mo Charleston ETOH _____
Burn center FM: _____

PE T 100° P 84 R 18 BP 140/78 Wt 211 Ht _____
Gen _____ Skin diffuse burns
Heent clear men
Neck Supraclavicular
CV R/R S1 S2 Pulses +2
Lungs scattered wheezes Chestwall _____
Abd _____ Rectal _____
Back/Spine _____
Extr _____
Neuro _____
Breasts MS - no affect GU _____
Pelvic _____

AP 1) HTN - Suboptimal control by H₂ Labs _____
↑ Lisinopril 100 mg BID
2) Depression & 2° stress Burns
↑ Paxil 10 mg qd from 5 mg qd
3) s/p Pulmonary trauma - Plw/Alc use needed in view of
↑ H₂S - OPVIA same
4) Chemical Pneumonitis - chronic cont MD
HM Needs Flu 3 vlt bld Other _____
RTO _____

Meds Sec. Sheet () Episodic Med

Date 12-24-97 Allergy NKDA
 Name Eddie Jones Age 54 Race W Sex M
 CC/HPI here for BP HAS across forehead 2 vertex c/w migr
day once twice can't stop it during day or 10 min open
 PE T 98.9 P R BP 118/86 W H
Lungs full of secretions gets nauseated
Was on ABX for infection in foot - came for that
 Dx: PE: TMS clear
 Plan: Ante brachitis / u/e Vanin 200 bid Phen Sup 50 if no dex
HTN doing great on Cardura 1mg 5 to phen
HA - Midrin as directed
Anxiety - cant Paxil 10 - doing fine w/ that
"Itching" - requests something besides Atarax - will try Zyrtec 10 qd
Flu 6 wks

Date 12-23-98 Allergy
 Name Eddie Jones Age 54 Race W Sex M
 CC/HPI 500 throat, clear - green nasal drainage, coughing, x 1 wk
inhalers, Duratuss Saw Dr Hill 12/23 for trouble swallow
 PE T 99.9 P 100 R 18 BP 152/86 W H
Can eat out of Abt. 100% No recent HTN
 Dx: Acute sinusitis Acute Pharyngitis
 Plan: Anxiety / Graf Reaction - loss of sen - Cerebral Subarachnoid
Duratuss 6 bid Ator 20 qd
Verigun 500 mg qd Paxil 20 qd
HTN Ator 100 bid

DATE 3/19/98 ALLERGY _____
 NAME Eddie Jones AGE 54 RACE W SEX F
 CC/HPI "My lungs are in distress" difficulty breathing in shower x24
Levamisole therapy - didn't do a lot of good
 PE T 99° P 88 R 20 Wt 138/90 Ht 5'11"
Thick mucous - using inhalers
g12°
PE NAD This could clear mm clear Neck crack
ASMA lung scattered wheezes
 Dx: Chronic obstructive pulmonary disease Referral Dr. Walker
Pulmonary Fibrosis Continue MDIs Continue med
injury Cast Ribs, Klavox bid x 4
ABGs ASAP - Van Need qd x 5
Need all blood ✓ CKR Home C2
from circulation Acute infarctive process

DATE 12/29/98 ALLERGY _____
 NAME Jones Eddie AGE 54 RACE W SEX F
 CC/HPI Recent reconstructive surgery abd keloids 2° Burns - on lipiflex for that
Please Duratuss 6 for sinus still having angina" for 4 weeks
One new problem of coronary artery
Excrute unstable on hand out 1h w/ 3 mi/hr SE/L Now less sinus
 PE Dysr Heart keeping his stroke walked - was he unable to work at computer possib
trial if 5/10/98 P 80 R 180/82 BP 138/82 Wt 235/1 Ht 5'11"
Cholesterol 6.4 mmol/L, no affect mm ess clear
Neck of throat / thyroid masses / MC trachea +2C
ab extensive incisional
edema c thick dark of hematoma drainage - extensive ecchymosis
 Dx: Pulmonary Fibrosis - cont current med hematoma 5/13/9
 Plan: Sub-incisional fascial drain hematoma drainage
HTN - adeq Charlton 12/31
Allergin - Try 2yr/2 pm cont Planase
Cont Duratuss 6
Colon ✓ ceded Referral gen Sur this year - Orlery preferably
Headache Resolved Eucilia Dysix put get retry Vag

DATE 2/8/99 ALLERGY _____
 NAME Jones, Eddie AGE _____ RACE _____ SEX _____
 CC/HPI Trouble concentrating at work (focus problem) needing to learn new
procedures who compensated by being distractible overall poor concentration
AS checked ADD symptoms suggestive
 PE T _____ P 76 lbs R _____ BP 140/52 Wt. _____ Ht. _____
Mood - dysphoric, anxious RN CTA today

Dx: S/P Extensive chemical Burns, Pneumonia, - cont MDIS, Flu Dr. Walker
 Plan: Poor concentration - likely worsening Depression, also consider
Δ Paxil to Effexor 37.5 mg qd x 2 wks then 75 mg qd
Flu 3-4 wks
think it may have become "resistant" to Paxil
several yrs - will try Δ SSRI → combination drug
otherwise consider Rx for ADD as it will run risk of losing job
if we don't solve this Hx is on Adderall given 7/20/92
 DATE 3/2/99 ALLERGY _____

NAME Jones, Eddie AGE 55 RACE _____ SEX _____
 CC/HPI Walling in on treadmill - clx Vertigo but overall improved concentration
& variability & values more refreshed - overall feels good - eating a lot less
not using food as sedative - feels better than the "Hugin 2 yrs" pills
 PE T _____ P 78 lbs R 110 lbs BP 124/78 Wt. _____ Ht. _____
TMS clear ENT Ext. ECG
Neuro intact NS - careful, endocrine - affected

Dx: ADD vs Depression - dramatic improvement
 Plan: Discontinue ADHD / Depression for this pt
Cont Effexor 75 qd Flu 6 wks
Respt status - cont Rx for Flu 1999

DATE 4/12/99 ALLERGY _____
 NAME James, Eddie AGE _____ RACE _____ SEX _____
 CC/HPI feels nervous, on Effexor for depression - initially, damaged
can't sleep - No. 15 Ativan which leaves him too sleepy
 PE T 98.4 P 80 R 12 BP 136/86 Wt. 244 Ht. 6'4"
NAD, mm r/s clear Neck (noisy) masses
cm pmt neck on 5mg
Nerv - grossly intact

Dx: HTN - B/P doing fine today
 Plan: Pneumonia? Chemical injury - see Dr. Walker today overall doing
Insomnia/Anxiety & Depression - maybe worsened? Effexor - will D/C same
Resume Pax. 2 to 20 mg. Referred Dr. Barmashman - it may be Ativan prev
pt to call Dr. Lowland his Gastro Surg. Gville -
About his swelling of colon - 2 last
endoscopy
 DATE 4/22/99 ALLERGY _____

NAME James, Eddie AGE _____ RACE _____ SEX _____
 CC/HPI onset = 1 week ago of congestion cough with phlegm, some hem-
TM 100° - Levagum 500 x 7 days - only min residual but not at all better
 PE T 98.4 P 80 R 14 BP 112/74 Wt. 244 Ht. 6'4"
Coarse, wet cough NAD Tris/canals clear & sinus tenderness
Neck masses R/S 15mg Lung & 14mg
Acute bronchitis in pt
Compromised Pulm: T rovir. 100 qhs x 10d
Prednisone 20 TTT c Sugar -
Resume Albuterol MDI 4 puffs q4h
Cont Flovent
Humid B/D
 DATE _____ ALLERGY _____

Dx: 95% phagocytosis - seems due to Carotid cont. prn? irritation? Inhaled steroids
 Plan: U. Retention, etc. - 2 components of anxiety
Stress/Anxiety D/O - cont. ψ care - cont. Neurotizing Group on dog as directed
Excessive Snoring! Needs Sleep Study - F. No. Neurology
Chemical/Heat Induced Pneumonia - ^{possible transfer to dog from concentration cage} ^{with issue} ^{Aspt. pending}
FLU GWs ^{DMOI ALB} ^{movement to} ^{Neuro. ser. pt. subj. reports impaired resp. fx}

DATE 8/3/99 ALLERGY _____
 NAME Copier, Eddie AGE _____ RACE _____ SEX _____
 CHCHI 1" not a leg - fracture p/leg - seeing a doctor about it
Indi - going to pulm clinic - keep status in p/leg
 PE T 98.9 P 74 R 18 BP 130/82 WL 237 HT 5'7"
mm clear neck drains, MM Spinal
CIA & sub/leg: add 80% NT 80% bypassing
p/leg's good but +2 pulse p/leg/leg
Leg pain - 2 med (Webb's - esp. not well at night - not wear
Yakima & leg for TSH, BMI
Pneumonia - stable
Snoring - Appt And Neuro for sleep apnea eval

DATE 6/29/99 ALLERGY _____

NAME Jones, Archie AGE _____ RACE _____ SEX _____

CC/HPI 4 hrs left him on Neurontin 300mg New Zoloff 25

PE T going to Pulm Rehab R Nebrulizer helping SOB BP 120/80 Wt 238 Ht 5'10"

Dx: _____

Plan: _____

DATE 8/4/99 ALLERGY _____

NAME Jones, Eddie AGE _____ RACE _____ SEX _____

CC/HPI Eddie reports Pulm Rehab does more for his lungs than

Recent hearing test at work 979 Nebulizer working well BP 120/80 Wt 239 Ht 5'10"

Dx: Tinnitus-

Plan: cont.

discontinued TMT as source Tinnitus - Tired
New shoes coming exercise Nebrulizer
1/25

DATE 10/6/99 ALLERGY _____

NAME Jones Eddie AGE _____ RACE Kabon SEX _____

CC/HPI Thick mucous in Nebs - had been on ABX weekly for
sinus infection, trouble sleep, constipation -
on Quasig 500 qid x 10d poor sleep, frequent HTAs

PE T 118/80 P _____ R _____ BP 118/80 WL _____ HL _____

nam clear. Neck pharynx
cm lung few coarse rhonchi

Dx: Mod exag. COPD card MDI

Plan: Levaquin 500 qid x 10d
Somato for sleep - short term
Constipation - cont Colace
Add-Muradex 1000 bid
B12 for fatigue

DATE 11/8/99 ALLERGY _____

NAME Jones Eddie AGE 7 RACE _____ SEX _____

CC/HPI No relief of SOB, Acute Dr. McQueen for sleep study - sucked Sinus gel
Dr. Thompson did + salbutamol B2H2 out. All other tests
99% Tachycardia, Resp rate 100, 110, 120, 130, 140, 150, 160, 170, 180, 190, 200, 210, 220, 230, 240, 250, 260, 270, 280, 290, 300, 310, 320, 330, 340, 350, 360, 370, 380, 390, 400, 410, 420, 430, 440, 450, 460, 470, 480, 490, 500, 510, 520, 530, 540, 550, 560, 570, 580, 590, 600, 610, 620, 630, 640, 650, 660, 670, 680, 690, 700, 710, 720, 730, 740, 750, 760, 770, 780, 790, 800, 810, 820, 830, 840, 850, 860, 870, 880, 890, 900, 910, 920, 930, 940, 950, 960, 970, 980, 990, 1000, 1010, 1020, 1030, 1040, 1050, 1060, 1070, 1080, 1090, 1100, 1110, 1120, 1130, 1140, 1150, 1160, 1170, 1180, 1190, 1200, 1210, 1220, 1230, 1240, 1250, 1260, 1270, 1280, 1290, 1300, 1310, 1320, 1330, 1340, 1350, 1360, 1370, 1380, 1390, 1400, 1410, 1420, 1430, 1440, 1450, 1460, 1470, 1480, 1490, 1500, 1510, 1520, 1530, 1540, 1550, 1560, 1570, 1580, 1590, 1600, 1610, 1620, 1630, 1640, 1650, 1660, 1670, 1680, 1690, 1700, 1710, 1720, 1730, 1740, 1750, 1760, 1770, 1780, 1790, 1800, 1810, 1820, 1830, 1840, 1850, 1860, 1870, 1880, 1890, 1900, 1910, 1920, 1930, 1940, 1950, 1960, 1970, 1980, 1990, 2000, 2010, 2020, 2030, 2040, 2050, 2060, 2070, 2080, 2090, 2100, 2110, 2120, 2130, 2140, 2150, 2160, 2170, 2180, 2190, 2200, 2210, 2220, 2230, 2240, 2250, 2260, 2270, 2280, 2290, 2300, 2310, 2320, 2330, 2340, 2350, 2360, 2370, 2380, 2390, 2400, 2410, 2420, 2430, 2440, 2450, 2460, 2470, 2480, 2490, 2500, 2510, 2520, 2530, 2540, 2550, 2560, 2570, 2580, 2590, 2600, 2610, 2620, 2630, 2640, 2650, 2660, 2670, 2680, 2690, 2700, 2710, 2720, 2730, 2740, 2750, 2760, 2770, 2780, 2790, 2800, 2810, 2820, 2830, 2840, 2850, 2860, 2870, 2880, 2890, 2900, 2910, 2920, 2930, 2940, 2950, 2960, 2970, 2980, 2990, 3000, 3010, 3020, 3030, 3040, 3050, 3060, 3070, 3080, 3090, 3100, 3110, 3120, 3130, 3140, 3150, 3160, 3170, 3180, 3190, 3200, 3210, 3220, 3230, 3240, 3250, 3260, 3270, 3280, 3290, 3300, 3310, 3320, 3330, 3340, 3350, 3360, 3370, 3380, 3390, 3400, 3410, 3420, 3430, 3440, 3450, 3460, 3470, 3480, 3490, 3500, 3510, 3520, 3530, 3540, 3550, 3560, 3570, 3580, 3590, 3600, 3610, 3620, 3630, 3640, 3650, 3660, 3670, 3680, 3690, 3700, 3710, 3720, 3730, 3740, 3750, 3760, 3770, 3780, 3790, 3800, 3810, 3820, 3830, 3840, 3850, 3860, 3870, 3880, 3890, 3900, 3910, 3920, 3930, 3940, 3950, 3960, 3970, 3980, 3990, 4000, 4010, 4020, 4030, 4040, 4050, 4060, 4070, 4080, 4090, 4100, 4110, 4120, 4130, 4140, 4150, 4160, 4170, 4180, 4190, 4200, 4210, 4220, 4230, 4240, 4250, 4260, 4270, 4280, 4290, 4300, 4310, 4320, 4330, 4340, 4350, 4360, 4370, 4380, 4390, 4400, 4410, 4420, 4430, 4440, 4450, 4460, 4470, 4480, 4490, 4500, 4510, 4520, 4530, 4540, 4550, 4560, 4570, 4580, 4590, 4600, 4610, 4620, 4630, 4640, 4650, 4660, 4670, 4680, 4690, 4700, 4710, 4720, 4730, 4740, 4750, 4760, 4770, 4780, 4790, 4800, 4810, 4820, 4830, 4840, 4850, 4860, 4870, 4880, 4890, 4900, 4910, 4920, 4930, 4940, 4950, 4960, 4970, 4980, 4990, 5000, 5010, 5020, 5030, 5040, 5050, 5060, 5070, 5080, 5090, 5100, 5110, 5120, 5130, 5140, 5150, 5160, 5170, 5180, 5190, 5200, 5210, 5220, 5230, 5240, 5250, 5260, 5270, 5280, 5290, 5300, 5310, 5320, 5330, 5340, 5350, 5360, 5370, 5380, 5390, 5400, 5410, 5420, 5430, 5440, 5450, 5460, 5470, 5480, 5490, 5500, 5510, 5520, 5530, 5540, 5550, 5560, 5570, 5580, 5590, 5600, 5610, 5620, 5630, 5640, 5650, 5660, 5670, 5680, 5690, 5700, 5710, 5720, 5730, 5740, 5750, 5760, 5770, 5780, 5790, 5800, 5810, 5820, 5830, 5840, 5850, 5860, 5870, 5880, 5890, 5900, 5910, 5920, 5930, 5940, 5950, 5960, 5970, 5980, 5990, 6000, 6010, 6020, 6030, 6040, 6050, 6060, 6070, 6080, 6090, 6100, 6110, 6120, 6130, 6140, 6150, 6160, 6170, 6180, 6190, 6200, 6210, 6220, 6230, 6240, 6250, 6260, 6270, 6280, 6290, 6300, 6310, 6320, 6330, 6340, 6350, 6360, 6370, 6380, 6390, 6400, 6410, 6420, 6430, 6440, 6450, 6460, 6470, 6480, 6490, 6500, 6510, 6520, 6530, 6540, 6550, 6560, 6570, 6580, 6590, 6600, 6610, 6620, 6630, 6640, 6650, 6660, 6670, 6680, 6690, 6700, 6710, 6720, 6730, 6740, 6750, 6760, 6770, 6780, 6790, 6800, 6810, 6820, 6830, 6840, 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17300, 17310, 17320, 17330, 17340, 17350, 17360, 17370, 17380, 17390, 17400, 17410, 17420, 17430, 17440, 17450, 17460, 17470, 17480, 17490, 17500, 17510, 17520, 17530, 17540, 17550, 17560, 17570, 17580, 17590, 17600, 17610, 17620, 17630, 17640, 17650, 17660, 17670, 17680, 17690, 17700, 17710, 17720, 17730, 17740, 17750, 17760, 17770, 17780, 17790, 17800, 17810, 17820, 17830, 17840, 17850, 17860, 17870, 17880, 17890, 17900, 17910, 17920, 17930, 17940, 17950, 17960, 17970, 17980, 17990, 18000, 18010, 18020, 18030, 18040, 18050, 18060, 18070, 18080, 18090, 18100, 18110, 18120, 18130, 18140, 18150, 18160, 18170, 18180, 18190, 18200, 18210, 18220, 18230, 18240, 18250, 18260, 18270, 18280, 18290, 18300, 18310, 18320, 18330, 18340, 18350, 18360, 18370, 18380, 18390, 18400, 18410, 18420, 18430, 18440, 18450, 18460, 18470, 18480, 18490, 18500, 18510, 18520, 18530, 18540, 18550, 18560, 18570, 18580, 18590, 18600, 18610,

DATE 11/29/99 ALLERGY codeine
 NAME Eddie Jones AGE 56 RACE W SEX M
 CC/HPI Nasal congestion, chest congestion, clear prod cough - using inhalers
has id Singulair - 750mg daily, Olaner (Echin) 11/27 PM
 PE T 99° P 98° R 12 BP 142/78 WL 170 HL 10
Had Cipro from Dr Albert = 1 week ago
TMS clear Nose Throat clear - Neck nodes enlarged
pharynx/bruit on S1, S2, CTA faint
 Dx: Wheezing - Minor exacerbation COPD - No ABX
 Plan: Needs lots fluid, Discharge BP
Cont current Meds.
↑ Nebulizer 401M x1 Scattered late inspir. wheezes

Use Flow meter daily
Cont with C. Dr. Mohan

DATE 12/7/99 ALLERGY codeine
 NAME Jones, Eddie AGE 56 RACE W SEX M
 CC/HPI started 1st Cipro 500 (10 days supply left)
secretions started to be yellow then AMPH (green) then pink
started himself on Cipro because of ↑ mucus, cough
by Dr. Mohan for direct laryngoscopy Dr. Helstrom for his gastrostomy area
infection Dr. Helstrom thought correct problem
esophagus inflamed started Provacid
 PE T 98° P 98° R 12 BP 118/70 WL 170 HL 10
TMS/Clia mm, CTA bifid sinus tenderness
Neck. Supr. Nodes
 Dx: ess Clear Lung sounds Disgust - Extra Tracheal
Acute Bronchitis
 Plan: Discontinue short term use S1/S2
Finish course Cipro
Add Proanthus in on severe cough
Postural chest physio
Rob. D.M. HC 9/10

DATE 3/9/00 ALLERGY _____
 NAME Thomas, Edddy AGE 56 RACE _____ SEX _____
 CC/HPI was on Levaquin for back P Prostata inflammation from Acne, then his short heart
was started next day Augmentin took the last one yesterday - having Tinnitus
remembering so has the Dr. told him can't use Clap 20 ear pain,
 T 101 P Also seems P. Richards BP 138/90 Wt. 110 Ht. 5'7"
0.1 level Also seems P. Richards Now 551 H/O to st. in domestic store
plus 100 also recently P sleep study - seeing therapist 2# 126.1
min min emphysema Neck Surg. 1998 525/192
lung coarse BS be double and 8th rib
 Dx: Resp Tract عف - already having just can't sleep
 Plan: Round ones - Symptom GM stain. C/S
Ceflor 500 BID for 14 days #20

cut muscles ✓ ✓ ✓ ✓
if not improving ✓ ✓ ✓ ✓
Anxiety seems to be overwhelming
she thinks X-ray ? Lingular Pneumonia
this probably discussed - Dr. Alden
 DATE 5/17/00 ALLERGY Codine

NAME Eddie Jones AGE 50 RACE W SEX M
 CC/HPI (R) first ecchymosis 20 fall - concerned for bone
scars on leg & back of RT plastic hip Trauma
 PE T 99° P 80 R 16 BP 114/66 Wt. _____ Ht. _____
+2 pulses +2 Refl 155 prognosis
has ess good ROM hips/knees Ankle
+2 Refl 155 Disability let malodorous
Foot/Ankle strain second

Dx: _____
 Plan: ✓ X-ray @ Ankle & leg

DATE 5-8-01 ALLERGY

NAME Eddie Jones AGE 57 RACE SEX

CC/HPI 5d increasing epigastric pain recently - seems to think its his Duodenum
4 told him it was peptic ulcer then told him to stay on Prednisone
feels worse at night 1090 Smoking 40s 3 children

PE T 98° P 80 HR 104 R BP 140/90 WL 221 Ht 6'1"

looks green 1/2 Best he's been in a long time

MA clear Neck & nodes Thyroid masses Bruit Hx of 13.7

RM CTA Ald soft no masses sign of gastric tenderness

GI discomfort ✓ UGI of not improving

start Cytotec since he must

try Nexium DIC Su-tan DM (Duodenum)

is resistant again

No Hx or glime evidence

of GI bleed

DATE 5/23/01 ALLERGY _____

NAME Eddie Jones AGE _____ RACE _____ SEX _____

CC/HPI Thinks reflux is giving him a problem with his lungs
* Despite Cytotec & the change to Nexium still having Epi given by burning
& his problem is worse despite his standard treatment

PE T 98° P 84 R 16 BP 130/90 Wt 224 Ht 5'10"
No Rhinorrhea examined secretions inflammation ABX
mm clear Neck Supple in "Bronchial tubes"
abd soft NT Home exp/insp ok

Dx: Erythematous Pain - X-Suclal DM fold

Plan: Dr. Warrhan Restart BID PPIs
6/4/12³⁰ ↑ Cytotec 200 qid
↑ Prednisone 20 bid then 15-40
then back to 10 mg
* pt known to your office Jhon

DATE 6/18/01 ALLERGY _____

NAME Eddie Jones AGE 57 RACE W SEX M

CC/HPI Home PPIs have been ok off Cindura -
Discontinued Plavix - Dr. Hinnant -

PE T _____ P 80 R 18 BP 118/68 Wt 222 Ht _____

Dx: H/O HTN off med

Plan: Prostatism J

DATE 7/18/01 ALLERGY _____
 NAME Eddie Jones AGE 57 RACE W SEX M
 CC/HPI changed Cardiac to Primar - Added Plavik
2 migration in the last few weeks - Remnant of midline
997 997 997 997 997 997 997 997 997 997
 PE T 997 P 997 R 997 BP 120/72 WL 226 HT 120/68
 Dx: H/L HTN
 Plan: Examination (2) upper arm reassurance - heat

DATE 8/22/01 ALLERGY Back on Shimm - Lactin -
 NAME Eddie Jones AGE 58 RACE W SEX M
 CC/HPI start mucromist helped to separate after my lungs have gotten better even after
injection 20mg for 2 weeks 15mg x 2 weeks 1mg 1mg
996 996 996 996 996 996 996 996 996 996
 PE T 996 P 996 R 996 BP 132/84 WL 226 HT 122/68
 Dx: H/L HTN plavik BK staying Great off Meds
 Plan: ADD - Mood/Axiety D/O
(B) innitus clear TM - H/L dental Appliance & Do TMJ exercise
HA - Midline relief if c Anura - 1/6 from Tinnitis SUC
COP - cont current Meds! Present Mucromist
good call - Risk Osteoporosis - meds - Needs DEXA

DATE 10/15/01 ALLERGY _____
 NAME Eddie Jones AGE 58 RACE W SEX M
 CC/HPI Lungs too bad to get out of house all summer - heavy secretions / acute bronch
considering post-traumatic stress - panic sleep each of 3 months
with cabin in moving center - on 20 prednisone for most New Back to 10 c ↓ lip
 PE T 98 P 98 R 98 BP 116/76 Wt. 160 Ht. 5'10"
arm numbness esp R olecranon

Burn Scarring (R) ulnar area

Dx:

Plan:

Osteopenia by DEXA - Cont Calc

(R) arm numbness still (w) same paresthesias as when
op for hosp for TIA - referral Dr. Oliver

COPD - cont home meds & /u Dr. Mohan

DATE 12/10/01 ALLERGY _____
 NAME Jones, Eddie AGE 58 RACE W SEX M
 CC/HPI saw Numb R. Paresthesias & New / ulnar numb
is back on - 20 prednisone - Numb is ulnar back to
5 mg prednisone & taking with since 11/1/01
Just finished ABX - Numb still in foot 2° oxidant
 PE T _____ P _____ R _____ BP 118/60 Wt. 143 Ht. _____

Burn (R) foot & ulcer - callous / corns lat. (R) foot
CTA - initial Rhonchi - clear & cough

Dx:

Plan:

Scanning etc. first - will coordinate sug
& pulm surg

Paresthesia arm - pt to observe

DATE 3/5/02 ALLERGY _____
 NAME Jones Eddie AGE 58 RACE _____ SEX _____
 CC/HPI pm motivation & Nags but overall doing well
daytime sleepiness up wk 2-7-8° sleep hrs too
excess clasp biting up teeth his open long draining night & white
10mg prednisone with this than now 5mg high
 PE T _____ P _____ R _____ BP 104/60 Wt. 160 Ht. 5'10"
Some preservatives HA x2 Nasal drainage bleeding 3x's
Trinitrol (K122) Glu 1276/01
Glu 71

Dx: _____
 Plan: Still waiting on foot surg
? Glu Intol
Panthenum worst splint hrs - ✓ C-spine X-ray
1500 cal diet

DATE 4/9/02 ALLERGY _____
 NAME Jones Eddie AGE 58 RACE _____ SEX _____
 CC/HPI Extra headache since last visit constant
decision making difficult head position trigging light
working in 1500 cal ADA diet even 2 caution 2 exlases
but → "sudden"
 PE T _____ P 98 R _____ BP 108/70 Wt. 237 Ht. _____
clap cony - PERLA; EOM

Dx: glucose Intol, Insulin Resistance 2° Steroids
 Plan: Needs Eye exam - Referral 1g-eye

DATE 2-5-03 ALLERGY Coderu
 NAME Jones, Archie Eddie AGE 59 RACE SEX
 CC/HPI is under care of Dr. for "leg infection", was kneeling for a prolonged period of time in @ knee 10 days ago then got P. & cellulitis
Penicillin would have improved - but heat Augmentin which he's on
anyway for P. & P. (P. & P. pressure on right joint & knee
 PE 98.6° P 76 R 144 BP 108/80 WL 235 HL

NAD, (R) LE markedly edematous & firmness calf
enough to mid ant tib & patellar area & cords
Ecchymosis (reports 13 Nov) to lat (R) knee & distal med joint line Ext. warm
 Dx: Cellulitis (R) leg in pt & Underlying
 Plan: chronic lymphedema 70 to old B. & trauma - already on Augmentin but a
his chronic use of same? efficacy since
cellulitis appears progressing. No activity elevate
venous duplex since he is at risk & venous
stasis", Δ Augmentin to Cipro 150 mg qid
& levaglin 500 qd - see ortho tomorrow

DATE 2-7-03 ALLERGY
 NAME Jones, Archie Eddie AGE 59 RACE SEX
 CC/HPI seen 2 days ago & cellulitis & Neg DVT & saw Orth.
2/0 did not fill Ciprocin until this AM ("I wasn't
sure who was going to pay for it - he wk)
 PE T 99.1° P R BP WL HL

No exam
No need to see me, had visited
& Ortho & PT was
 Dx: not compliant & my
 Plan: instructions
Keep F/U's @ Dr. Hernandez
See me as per
routine

DATE 7-24-03 ALLERGY _____

NAME Jones Archie AGE _____ RACE _____ SEX _____

CC/HPI Projections around house - had 4 cbs - pulm cbs stable
made him x 100 on Mch 1. Home BP 130/80
PE T 97.4 P 70 R 108/80 Wt 230 Lb Improves
with
SH
neck supple under/brut + 2 cbs
CTA sub OCCE Nails - Rudonol (R) great for nail
Insomnia + Risperidol to 0.5 hs
Plan: BP 130/80 + 10mg p. 4 x 2
Thrush - Mtd - 15 on Nystatin try Antidote
? Only ho much cannot take for Nails + Risperidol
(R) good
Ice

DATE 8/15/03 ALLERGY _____

NAME Jones Archie AGE (R) elbow pain RACE _____ SEX _____

CC/HPI 6/6 sharp pain in (R) CVA - 7 pain of deep
Pricking Started - had had day and night - so
PE T 97.6 P 70 R 108/80 Wt 230 Lb Improves
with
SH
neck supple under/brut + 2 cbs
CTA sub OCCE Nails - Rudonol (R) great for nail
Insomnia + Risperidol to 0.5 hs
Plan: BP 130/80 + 10mg p. 4 x 2
Thrush - Mtd - 15 on Nystatin try Antidote
? Only ho much cannot take for Nails + Risperidol
(R) good
Ice

DATE 5/21/04 ALLERGY _____
 NAME Jones, Eddie AGE _____ RACE _____ SEX _____
 CC/HPI "bleeding" (R) lat foot just at level of toes - noticed
the wound Pressure 5.5 cm
 PE T 96 P 70 R 16 BP 122/86 WL _____ HR _____
cleansed Betadine - 3 4-0 Nylon
Intermittent - am Ant Ag Day
hemostasis
 Dx: Uncontrolled bleeding - hemostasis obtained &
 Plan: suture & Ag 400p - wound can be closed
JH

DATE 5-25-04 ALLERGY _____
 NAME Jones, Eddie AGE 60 RACE C SEX M
 CC/HPI Returns for suture removal No further
bleeding No other problems
 PE T _____ P _____ R _____ BP _____ WL _____ HL _____
 Dx: _____
 Plan: _____
JH

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DATE 10/6/05 ALLERGY X-ray (12/06/05)
 NAME Jones Eddie AGE 62 RACE Black SEX Male
 CC/HPI flu, foot wounds, elbow - saw Dr. A. pro. clon.
about (R) elbow - told to leave hematoma alone - it's immovable
PEO in pain free - Dr. Tolson foot specialist in Gville requiring
 PE T 11M P CTA R BP 136/80 WL 226 HL 11.5
Elbow/foot as noted below -

Dx: ulceration 2: skin breakdown (R) lat foot -
 Plan: getting wound done, at Am Med - but needs
surgeon's referral Dr. Tolson in Gville -
Episodes 1st Metatarsal head (left foot) -
pt does have surgery & has
breakdown -
has & steroid in hopes of improved skin heal

DATE 12/14/05 ALLERGY
 NAME Jones Eddie AGE 62 RACE Black SEX Male
 CC/HPI was feeling fatigued but sugar "peaks him up" denials decreased
problem of GI/GU ch. pt. As girl usual PR & 2 weeks -
 PE T 10/leg P 11/leg R 11/leg BP 136/80 WL 224 1/2 HL 11.5
NA checked in m. clear No. Sg. No. No. BH 7.2
pt. on Thiazide/Insulin/Blood 17C MCT 11M ASCTA - no C.M.
And obese soft Extremities No grossly at
 Dx: hypothyroidism - info gave New Rx Synthroid 0.5 mcg
Radio thyroid Referred in 3 mos
 Plan: Episodes vertigo - continue Keep hydrated
Foot skin breakdown - hair foot foot Orth. ped. 1/16
Fatigue - still seems depressed - could be 1/16
Review that c. Motion & 40

DATE 10/27/05 ALLERGY _____
 NAME Jones Eddie AGE 62 RACE PIA/PAU/PCY/CA SEX M
 CC/HPI FLU HTN; cough, better. Started thyroid medication - stable
has been using Nefopamides periodically for BP. Persistent
foot healing - gets debridement from wound care; persistent
 PE T P 70 R 14 BP 128/72 WL 227 H 5'10"
Smiling NC clear mm Neck Soft & node / Bmt + 2 C MIT
LM Strong CM abd soft / BPS NT Edg - fluid x Bladder limited / BPS
ball of foot tender distal tip / no tenderness / +2 d/t disk EDE
 Dx: 6 HTN - stable

Plan: (1) Hypothyroidism - not related to #3
(2) Fatigue Biz 1M - Needs some activity / 2000 Depressant rec'd
(3) Skin breakdown feet - still hasn't seen
shoulder pain Ortho Giville Dr T. Ellison; gas bubble in knee
Li doderin patch - Topical Ralox / heart
tylenol - HEP OK ALBUT

DATE 11/30/05 ALLERGY _____
 NAME Jones Eddie AGE _____ RACE LI doderin SEX he
 CC/HPI FLU foot Wounds; fatigue, NGL, shoulder pain; HTN & Unpleasant
Released from wound care but has significant pain / 10/10 / 10/10
Resp - stable cont medns one daily / 10/10 / 10/10
 PE T P 72 R 14 BP 120/70 WL 235 H 5'10"
NAT? NC clear mm mm Bmt + 2 C MIT
SM Strong CM abd soft / BPS NT Edg - fluid x Bladder limited / BPS
 Dx: (1) Hypothyroidism - cont level to 50 mEq
(2) HTN - stable
 Plan: (3) Fluid retention - PT Marie scaling ✓ 10
(4) Must initiate w/ LOS
(5) Stomatitis - on Multivit; Acid Mycelin TR
(6) Motivation - get back to Dr. Richards

NAME Jones, Eddie AGE 21 RACE W SEX M

Full Name: Sanderson, C. 85-45 AM- (P) (S) (D) (A) (I)

Dx: Metabolic syndrome - conf Risk Mod.

1. Intermediation - started from the 1970s and 80s

Foot pain - due to use Lixidom

Motivation - Dr Richards + Dexedrine to 15mg

TIA - cyclophosphamide
Lipids CML 109 7/04 - would encourage C80

pt to card efforts lifestyle

DATE _____

NAME _____ AGE _____ RACE _____ SEX _____

CC/HPI _____

PE T P R BP WL HL

Dx: _____

Plan: _____

Date 3-3-06 PM Allergy _____
 Name James, Archie Age 62 Race _____ Sex _____
 CC/HPI Chl Prazosin yesterday - brief vertigo type
forget his home med his Tues PM 5
was sick all day wed. 3 Thurs am had
 ROS visits x 2 preces/chills NVD ABD pain GU c/o
 PMH Rev. w/ Pantlen list PMH/H Social: Tobacco 0
 ETOH 0
 FM: _____
 PE T 98.5 P 84 R 16L BP 144/80 Wt 230 Ht _____
 Gen _____ Skin 0/25/80
 Heart clear mm/regular Mapp/mmap/s
 Neck single l nodes/TND Thyroid normal trachea +7 cm
 CV normal PMT full Pulses 12 c/s R/R
 Lungs CTAX fine exp w/ Chestwall _____
 Abd soft no mass Rectal _____
 Back/Spine _____
 Extr good 1 cm
 Neuro intact CNS C/S MSTK
 Breasts _____ GU 1/0 SH 2.6
 Pelvic OK BMP
 A/P 1) Vertigo history autonomic INT Labs FSGH 77
exercises - May by no doing in - try not to run down
 2) H/O hypertension - stable Routine med
 3) HTN - ess stable X Rays 226 137 7.1
 4) _____ Other 39 33 11.6
 HM Needs _____
 RTO _____ Meds Sec. Sheet () Episodic Meds 1 4 905 110

Date 3-8-06 Allergy

Name JONES, Archie Eddie Age Race Sex

CC/HPI Auto TIA - Nothing resembling TIA since on Plavix - can't
HTN - on home BP's - on Lasix
Multiple f/ps - Rx Plavix R/U Thyroid - stable

ROS Went healed fine - uses Lidocaine to areas of tenderness

PMH Review Problems - List PMH / SH Social: Tobacco
 ETOH
 FM:

PE T P 72/60 R 160 BP 140/80 Wt 232 Ht

Gen Skin

Head

Neck

CV MI Pulses

Lungs CTA Chestwall

Abd Rectal

Back/Spine

Ext

Neuro

Breasts GU

Pelvic

A/P 1) TIA - can't Plavix Labs

2) HTN - stable

3) Leg / Ankle / Foot Pain - stable X Rays

4)

HM Needs Other

RTO Meds Sec. Sheet () Episodic Meds

Date 4/21/06 Allergy _____
 Name Mr. Eddie Age 62 Race _____ Sex _____
 CC/HPI (R) ankle c/ intermittent pain started last night
- 3rd day pain in medial malleolus
(R) foot has Extensive burn damage - scars, prev. flap
placement; non-healing chronic wound; No vascular throm
Home O2 85-90 on 2L O2 per SIM w/ team
 PMH see problem list CMH/ST Social: Tobacco _____
 ETOH 0
 FM: _____

PE T _____ P 70 bpm R 14 bpm BP 122/70 Wt _____ Ht _____
 Gen _____ Skin _____
 Heart _____
 Neck _____
 CV MM ul S, S₂ Pulses + Doppler Pulses
 Lungs CTA of wheezes Chestwall _____
 Abd _____ Rectal _____
 Back/Spine _____
 Extr brcc & head/neck - normal skin des c/o tumors/grafes
 Neuro offic ROM
 Breasts _____ GU _____
 Pelvic _____

A/P 1) Ankle pain - Not in any way Labs _____
Swagman for DVT - prob of
extensoritis - observe
if worse or not better in 3-4 days ✓ X Ray
 3) _____ X Rays _____
 4) _____
 HM Needs _____ Other _____
 RTO _____ Meds Sec. Sheet () Episodic Meds

DATE 8-15-06 ALLERGY _____
 NAME Jones Archie AGE 63 RACE _____ SEX Male
 CC/MP All epigastric pain - we changed Nexium to Nexium
last week & still now has No AM Epigastric Burning but
still periods of discomfort during day - eating the meals resolved discomfort
 ROS 100% better in one week; still on PPI & antacids - even stopped
Artimid & Celebrex - lots of stress & anxiety
 PMH New UGI - mild Nephritis Social: Tobacco 0
He has problem w/ H/H/HT/Kidney ETOH 0
 FM: _____

PE T _____ P 70/leg R 16cm BP 120/80 WL 231 HL _____
 Gen _____ Skin _____
 Heart clear w/ m
 Neck supple, nodes / thyro
 CV normal Pulses +2C/B/R/K
 Lungs CTA & w/ m Chestwall _____
 Abd soft & BSS Rectal _____
 Back/Spine good ROM
 Extr good ROM
 Neuro _____
 Breasts _____ GU _____
 Pelvic _____

A/P: 1) epigastric pain cont BID Nexium tabs 8/8 UGI N/CMP
stay off Advil but
 2) on to cont Celebrex Labs 2/3/1.3
 3) _____ X Rays Ampl 50
 4) _____
 HM Needs _____ Other _____
 RTO _____ Meds Sec. Sheet () Episodic Meds

DATE 9-21-06 ALLERGY _____
 NAME Jones, Archie AGE 63 RACE _____ SEX _____
 CC/HPI Low Back pain - several days Bil Lumbos
starts p walking on Car -
 ROS _____
 PMH Reviewed Problem List PMH/PHH/HC Social: Tobacco ✓
 ETOH ✓
 FM: _____
 PE T _____ P _____ R _____ BP 141/80 WL 230 HL _____
 Gen _____ Skin _____
 Heart _____
 Neck _____
 CV ✓ Pulses _____
 Lungs ✓ Chestwall _____
 Abd _____ Rectal _____
 Back/Spine Ext tense Bil PMs
 Extr _____
 Neuro grossly intact
 Breasts _____ GU _____
 Pelvic _____
 A/P: 1) Low Back Pain - not relieved Labs _____
by x - H&H reviewed
 2) ✓ x-ray of lumbar spine Labs 8/8/06 - Neg US +
ice, Lortab 5 pr
 3) Low Back Pain - not relieved X Rays 8/14/06 DAA # 656, 70102
 4) ⇒ add gabap
 HM Needs _____ Other _____
 RTO _____ Meds Sec. Sheet () Episodic Meds

Jones, Eddie date 12-8-06 age 63 race C sex M

Allergy: _____ meds reviewed as per med list
Problem List reviewed for PMH/SH/Tob. & ETOH & Caff & Drugs &
c/o (R) Testicular swelling location 192 location _____ relief _____ exac. _____ worsening
c/o _____ duration _____ location _____ relief _____ exac. _____
f/u problem 1) has been checked by Dr. Hinnant mos ago &
f/u problem 2) no didn't really comment
f/u problem 3) pt very concerned
f/u problem 4) _____
exercise _____ diet (R)
ros: fever; chills; wt loss or gain; nl vision; dimmness; headache; otalgia; rhinorrhea;
sore throat; neck pain; back pain; chest pain; palpitations; SOB; cough; chest congestion;
n/v/d; dysphagia abdominal pain: nl b/m; nl voids; vagheeding; pelvic pain; nl bse; leg
swelling; joint pain or swelling; nl rom; foot pain; TIA; numbness; weakness; falls; nl
hair/skin/nails; depression; anxiety; insomnia: usual bil LE 4/05, on feet of
T 98.0 P 120 R 110 BP 140/70 BP _____ Wt. 230 Ht _____ BMI _____
Normal Abnormal

A&O x4: euthymic; nl affect
NC/AT: nl hair skin nails; warm/dry; no rashes/lesions
Clear conjunct; TMs/canals/mm nose/throat; good dentition
Neck supple/no thyromeg/bruit/adenopathy/masses/midline trach
(R) no murmur/gallopp/rub: nl S1S2; nondisplaced PMI
+2 carotids/brach/rad/fem/PT/DP pulses
(C) A; no wheezes/crackles/rubs/rhonchi; no incr WOB
Abd soft; good BS/NT; no masses/HSM/guarding/reb/nodes
Back FROM: no PSMS; no SP tenderness; no CVAT
Extr FROM: no joint/bony abnl; no CCE; no effusions
Neuro all tested in usual fashion: nl CNS/M/S/C/+2 Reflexes
Mood euthymic; nl speech; no abnl thoughts; no SI
Chest wall NT
Breasts sym: no dimpling; discharge; masses; adenopathy
NI vulva/vag/cervix/cuff; no adnexal masses; no guarding/
No tenderness; nl uterus; pap _____
Rectal good tone; no masses; heme _____
Prostate firm; no masses/nodules
Testes descended; no hernia/masses/ nl penis

fullness @ scrotum
& epididymal swelling

Lab findings _____ u/A ess clon

Labs/xrays ordered

A/P (R) Testicular Swelling / scrotal swelling -
A/P US 12/11 - defer Rx - NOT c/w infect
A/P tachycardia - hold Dextrose - cont Ondia z
A/P HTN - Cardizem
A/P _____ F/U

Jones, Eddie date 1/5/07 age 40 3 race C sex M

Allergy: Codine meds reviewed as per med list
Problem list reviewed for PMH/SH Tob. ETOH Caff Drugs
c/o (L) flank pain duration 60 location relief exac.
c/o duration location relief exac.
f/u problem 1) worsening pain & movement to cough
f/u problem 2) No trauma but did do get dextaf
f/u problem 3) while "screaming" Sharp pain - 1 pmf
f/u problem 4) on side -

exercise diet Res
ros: fever: chills: wt loss or gain: vision: tinnitus: headache: otalgia: rhinorrhea
sore throat: neck pain: back pain: chest pain: palpitations: SOB: cough: chest congestion:
n/v/d: dysphagia abdominal pain: nl bps: nl voids: vag bleeding: pelvic pain: nl testis
swelling: joint pain or swelling: d from: foot pain: TI: numbness: weakness: falls: nl
hair/skin/nails: depression: anxiety: insomnia: painful cough: no nasal congestion
T 98° P 70/60 R 14 W BP 120/80 BP Wt. Ht. BMI 20.5 only usual for
Normal Abnormal

A&O x4: euthymic: nl affect
NC/AT: nl hair skin nails: warm/dry: no rashes/lesions
Clear conjunct: TM/canals/mm nose/throat: good dentition
Neck supple: no thyromeg/brui/adenopathy/masses/midline trach
RRR no murmur/gallopp/rub: nl S1S2: nondisplaced PMI
+2 carotids/brach/rad/fem/PT/DP pulses
CTA: no wheezes/crackles/rubs/rhonchi: no incr WOB
Abd soft: good BS/NT: no masses/HSM/guarding/reb/nodes
Duck FROM: no PSMS: no SP tenderness: no CVAT
Exir FROM: no joint/bony abnl: no CCE: no effusions
Neuro all tested in usual fashion: nl CNS/M/S/C: +2 Reflexes

NAD

pushular/papules in linea distribution

Chest wall NT
Breasts sym: no dimpling/discharge/masses; adenopathy
No tenderness: nl uterus: pap
Prostate firm: no masses/nodules
no hernia/masses/ nl penis

Lab findings

U/A Neg

Lab x-rays ordered

? shoulder CTs Dermatology - Fam. Vir. SOUTDTH
A/P Tylenol, Advil, has lidocaine patch
A/P Corticosteroids from severe cough
A/P cut off out in morning
A/P

Jones, Eddie date 3/7/07 age _____ race _____ sex _____

Allergy: _____ meds reviewed as per med list

Problem List reviewed for PMH/SH/meds/ob. ETOH Caffe Drugs

c/o _____ duration _____ location _____ relief _____ exac. _____

c/o _____ duration _____ location _____ relief _____ exac. _____

/u problem 1) HTN - 6 wks BP med relief

/u problem 2) Hx TIA on ASA so on Plavix - need to continue

/u problem 3) Hypertension - needs med rx

/u problem 4) _____

exercise _____ diet _____

ros: fever: chills: wt loss or gain: nl vision: tinnitus: headache: otalgia: rhinorrhea:

sorethroat: neck pain: back pain: chest pain: palpitations: SOB: cough: chest congestion:

n/v/d: dysphagia abdominal pain: nl bm: nl voids: vag bleeding: pelvic pain: nl bse: leg

swelling: joint pain or swelling: nl rom: foot pain: TIA: numbness: weakness: falls: nl

hair/skin/nails: depression: anxiety: insomnia: gen feel well

T _____ P 74 R 16 BP _____ BP 140 Wt 236 Ht _____ BMI _____

Normal Abnormal

A&O x4: euthymic: nl affect

NC/AT: nl hair skin nails: warm/dry: no rashes/lesions

Clear conjunct: TMs/canals/mm nose/throat: good dentition

Neck supple: no thyromeg/bruit/adenopathy/masses/midline trach

RRR no murmur/gallop/rub: nl S1S2: nondisplaced PMI

+2 carotids/brach/rad/fem/PT/DP pulses

CTA: no wheezes/crackles/rubs/rhonchi: no incr WOB

Abd soft: good BS/NT: no masses/HSM/guarding/reb/nodes

Back FROM: no PSMS: no SP tenderness: no CVAT

Extr FROM: no joint/bony abnl: no CCE: no effusions

Neuro all tested in usual fashion: nl CNS/MS/C/+2 Reflexes

Mood euthymic: nl speech: no abnl thoughts: no SI

Chest wall NT

Breasts sym: no dimpling/discharge/masses: adenopathy

NI vulva/vag/cervix/cuff: no adnexal masses: no guarding/

No tenderness: nl uterus: pap _____

Rectal good tone: no masses: heme _____

Prostate firm: no masses/nodules

Testes descended: no hernia/masses/ nl penis

Lab findings

Labs/xrays ordered

A/P HTN stable

A/P Hypertension - TSH

A/P Hx TIA on ASA - cont Plavix

A/P Pulm issues - stable

A/P _____ F/U

James Eddie date 4-20-07 age 63 race C sex M

Allergy: _____ meds reviewed as per med list

Problem List reviewed for PMH/SH/PSY/Rob. ETOH Caff Drugs

c/o unusual breakdown duration 10d location Right relief _____ exac. _____

c/o _____ duration _____ location _____ relief _____ exac. _____

Problem 1) HIV - home monitoring off Peridurine - improved

Problem 2) _____

Problem 3) _____

Problem 4) _____

exercise None per AP diet Reg

ros: fever, chills; wt loss or gain; nl vision; tinnitus; headache; otalgia; rhinorrhea;

sorethroat; neck pain; back pain; chest pain; palpitations; SOB; cough; chest congestion;

nl/d; dysphagia; abdominal pain; nl bm; nl voids; vag bleeding; pelvic pain; nl bse; leg

swelling; joint pain or swelling; nl foot; foot pain; TIA; numbness; weakness; falls; nl

hair/skin/nails; depression; anxiety; insomnia;

T P 72/44 R 68/44 BP BP 144/90 Wt. _____ Ht. _____ BMI _____

Normal Abnormal

A&O x4; euthymic; nl affect

NC/AT: nl hair skin nails; warm/dry; no rashes/lesions

Clear conjunct: TMs/canals/mm nose/throat; good dentition

Neck supple; no thyromeg/brui/adenopathy/masses/midline trach

RRR no murmur/gallopp/rub; nl S1S2; nondisplaced PMI

+2 carotids/brach/rad/fem/PT/DP pulses

CTA: no wheezes/crackles/rubs/rhonchi; no incr WOB

Abd soft; good BS/NT; no masses/HSM/guarding/reb/nodes

Back FROM: no PSMS; no SP tenderness; no CVAT

Extr FROM: no joint/bony abnl; no CCE; no effusions

Neuro all tested in usual fashion; nl CNS/M/S/C/+2 Reflexes

Mood euthymic; nl speech; no abnl thoughts; no SI

Chest wall NT

Breasts sym; no dimpling/discharge/masses; adenopathy

NI vulva/vag/cervix/cuff; no adnexal masses; no guarding/

No tenderness; nl uterus; pap _____

Rectal good tone; no masses; heme _____

Prostate firm; no masses/nodules

Testes descended; no hernia/masses/ nl penis

Lab findings _____

Labs/xrays ordered _____

A/P HIV - stable

A/P Denuded graft (R) ant med hb - using heparin stain

A/P Antibiotic - cont wound

A/P staph carbap - left hand wound care

A/P Elevate leg

James Eddie date 5-10-07 age 6.3 race C sex M

Allergy: Codeine meds reviewed as per med list
Problem List reviewed for PMH/SH/PTA Tob. 1 ETOH 1 Caff 0 Drugs 0

c/o _____ duration _____ location _____ relief _____ exac. _____
c/o _____ duration _____ location _____ relief _____ exac. _____

Problem 1) (R) leg wound - broken bone wound does wound care since 4/18/07

Problem 2) for a year but the wound has not healed

Problem 3) chronic foot infection - long ago

Problem 4) _____

exercise _____ diet _____

ros: fever; chills; wt loss or gain; nl vision; tinnitus; headache; otalgia; rhinorrhea;
sore throat; neck pain; back pain; chest pain; palpitations; SOB; cough; chest congestion;
n/v/d; dysphagia; abdominal pain; nl bm; nl voids; vag bleeding; pelvic pain; nl bsc; leg
swelling; joint pain or swelling; nl rom; foot pain; TIA; numbness; weakness; falls; nl
hair/skin/nails; depression; anxiety; insomnia; only usual MS clon

T 98.6 P 72 R 18 BP 120/80 Wt 240 Ht _____ BMI _____
Normal Abnormal

A&O x4: euthymic; nl affect
NC/AT: nl hair skin nails; warm/dry; no rashes/lesions
Clear conjunct; TMs/canals/mm nose/throat; good dentition
Neck supple; no thyromeg; bruit/adenopathy/masses/midline trach
RRR no murmur/gallop/rub; nl S1S2; nondisplaced PMI
+2 carotids/brach/rad/fem/PT/DP pulses
CTA: no wheezes/crackles/rubs/rhonchi; no incr WOB
Abd soft; good BS/NT; no masses/HSM/guarding/reb/nodes
Back FROM: no PSMS; no SP tenderness; no CVAT
Extr FROM: no joint/bony abnl; no CCE; no effusions
Neuro all tested in usual fashion; nl CNS/M/S/C/+2 Reflexes
Mood euthymic; nl speech; no abnl thoughts; no SI
Chest wall NT
Breasts sym; no dimpling/discharge/masses; adenopathy
NI vulva/vag/cervix/cuff; no adnexal masses; no guarding/
No tenderness; nl uterus; pap _____
Rectal good tone; no masses; heme _____
Prostate firm; no masses/nodules
Testes descended; no hernia/masses/ nl penis

Superficial area of
necrosis ~ 1 cm
but a sterile Probe
tract from base of wound
~ 1/4" - drainage
tract purulence &
drains

Lab findings _____

Labs/xrays ordered _____

AP Wound (R) leg & Tract that may be ardi Osteomyelitis

AP plain x-ray, Bone Scan in AM

AP Appt Dr Kraftsindler 5/11/07 - possibly

AP will need surgical debridement - pt has no diff in

AP Shut bedpan 50mg of sang 20 to his nose

AP HTN stable Dr

Jonas Eddie date 4/13/07 age 63 race W sex F

Allergy: Cadexyl meds reviewed as per med list

Problem List reviewed for PMH/SH/Tob. ETOH Caff Drugs

c/o duration location relief exac.

c/o duration location relief exac.

Problem 1) Nocturnal urgency - sleep disrupting

Problem 2) (5-6x) even to Flomax - just a whack

Problem 3) all started 7 years ago - which he accidentally

Problem 4) pulled out 4 yrs ago - then saw local urologist

exercise None diet Reg dissatisfied then

ros: fever: chills: wt loss or gain: nl vision: tinnitus: headache: otalgia: rhinorrhea: saw urologist

sore throat: neck pain: back pain: chest pain: palpitations: SOB: cough: chest congestion: doesn't want

n/v/d: dysphagia: abdominal pain: nl bowel: voids: vag bleeding: pelvic pain: nl bse: leg: to let

swelling: joint pain or swelling: nl rom: foot pain: TIA: numbness: weakness: falls: no

hair/skin/nails: depression: anxiety: insomnia: mood 4 issues start

T P 76 R 16 BP BP 110/60 Wt 235 Ht BMI

Normal Abnormal

A&O x4: euthymic: nl affect

NC/AT: nl hair skin nails: warm/dry: no rashes/lesions

Clear conjunct: TMs/canals/mm nose/throat: good dentition

Neck supple: no thyromeg/bruit/adenopathy/masses/midline trach

RRR: no murmur/gallop/rub: nl S1S2: nondisplaced PMI

+2 carotids/brach/rad/fem/PT/DP pulses

CTA: no wheezes/crackles/rubs/rhonchi: no incr WOB

Abd soft: good BS/NT: no masses/HSM/guarding/reb/nodes

Back FROM: no PSMS: no SP tenderness: no CVAT

Ext FROM: no joint/bony abnl: no CCE: no effusions

Neuro all tested in usual fashion: nl CNS/M/S/C+2 Reflexes

Mood euthymic: nl speech: no abnl thoughts: no SI

Chest wall NT

Breasts sym: no dimpling/discharge/masses: adenopathy

NI vulva/vag/cervix/cuff: no adnexal masses: no guarding/

No tenderness: nl uterus: pap

Rectal good tone: no masses: heme

Prostate firm: no masses/nodes

Testes descended: no hernia/masses: nl penis

Lab findings 1 PSA 1.8 (2/7/07) 11/06 2.4 TS14

Labs/xrays ordered already on Flomax

A/P Urinary c/c - P&TUD, has seen the urologist & see

A/P HTN stable 7/13 Dr Eric 7/13

A/P Hypothyroidism Dr Drq Needs TSH - Grassmell

A/P Ulcerated leg - healing Flu Dr Webb (1)

A/P

Jones, Eddie date 8/20/07 age 64 race sex

Allergy: _____ meds reviewed as per med list
Problem List reviewed for PMH/SH _____ Tob _____ ETOH _____ Caff _____ Drugs _____
duration 4 54 location relief exac:
duration location relief exac:
/u problem 1) Vocals No acute injury using Acticoat to legs
/u problem 2) started a new little achy
/u problem 3) TSSA stuff off with a protective dress
/u problem 4) _____
exercise diet
ros: fever: chills: wt loss or gain: nl vision: tinnitus: headache: otalgia: rhinorrhea:
sorethroat: neck pain: back pain: chest pain: palpitations: SOB: cough: chest congestion:
n/v/d: dysphagia abdominal pain: nl bm: nl voids: vag bleeding: pelvic pain: nl bse: leg
swelling: joint pain or swelling: nl rom: foot pain: TIA: numbness: weakness: falls: nl
hair/skin/nails: depression: anxiety: insomnia:
T 78.7 P 70 R 16 BP 144/50 Wt _____ Ht _____ BMI _____
Normal Abnormal

A&O x4: euthymic: nl affect
NC/AT: nl hair skin nails: warm/dry: no rashes/lesions
Clear conjunct: TMs/canals/mm nose/throat: good dentition
Neck supple: no thyromeg/bruit/adenopathy/masses/midline trach
RRR no murmur/gallop/rub: nl S1S2: nondisplaced PMI
+2 carotids/brach/rad/fem/PT/DP pulses
CTA: no wheezes/crackles/rubs/rhonchi: no incr WOB
Abd soft: good BS/NT: no masses/HSM/guarding/reb/nodes
Back FROM: no PSMS: no SP tenderness: no CVAT
Extr FROM: no joint/bony abnl: no CCE: no effusions
Neuro all tested in usual fashion: nl CNS/M/S/C/+2 Reflexes
Mood euthymic: nl speech: no abnl thoughts: no SI
Chest wall NT
Breasts sym: no dimpling: discharge: masses: adenopathy
NI vulva/vag/cervix/cuff: no adnexal masses: no guarding/
No tenderness: nl uterus: pap _____
Rectal good tone: no masses: heme _____
Prostate firm: no masses/nodules
Testes descended: no hernia/masses/ nl penis

mm
all 15
Painless

Lab findings _____ PSGL 65 TSIT 2.849
Labs/xrays ordered _____
A/P Wound (blow by) cont Acticoat for Now
A/P at MOP s. See Wound specialist 8/22
A/P H7N - stable
A/P Hypercalcemia - stable -
A/P PPH/Urino c/os - saw Urol. started Sanctura - F. 8/22

Allergy: _____ meds reviewed as per med list ✓
 Problem List reviewed for PMH/SH PMH/SH ETOH Caff Drugs ✓
do infection for duration _____ location _____ relief _____ exacc _____
do wound duration _____ location _____ relief _____ exacc _____
 #u problem 1) same ulcer as 8/20 - seems to be getting bigger
 #u problem 2) skin - much worse drainage - harder to
 #u problem 3) change pads white day - making sure surrounding
 #u problem 4) issue - fissure
 exercise _____ diet Reg
 ros: fever: chills: wt loss or gain: nl vision: tinnitus: headache: otalgia: rhinorrhea:
 sorethroat: neck pain: back pain: chest pain: palpitations: SOB: cough: chest congestion:
 n/v/d: dysphagia: abdominal pain: nl b/m: nl voids: vag bleeding: pelvic pain: nl bsc: leg
 swelling: joint pain or swelling: nl r/o: foot pain: TIA: numbness: weakness: falls: nl
 hair/skin/nails: depression: anxiety: insomnia: foot deformities non-painful
 T 98 P 78 R 16 BP _____ BP 108/70 Wt. _____ Ht. _____ BMI _____
 Normal Abnormal

A&O x4: euthymic: nl affect ✓
 NC/AT:nl hair/skin/nails: warm/dry: no rashes/lesions ✓
 Clear conjunct: TMs/canals/mm nose/throat:good dentition ✓
 Neck supple: no thyromeg/briui/adrenopathy/masses/midline trach ✓
 RRR no murmur/gallop/rub: nl S1S2: nondisplaced PMI ✓
 +2 carotids/brach/rad/fem/PT/DP pulses ✓
 CTA : no wheezes/crackles/rubs/rhonchi: no incr WOB ✓
 Abd soft: good BS/NT: no masses/HSM/guarding/reb/nodes ✓
 Back: FROM:no PSMS:no SP tenderness: no CVAT
 Extr FROM: no joint/bony abnl: no CCE: no effusions
 Neuro all tested in usual fashion: nl CNS/SC/+2 Reflexes
 Mood euthymic: nl speech: no abnl thoughts: no SI
 Chest wall NT
 Breasts sym: no dimpling/discharge/masses: adenopathy
 NI vulva/vag/cervix/cuff: no adnexal masses: no guarding/
 No tenderness: nl uterus: pup _____ pt 5 sensation
 Rectal good tone: no masses: heme _____ in foot
 Prostate firm: no masses/nodules swelling & great
 Testes descended: no hernia/masses/ nl penis

Lab findings CT chest - moderate @ caudal spine to issue macrocystic
Labs/xrays ordered Rx Kefton 500 and #40
A/P ulcer/wound (R) 1st MTP wound care will
A/P see him this afternoon due to coming D/C
A/P Call stoner on CT chest - asympt - pt declines current
A/P Pulmonary fibrosis stable by b12 chest (T. Luma) (Rx)
A/P lost track removed Rx given EAT

foot deformities
as per Hx
① Doppler pulse R foot
great for med over
1st MTP -
seems to be larger
subjectively
surrounding
to issue macerated

Jones, Eddie date 10-8-07 age 64 race C sex M

Allergy: Codomo meds reviewed as per med list
Problem List reviewed for PMH/SH/PSY/Tob. ETOH Caff Drugs
c/o duration location relief exac
c/o duration location relief exac
f/u problem 1) had surgery on R hip joint to remove bone from joint
f/u problem 2) then was stabilized on brace when NIV started
f/u problem 3) so on 10/5 also had surgery on L hip - so placed in Phem
f/u problem 4) but today still ventilated even on Phem - left hand
exercise diet 2d started 1st 5 Tolerating it
ros: fever-chills; wt loss or gain: ni vision/tinnitus; headache: otalgia rhinorrhea:
sore throat; neck pain; back pain; chest pain; palpitations; SOB; cough; chest congestion;
n/v/dysphagia abdominal pain; ni bny; ni voids; vag bleeding; pelvic pain; ni hse; leg
swelling; joint pain or swelling; ni rom; foot pain; TIA; numbness; weakness; falls; ni
hair/skin/nails; depression; anxiety; insomnia: only usual 1 EISS was 26 to burn
TTP 70/60 R 110/60 BP 114/50 Wt. Normal Ht. Normal BMI Abnormal

A&O x4: euthymic; ni affect
NC/AT: ni hair skin nails; warm/dry; no rashes/lesions
Clear conjunct: TMs/canals/mm nose/throat; good dentition
Neck supple; no thyromeg; bruit/adenopathy/masses/midline trach
RRR no murmur/gallop/rub; ni S1S2; nondisplaced PMI
+2 carotids/brach/rad/fem/PT/DP pulses
CTA: no wheezes/crackles/rubs/rhonchi; no incr WOB
Abd soft; good BS/NT; no masses/HSM/guarding/reb/nodes
Back FROM: no PSMS; no SP tenderness; no CVAT
Ext FROM: no joint/bony abnl; no CCE; no effusions
Neuro all tested in usual fashion; ni CNS/M/S/C/+2 Reflexes
Mood euthymic; ni speech; no abnl thoughts; no SI
Chest wall NT
Breasts sym; no dimpling; discharge; masses; adenopathy
NI vulva/vag/cervix/cuff; no adnexal masses; no guarding/
No tenderness; ni uterus; pap
Rectal good tone; no masses; heme
Prostate firm; no masses/nodules
Testes descended; no hernia/masses/ ni penis

grossly unwell Negan
initially at gait abnorm
but improved & achu

Lab findings no U/A no CBC 140/104 38/1.8 no UFP
4.5 27 120 GFR 41
Labs/xrays ordered
A/P Diagnostic Vertigo - unlikely Cardiac/CNS - Nephrologist sp
A/P Caution exercises, Phenomenon Neck 2nd of 2000
A/P Azotemia - Rev - Prob 2° to dehydration
A/P Recent NIV - cont to hydrate
A/P Foot wound - s/p Surg bone debridement - cont Graft

RE: Patient/Client : A. Eddy Jones
Date of Injury : June 3, 1997
Social Security No. : [REDACTED]
Date of Birth : [REDACTED]

Based on my review of the medical records and notes related to this patient, it is my opinion to a reasonable degree of medical certainty that:

☒ YES

Mr. Jones is permanently and totally disabled as a result of injuries sustained in his accident at work on June 3, 1997.

☐ NO

Mr. Jones is not permanently and totally disabled as a result of injuries sustained in his accident at work on June 3, 1997.

June Sauvignon M.D.
June Sauvignon, M.D.

10/4/07
Date

Crawford
HEALTHCARE
MANAGEMENT SERVICES

William B. Bivens
Branch Manager

October 8, 2001

Jane Souviron, MD
2405 N. Main Street
Anderson, SC 29621

RE: CLAIMANT : Archie Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : WC555-248068
OUR FILE NO. : 531-4400

Dear Dr. Souviron:

As Mr. Jones' primary physician, you have been providing and coordinating medical treatment with Dr. Mohan regarding his pulmonary difficulties. When I last met with you on 8-22-01 you said that Mr. Jones had not reached Maximum Medical Improvement (MMI).

The Worker's Compensation insurance carrier, Liberty Mutual is requesting your documentation regarding the claimant's prognosis and long term treatment plans for Mr. Jones' pulmonary disorder. When do you anticipate MMI?

A copy of your documentation should be mailed to:

Karen Gamlin, Claims Adjuster
Liberty Mutual Insurance Company
P.O. Box 31204
Tampa, FL 33631-3204

Should you have any questions please do not hesitate to contact me at 864-228-9679.

Thank you for your time and consideration regarding the above information.

Sincerely,
Crawford & Company
Healthcare Management
Mary Cocke
Mary Cocke, RN, CCM
Medical Services Consultant

MC/pls

10/17/01
My Prognosis is based on
his unstable
psychiatric condition
& his pulmonary
status both plans
are under
the direction
of other physician
& I am
merely a
clinical observer
June Bivens

Preferred Works

October 29, 2001

SECOND REQUEST

Mr. Archie Jones Jr.
1229 Salem Church Rd
Anderson, SC 29625

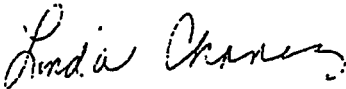
Re: 3M Long-Term Disability Benefits
Location: 147
Employee #: 254508

Dear Mr. Jones:

Your Disability Plan requires that we obtain current, objective medical evidence so that we may continue your Disability benefits. Please have your primary attending physician complete the enclosed Form. This doctor must use data that is less than six (6) months old. For your doctor's convenience, we have provided a return envelope.

Thank you for your cooperation. If you have any questions regarding your claim, please call me.

Sincerely,



Linda Chavez
Claims Examiner

Enclosures: Disability Progress Report
Return Envelope

cc: Beth Erickson-Preferred Works, 3M Center

11/12/01
Mailed

Archie Jones
Patient's Name

59
Age

Bronchiectasis & COPD
Nature of Illness or Injury Due to Respiratory thermal injury

Please describe any other disease or infirmity affecting the present condition

chronic anxiety & depression; obstructive sleep apnea
Attention deficit disorder; extensive scarring of Both
Is the patient still under your care for this condition? ☒ Yes ☐ No upper & lower extremities
If discharged, give date _____ & Trunk with contracture
& Nerve damage from fire

Give dates of treatment: since 6/02

Office: 6/10/02; 7/22/02; 11/8/02 Hospital None

Date of Last Office Visit 11/8/02

Please complete if the patient was hospitalized since the last report:

Hospital None

Address _____

Date Admitted _____

Date Discharged _____

Is the condition or illness or injury due to the patient's employment?

☒ Yes ☐ No

If yes, please explain

Lung damage is his Primary illness - this is due to
chemical fire at job site

When was or will the patient be able to return to work? ☐ Full Time Never

☐ Part Time Never

If the date is undetermined, please estimate

☐ 1 - 3 Months

☐ 3 - 6 Months

☐ 6 - 12 Months

☐ 1 - 2 Years

☐ Never

Signature

June P. Souvillon M.D.

Date

1/31/03

Physician's Name (Printed or Typed)

June P. Souvillon MD

Telephone

864-231-7003

Address

2405 N. Main St. Anderson, SC 29621

LIBERTY
MUTUAL

248058

Crawford

HEALTHCARE
MANAGEMENT
William B. Bivens
Manager

Claim #:	WC555-248098	Date of Assignment:	4/9/03
SSN:	~~602-5440~~	Duration of Visit:	N/A
RN Name:	Mary Cocke, RN, CCM	Travel Time:	N/A
Our File No.:	531-5134	Mileage/Expense:	N/A

Ms. Marcella Wheeler
Liberty Mutual Insurance Co.
P.O. Box 31204
Tampa Florida 33631

Claimant: Archie Jones

Report Date: December 5, 2003

Target RTW Date: N/A

Medical Information:

Pulmonologist

Treating Providers:

Dr. Goddhami Mohan,

Dr. Robert Richards, Psychiatrist

Dr. C. William Hinnant, Jr.,

Urologist

Dr. Altman, Podiatrist

Boris Ilg, M.D., Ophthalmologist

James E. Lovett, III, M.D.,

Plastic Surgeon

Dr. Tysel, DDS

Diagnoses: Second and third degree burns – 60% of total body surface to chest,
back and bilateral lower extremities
Bronchiostasis
Bipolar Disorder

ICD-9 Code: 310.8

Treatment History: DOI: 6-3-97. The claimant sustained third degree burns over 45% of his body and was hospitalized for three months at Charleston Medical Center. He had extensive grafting over the burned areas on his trunk, arms, legs and feet. He has been treated for multiple difficulties including Bronchiostasis, sleep apnea and bipolar disorder. He has been placed at MMI by Drs. Richards and Dr. Mohan.

Medications: Albuterol, Atrovent, Combivent, Xopenex Nebulizer, Serovent, Pulmacort, Singulair, Theophylline, Humibid, Prednisone, Prevacid, Sudal DM, Su-Tuss DM Cough Syrup, Flomax, Risperdal, Depakote, Plavix, Dexadrine, Zolof, Actinil, Celebrex, Amalactin, Colace, Multiple Vitamins, Biaxin, Multi-vitamin, Vitamins C,E and Calcium

Current Medical Status: The claimant reports that he continues to have difficulty with depression and apathy. Dr. Richards has increased the Dexadrine and Zolof. He has lowered his dose of Prednisone to 15mg. daily. He said that his feet are doing better using the silicone dressing and staying off of the feet. He stated the pharmacist is having difficulty finding the silicone dressing. Dr. Lovett had given him the silicone that he has been using. He is to contact Dr. Lovett to find out where to get the dressing or if he should continue to use it. Mr. Jones said that the Guaifenesin tab. he has been taking are now available over the counter. The cost is \$40.00 which he has paid since the pharmacy can no longer charge the insurance company. He was advised that if Dr. Mohan has prescribed the medicine that she would need to write a prescription. The claimant can send the prescription and the receipt to the adjuster for review and possible reimbursement. It was suggested that Dr. Mohan review all of his prescriptions to see if any need to be changed or discontinued. The claimant said that Dr. Ilg, the ophthalmologist was again denied payment for his glaucoma checks. He has an appointment for a recheck in January, 2004.

Provider Treatment Plan: Mr. Jones continues to see Dr. Richards on a regular basis for his review of his medication for depression/bi-polar disorder. Dr. Mohan also sees Mr. Jones on scheduled appointments and as needed. He will frequently call the office if he has any difficulty.

Job Information: Current Position: The claimant remains out of work.

Case Management Action Plan:

Professional Time: 2.5 Hrs.

1. Contact with Claimant: Contact with the claimant will be maintained to remain apprised of his status. The claimant will be requested to contact me or the adjuster if there are any changes with his treatment or medications so as to determine if it is related to his workers compensation injury.

CRAWFORD & COMPANY
HEALTHCARE MANAGEMENT


Mary Cocke, RN, CCM
Medical Services Consultant

MC



William B. Bivens
Branch Manager

April 28, 2003

Jane Souviron, MD
2405 N. Main Street
Anderson, SC 29621

RE: CLAIMANT : Archie E. Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : WC555-248098
OUR FILE NO. : 531-5134

529-13
perfect to
8641-775-1697
JS

Dear Dr. Souviron:

I am a Nurse Case Manager with Crawford & Company Healthcare Management and have been working with the above named during his recovery and treatment of his burn injury. When I met with Mr. Jones on 2/15/03, he reported that a couple of days prior he was kneeling down outside his home on the ground repairing a door under his house. Later that day he was kneeling and discovered his right knee to be swollen. He went to his orthopedic physician who reportedly referred him to you for treatment. Mr. Jones reported he was placed on antibiotics and was referred to another physician to rule out a clot.

The workers compensation insurance carrier has reported receiving charges for treatment from Dr. Kirk Hensarling for treatment of Mr. Jones' right lower extremity cellulitis and prepatellar bursitis.

The workers compensation insurance carrier, Liberty Mutual, is requesting your documentation regarding the treatment of the cellulitis and the causal relationship to Mr. Jones' workers compensation burn injury.

A copy of your report should be sent to:

Ann Hutchinson
Liberty Mutual Insurance Company
PO Box 31205
Tampa, FL 33631

DEA # _____

JUNE P. SOUVIRON, M.D.

FAMILY PRACTICE

2405 N. MAIN STREET

ANDERSON, SC 29621

864-231-7003 Fax: 864-225-0233

NAME _____

ADDRESS _____

DATE 4/6/97

R (Please Print)

Re. Eddie Jones
He had another
aphasia (Ramon Ukahner
Spell went to ER. See
note - I have nothing else
to tell you - he's been fine,
except for his pulmonary
psychiatric issues (Molitor
Psych-G-0116) - I've ordered a
few at a time. Guaranteed
are coming to

DISPENSE AS WRITTEN

M.D.

SUBSTITUTION PERMITTED

M.D.

22-JUL-97

TR030722, 100186767-33_01_32719_0001

9-22-04 Mr. Eddie Jones is a 61 y.o. male
 12³⁴ who had chemical/thermal burns to
 45% (3rd degree) of his body in 1997.
 He presents = draining burn scar
 of right foot x 2 days. ~~diagnosis~~
 Erythema + swelling @ foot (extremely swollen)
 Small open wound dorsal aspect @ foot
 slightly debrided, CTS taken,
 packed w/ saline gauze
 Rx Cefaz 500 q BID (20)
 Return to Dr Luvette's care
 Hol

2/3/05 very superficial ex corium ~ 8 mm
 @ medial Tarsal/metatarsal joint -
 2.5 x 7 mm ulcer (good granulation)
 over mid foot ⇒ advice to create
 "donut" around ulcer to prevent shear
 also Rx Regranex (this has worked well)
 RTZ pm 12

P.03

jb-22-06 12:36P

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE E. JONES Social Security Number: 252-10-5112

1. Diagnosis: Hypertension, TIA/Transient Ischemic Attack
 2. Treatment: Small vessel Cerebrovascular Ischemia, chronic obstructive pulmonary disease, hip pain, shoulder pain, Insulin Resistance
- a. Date of first treat visit: Month 12 Day 29 Year 2004 5/1/95
 b. Date of last visit: Month 12 Day 29 Year 04
 c. Frequency of treatment: Weekly ☐ Monthly ☐ Other ☒ every 2-3w

3. Progress Recovered ☐ Improved ☐ Unimproved ☒ Regressed ☐

4. Extent of Disability For Any Occupation

- a. Is patient now totally disabled? Yes ☒ No ☐
 b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year _____
 c. If yes, when do you think patient will be able to resume any work?
 Approximate Date: _____
 Indefinite ☐
 Never ☒

5. Mental Condition:

Remarks:

*Ask his psychiatrist for details
 he is alert & oriented x4, pleasant
 & cooperative, some flight of ideas
 some what hyperverbal Normal affect
 no speech, thought processes*

2/14/05 J. H. Powell MD 864-231-761
 Date Signature (Attending Physician) Degree Telephone No.
2469 N. Main St. Anderson SC 29621
 Street Address City or Town State Zip Code

Return form to:
 3M Disability Program, Building 551-1W-04, PO Box 33115, St. Paul, MN 55133-3115

261-1600

ANMED HEALTH

APPT. DATE: 9/16/05 TIME: 2:30

OUTPATIENT PHYSICIAN'S ORDER

PATIENT NAME: Archie Eddie Jones

PATIENT COMPLAINT: Extensive burn with grafting with current acute breakdown

OUTPATIENT PROCEDURE(S):

Anderson Area Medical Center 281-1000
 OSC Fax for Orders 281-1911
 Rehab (P.T., O.T., Speech) 281-1186

AmMed Health Campus 281-1000
 LifeChoice 716-6647
 (Cardiac Rehab, Pulm. Rehab, Wellness)

AmMed FirstCall
 To schedule appointment 281-2255
 To pre-register for scheduled procedure 281-1482

See other side for locations of outpatient facilities.

FORM 1143

PATIENT: You must bring this order with you at time of service

20.00 charge

Ann Hultchison
 1-800-282-6218
 ext 2612

2-24-06 - Cantina XT 040 my #30 (12.25)
 B: 6 months ago
 8/6/07 call today asking for Midea - advised not to take that for
 HA 2° HTZ microischemic vessels

Return#: 1-614-794-9582

09/23/2005

June P Souviron
2405 N Main Street
Anderson, SC 29621

Dear Dr Souviron,

Statement of Medical Necessity for Medication

RE: Eddy A. Jones
DOB: 06/23/1954
Claim #: WC555-248098
Date of Injury: 06/03/1997
Injury description: Burn/Multiple Body Part & Body systems
(may involve external/internal injuries)

On behalf of Liberty Mutual Branch 555, our company is administering the medication services for treatment of the work-related injury of your patient. In order for us to continue to provide covered services to complete this process, we will need this letter completed and faxed back to: 1-800-795-6329 by September 30, 2005.

Completion and return of this letter will expedite services for this particular prescription.

1. Medication name and dosage:
SMZ/TMP DS Tab 800-160 1.6117

Diagnosis for which medication is being prescribed:

Expected Length of use:

Briefly relate the need for medication for our accepted injury of Burn/Multiple Body Part & Body systems (may involve external/internal injuries):

Additional Inquiry:



JUNE P. SOUVIRON, M.D.

DIPLOMATE AMERICAN BOARD OF FAMILY PRACTICE

2405 N. Main St. • Anderson, SC 29621
Ph. (864) 225-7000 • Fax (864) 225-0233

DEA #

JUNE P. SOUVIRON, M.D.

FAMILY PRACTICE
2405 N. MAIN STREET
ANDERSON, SC 29621
864-231-7000 FAX 864-225-0233

NAME

ADDRESS

R (Please Print)

14 day supply -
Acticoat 7

MepiTex

Meditore 2" or Pager tape

Dr. Wounds @ foot - ulcer type
secondary to tissue breakdown
from sun graft site

Progeniv

22-JUL-05

SHEET

9-30-05

via

lie Jones

1-923-7655

1-225-0233

_____ contains confidential information belonging
to the sender which is protected by the physician/patient privilege.
This information is intended only for the use of the individual named
above. If you are not the intended recipient, you are hereby notified
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PLEASE NOTIFY US IF THE TELECOPY YOU RECEIVED IS INCOMPLETE OR ILLEGIBLE.

1/2/3/4/5
are not
is disability
factors
All *

Patient's Name: ARCHIE JONES Social Security Number: 250-123-4567

1. Diagnosis: Hypertension, TIA (Transient Ischemic Attack), Small vessel
cardiovascular ischemia; chronic Pulmonary disease; hip pain; shoulder pain

2. Treatment: insulin resistance; anxiety d/o; all HD; Depression (5)
a. Date of first treat visit: Month 5 Day 1 Year 98 97/95
b. Date of last visit: Month 09 Day 29 Year 06 not 95
c. Frequency of treatment: Weekly [] Monthly [] Other [X] 3-6 mths

3. Progress Recovered [] Improved [] Unimproved [X] Regressed []

4. Extent of Disability For Any Occupation

a. Is patient now totally disabled? Yes [X] No []
b. If no, when was patient able to go to work? _____ Month _____ Day _____ Year
c. If yes, when do you think patient will be able to resume any work?
Approximate Date: _____
Indefinite []
Never [X]

5. Mental Condition:

Remarks: Ask his psychiatrist for details he
is alert & oriented x 4. pleasant &
cooperative; some flight of ideas
some what hyperverbal normal affect
in speech; & thought processes

11/9/06 James Burton MD MD (864) 231-7003
Date Signature (Attending Physician) Degree Telephone No.
2405 N. Main St Anderson SC 29621
Street Address City or Town State Zip Code

Return form to:
3M Disability Program, Building 551-1W-04, PO Box 33115, St Paul, MN 55133-3115

* This patient is disabled from his severe
pulmonary disease created by thermal burns
in 1995. His secondary disability is from a
psychiatric diagnosis: chronic depression, anxiety &
Adult attention deficit disorder that has
remained chronic & unchanged since 1995

Maintenance updates.doc 01/13/05

PATIENT NAME Opner, Eddie CHART NO. 7130143
 DATE OF BIRTH 7/30/43

PROBLEM	DATE ONSET	DATE RESOLVED	PROBLEM	DATE ONSET	DATE RESOLVED
40% total body burns	1998		DEXA 4/04 spine 1.3	hip - 0.6	
Severe sleep apnea by study			MRI Brain 4/04 - R. Parietal Hypodensity		
Widened			likely small vessel disease		
shipped some for medical structure			Carotid Duplex 4/04 Normal BUI		
Arthritis, mainly knee			Transcranial Doppler 4/04		
Neg. Tumor markers 6/01			TARBS 2001		
Neg. CT head 6/01			MEAT, GPT 12/01 Abnormalities in liver		
D&A -			USL Spleen 12/01		
MRI Brain - 2 small areas demyelination			CT Lung 12/01 - Right Atelectasis, Emphysema -		
FSA 1.1 / 2002					
Heart 4/04 - Norm					
Echocardiogram 4/04 - mild concentric Hypertrophy					
CLV Prosthetic Valve					

DATE	TIME	DOSE	DATE BEGUN	U/C	VACCINE	DOSE	DATE GIVEN	RTU SITE	PROV. SIGN.	DATE REC'D	DATE LOT #	SIGNATURE OF PERSON PROVIDING VACCINE
					05		10/30/97	Flu vaccine				
					Flu		10/23/98					
					Flu		10/23/99					

Archives

MEDS		Jones Eddie						DATE			
		3/9/07	3/22/07	4/12/07	6/19/07	3/22/07	9/18/07				
Plavix 75mg	#40	✓			✓						
Homax 0.4mg	#30	✓			✓						
Timoxamide 20mg	#30	✓			NOV						
Levothyroxine 0.25	#30	✓			✓						
Theophylline 300mg	✓				BID	✓					
Dexacort 6.25mg	✓				✓		750mg				
Propranolol 20mg	✓				10mg						
Zolof 100mg	✓				150mg						
Diltiazem 60mg	✓	#30	✓		✓						
Guafenesin PSE	✓										
Docusate 100mg	✓				✓						
Dexedrine 15mg	✓				NO						
Celebrex 200mg	✓				✓						
Percocet 30mg	✓				✓						
Singulair 10mg	✓				BID	✓					
Risperdal 0.5mg	✓				✓						
Pulmicort	✓				✓						
Albuterol	✓				✓						
Serevent Diskus	✓				✓						
Atrivent	✓				✓						
Pulmicort amp	✓				✓						
Xopenex 1.25mg	✓				✓						
Lido derm patches			#1 Bt	0							
Santura 20mg											
Loraz 5										#90	

Nov 11

11/20/07 - 11/20/07 - 11/20/07

Continuance of Disability Claim Form

Employee Name: ARCHIE E. JONES Employee Number: 254508
Current Address: 1229 SALIEM CHURCH ROAD

ANDERSON, SC 29625-1310 Telephone Number: 864-224-2669

Attending physician: Name Jane P. SOUVIRON, MD

Address 2405 N. Main St, Anderson, SC 29621

Phone 864-231-7003

Dates of Treatment since last report: 10/8/07; 9/21/07; 8/20/07; 6/15/07; 5/10/07; 4/12/07;
3/9/07; 2/11/07; 1/5/07; 12/8/06; 11/9/06;

Have you returned to work? NO

If yes, the date you returned to work —

How many hours per week? N/A

Name, address, and telephone number of current employer: —

N/A

Health Care Provider's Statement of Disability

Patient's Name: ARCHIE E. JONES Employee Number: 254508

1. Diagnosis: Severe pulmonary disease 2° to thermal burns to lungs
2. Treatment: chemical burns Secondary chronic depression/anxiety
Micro ischemic Cerebrovascular disease Non healing wounds
due to severe 3rd degree burns 1997
 - a. Date of first treat visit: Month 5 Day 1 Year 97
 - b. Date of last visit: Month 10 Day 08 Year 2007
 - c. Frequency of treatment: Weekly ☐ Monthly ☒ Other ☐

3. Progress Recovered ☐ Improved ☐ Unimproved ☐ Regressed ☒
4. Extent of Disability For Any Occupation His feet are getting more frequent fissure
breakdown/fissures due to skin grafts
& Neuropathy
 - a. Is patient now totally disabled? Yes ☒ No ☐
 - b. If no, when was patient able to go to work? Month _____ Day _____ Year _____
 - c. If yes, when do you think patient will be able to resume any work?
Approximate Date: _____
Indefinite ☐
Never ☒

5. Mental Condition: depression/anxiety under
Psychiatrist's care

Remarks: As O & T, pleasant/cooperative,
poor focus/concentration

10/24/07 Quintanar MD 804-231-7003
Date Signature (Attending Physician) Degree Telephone No.
2405 N. Main St. Anderson SC 29621
Street Address City or Town State Zip Code

Return form to:
3M Disability Program, Building 651-1W-04, PO Box 33115, St. Paul, MN 55133-3115

ANDERSON AREA MEDICAL CENTER

RADIOLOGY CONSULT REPORT

ATTENDING PHYSICIAN: SOUVIRON, JUNE PETRYSZN

REQUEST DATE/TIME ORDERING PHYSICIAN
03/23/98 10:44 SOUVIRON, JUNE PETRYSZN

SEX AGE BIRTHDATE F/C RADIOLOGIST CODES
M 054Y 03/18/43 6

RADIOLOGY REPORT

JONES
ARCHIE EDWARD
MR # 06-64-41
ORDER # 2967152
ACCOUNT # 2997121
XR 0-

CLINICAL HISTORY
PNEUMONITIS 2 HEAT INJURY

***** 421-0100 CHEST; AP/LAT; TWO VIEWS *****
ORDER COMMENTS

CALL REPORT
SEND COPY TO DR. WILLIAM WALKER

JONES CHEST, TWO VIEWS

CLINICAL HISTORY: This is a 54 y/o male patient with pneumonitis and shortness of breath. He had a previous heat injury. Findings were compared and correlated with the post recent exam dated 10/15/96.

FINDINGS: PA and lateral views of the chest show minimal discoid atelectasis and linear opacities in both lung bases. There is no evidence of focal alveolar consolidation or pleural fluid. The cardiomeastinal silhouette and pulmonary vascularity are otherwise within normal limits. There is mild atherosclerotic tortuosity of the aorta and thoracic spondylosis seen.

IMPRESSION: DEVELOPMENT OF MILD DISCOID ATELECTASIS IN THE LUNG BASES IN 17 MONTHS.

KYLE C. BRYANS, M. D.

JB/mgw
3/23/98 DD
3/24/98 DT 15:27:26 TT

67152/MEDREC/RAD

RADIOLOGY REPORT
CHART

PAGE 1

RE: ARCHIE EDWARD JONES, JR. "EDDIE"
IMA: 31513

3-31-98

WEIGHT: 225.5

Mr. Jones is a fifty-four year old gentlemen that we saw today for pulmonary evaluation.

Mr. Jones was involved in an industrial accident with chemicals and heat. He sustained multiple body burns and pulmonary burns. This was in June of 1997. He was transferred to the Medical University of South Carolina. He was on a ventilator for three months. He was discharged home in October 1997. He had extensive burns and skin problems with his legs. At Christmas time of 1997, he had several surgical procedures. He was at bed rest for approximately nine weeks. He has been up and around since the middle of February. Shortly after this, Mr. Jones developed a progressive cough with purulent secretions. He was treated with Prednisone and antibiotics. It is not entirely clear whether he was on Levaquin, Cedax or both, but he has completed a course of antibiotics. He has completed a course of Prednisone. At this time, he does have some slight cough. He is somewhat short of breath at times.

Mr. Jones is trying to exercise. He is trying to get his muscle strength up. He is trying to improve his breathing capacity.

He denies chest pain, abdominal pain, diarrhea, constipation, urinary frequency or burning.

He does have a lot of problems with his skin due to the burns he received.

Patient also has a lot of problems with anxiety and depression. Currently, he takes Paxil 20 mgs. a day, Amitriptyline 50 mgs. a day, Prilosec 20 mgs. a day, Cardura 1 mgs. a day, Atarax 25 mgs. two to four times a day. Colace twice a day, Dura tuss twice a day, Atrovent three puffs twice a day, Albuterol PRN, Serevent two puffs twice a day and Azmacort three puffs twice a day.

Prior to this, Mr. Jones had been in good health. He had been on no medication.

Patient lives at home with his wife.

PHYSICAL EXAM: Blood pressure is 150/90. Pulse is 100. HEENT are unremarkable. Neck is supple. Chest - clear. Cardiac exam reveals regular rhythm. Abdomen is soft with bowel sounds present. Rectal exam and genitalia not examined. Neurologic exam - there are no lateralizing signs. Patient has extensive burns and skin problems.

RE: ARCHIE EDWARD JONES, JR., "EDDIE"
IMA: 31513

3-31-98
PAGE 2

RECENT PULMONARY FUNCTIONS: Show an FVC of 3.27, which is 69% of predicted. FEV1 1.62, which is 47% of predicted. FEF 25-75 is 18% predicted. TLC is 97% of predicted. RV is 135% of predicted. DLCO is 84% of predicted. P02 is 76. PCO2 is 42. pH is 7.4.

Chest x-ray shows some basilar atelectasis.

Mr. Jones has significant lung disease from his injury. I want him to continue his present medicines. I am going to have him enter pulmonary rehab. I have discussed the situation with Mr. Jones and with Mrs. Stetzman from his workmen's compensation. I think the future of his lung disease is unpredictable at the moment. I hope in the next six months, we will have him at maximum capacity or certainly positioned for that. I am going to have him start pulmonary rehab. We will continue present medicines.

WWW/lhm

cc: Dr. June Souviron

RE: ARCHIE EDWARD JONES, JR.
IMA: 3151

4-29-98

WEIGHT: 227

I have discussed Mr. Jones with the speech therapist. There is a question that Mr. Jones may have esophageal reflux.

Mr. Jones has some cough. He has some mucoid sputum in the mornings. He is anxious and getting somewhat depressed at times.

On physical exam, blood pressure is 176/108. Pulse is 108. Chest is clear. Cardiac exam reveals regular rhythm.

I think Mr. Jones' sputum is stable and probably improving. I don't want to push antibiotics at the moment. I think he is having less and less sputum. He has had an adequate course of antibiotics. I have spent some time trying to encourage him. He is going to pulmonary rehab. I am concerned with his possible aspiration from his reflux. I want to arrange for Dr. Wortham to see him for his evaluation.

WWW/lhm

W. W. Walsh MD

cc: Dr. Michael Hellstrom

cc: Dr. June Souviron

INTERNAL MEDICINE ASSOCIATES OF ANDERSON, P.A.

2000 East Greenville Street • Suite 1100 • Anderson, SC 29621 • (864) 225-5667 • FAX (864) 224-9895

June 15, 1998

Dr. June Souviron
Family Care Associates
2405 North Main Street
Anderson, South Carolina 29621

RE: ARCHIE EDDIE JONES
IMA: 31513

Dear Dr. Souviron:

I have just seen Mr. Archie Jones in my office today. I have seen Mr. Jones off and on since you referred him to us. As you know, Mr. Jones has significant pulmonary disease from an industrial accident. Mr. Jones has recently had a flare-up of his lung disease with increasing cough, congestion, production of purulent sputum. We placed Mr. Jones on antibiotics. He responded slowly to this. We increased his antibiotics and gave him a course of Prednisone. He seems to be responding nicely to this. He is having less cough and less sputum production.

We were concerned with Mr. Jones' G.I. problems. He had some difficulty with aspiration. We had a speech therapy consult. I was not totally satisfied with that and I had Dr. David Wortham to see him for a G.I. evaluation and particularly if and why Mr. Jones may be aspirating. Dr. Wortham felt that Mr. Jones had had a significant burn during his industrial accident to his pharynx and was having trouble with transfer of material in his pharynx and this caused him to be highly susceptible to aspiration.

Mr. Jones recently had pulmonary functions at the Health Campus on 3/23/98. Enclosed is a copy of those pulmonary functions.

On physical exam today, blood pressure is 150/90. Chest shows an occasional wheeze. Cardiac exam reveals a regular rhythm.

Internal Medicine/Cardiology
JOHN B. MARTIN, JR., M.D., F.A.C.P.

Invasive Cardiology
THOMAS J. SULLIVAN, JR., M.D., F.A.C.C., F.A.C.P.

General Internal Medicine
HENRY C. MARTIN, M.D. JOSEPH A. FARMER III, M.D.
C. WILSON SOFLEY, JR., M.D. DANIEL A. KEENAN, JR., M.D.
Gastroenterology/Hepatology
DAVID T. WORTHAM, M.D.

Pulmonary and Critical Care
WILLIAM W. WALKER, M.D., F.A.C.P.
STEPHEN H. HAND, M.D.
Nurse Practitioner
ANGELA REEVES, R.N., F.N.P.

DR. JUNE SOUVIRON
RE: ARCHIE EDDIE JONES
IMA: 31513
6-15-98
PAGE 2...

I spent some time talking with Mr. Jones and the Medical Case Manager from his insurance company. I think at the moment, Mr. Jones can stop taking his Propulsid and his Prilosec on Dr. Wortham's recommendation. I have explained the need to slowly swallow and be careful because of the possibility of aspiration in food transfer in his pharynx. Mr. Jones has severe lung disease from his accident. I suspect he has a chronic low grade bronchitis with a significant obstructive component and he is going to intermittently have acute flare-ups of varying severity and duration. I told Mr. Jones and his case manager that he was not able to do severe physical activity from a pulmonary standpoint because of his lung disease.

I told Mr. Jones and his Case Manager that I felt that if they had an employment position with the above qualifications that he could engage in this activity, as far as I was concerned.

Sincerely,



William W. Walker, M. D.

WWW/lhm

cc: Margaret (Peg) Stutsman, BSN, CRRN

enclosures:

RE: Jones, Archie
IMA# 31513
7-21-98

Weight 234

Mr. Jones comes in today. He is having more cough, more congestion, more SOB. He has recently completed a course of Prednisone.

On physical exam, BP is 120/80, pulse 100. Chest shows some scattered wheezes. Cardiac exam reveals regular rhythm.

Mr. Jones continues to be marginal. He takes Atrovent three puffs four times a day, Serevent two puffs twice a day, Albuterol prn usually about three times a day, Azmacort two puffs twice a day. I am going to place him on Prednisone 30 mg a day tapering 10 mg every five days and I am going to add Singulair 10 mg a day. Will see him back in three weeks for follow-up.

WWW:dlk

cc: June Souvion, M.D.

Wm W Walden M.D.

RE: Archie Jones
IMA#31513

10-19-98

Weight: 236

Mr. Jones comes in today. He is having severe pain in his left costochondral joint approximately the fifth interspace. He says that he was recently in Michigan and did quite well, but upon returning home he had a cough.

He recently saw Ms. Sarah Browne in the office who felt that he had a fractured rib. X-ray films were negative.

On exam today, his chest is clear. There is an area of discrete tenderness in the left precordial area.

I am going to have Mr. Jones continue his Singulair, Albuterol p.r.n., and Atrovent. I have stopped his Azmacort and I am going to place him on Flovent 2 puffs b.i.d. Continues to take Serevent tonight.

I have talked to Dr. Loudermilk at the pain clinic and I think that Mr. Jones has a pull in his costochondral junction and I am going to see if Dr. Loudermilk at The Pain Clinic can help this.
WWW/pbm

pc: Dr. June Savirbn

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

06-64-41
JONES, ARCHIE EDWARD
DAVID TODD WORTHAM, M.D.
3042967
06/05/08
06/12/98

PROCEDURE NOTE

NAME OF PROCEDURE: EGD with Maloney dilation

ENDOSCOPIST: Dr. David Wortham

REFERRING PHYSICIAN: Dr. Walker

INDICATIONS: This is a 54 year old gentleman with a history of extensive burns that occurred about one year ago. He had aspiration of hot material during that time as well. He has been having some problems with dysphagia, transfer type in some ways and is here for endoscopic evaluation, rule out esophageal stricture, scarring from the previous burn or other abnormality.

MEDICATIONS: Demerol, 25 mgms. IV and Versed 6 mgms. IV.

PROCEDURE: Informed consent was obtained from the patient and the patient placed in the left lateral decubitus position and topical Cetacaine was used for oral anesthesia. The medications for adequate sedation. The scope was inserted into the oropharynx through bite block and passed to the second portion of the duodenum. It was slowly withdrawn with good visualization of all segments. The patient tolerated the procedure well.

FINDINGS: The oropharynx appeared normal and it was photographed. There was some slight scarring but no obvious large scars were notable. The esophagus was normal in contour and there was no obvious strictures although the upper esophageal sphincters appeared somewhat snug on withdrawal of the scope. The body of the esophagus and distal esophagus all appeared normal without sign of stricture or abnormality. The gastroesophageal junction was fairly sharp and well demarcated. The stomach was entered and insufflated and the fundus, body and antrum were all normal without signs of gastritis or gastric ulcer. The pylorus was seen and intubated. The scope passed into the duodenum and there was duodenitis or duodenal ulcer.

At the completion of the upper endoscopy 50 French Maloney dilator was passed times 1 with just minimal resistance through the upper esophageal sphincter.

IMPRESSION:

1. Basically normal upper endoscopy

Continued
DTW:mhk

Page 2
PROCEDURE NOTE

JONES, ARCHIE EDWARD
DAVID TODD WORTHAM, M.D.

2. Somewhat tight upper esophageal sphincter appreciated and was dilated with 50 French Maloney today.

PLAN: Follow the symptoms. I still would like for him to follow up with the speech therapist for further evaluation.

DTW:mhk
CC: Dr. William Walker


DAVID TODD WORTHAM, M.D.

JONES, JR., MR. ARCHIE EDWARD

AGE 50

DR. SOUVIRON

6/23/98 Mr. Jones is here following a significant history during the last two years. The patient was seriously injured and burned in an accident involving liquid gas. This occurred during the course of his employment with the 3M Corp. He experienced a 40% TBSA burn involving primarily his lower extremities and feet. His face was also burned as well as a small portion of his torso. He presently is undergoing rehabilitation and has undergone extensive grafting for coverage of his burns. There is a small contracture involving his left brow which Dr. Tracy Harvey is planning to revise in the near future. The patient has no voiding symptoms today but unfortunately wore a foley catheter for around 3½ months during his recuperation from the burn. This has resulted in a traumatic hypospadias. He desires to have this repaired as it is very difficult for him to direct his urinary stream. He also thinks it's interfering with his ability to have intercourse.

Examination revealed the patient to have a coronal hypospadias. There is a gaping urinary meatus present. The penis, however, is amenable to repair with a flip-flap urethroplasty or potentially even with a GAP procedure. There is no chordee. The patient has previously been circumcised, however, there does appear to be adequate tissue present to perform a good repair.

Mr. Jones and I discussed the procedure today. It should be able to be performed as an outpatient. The patient may require catheter drainage at least in the short-term thereafter. We have tentatively made plans to proceed with that procedure on 7/9/98. The patient will let me know if he has any problems prior to that time. He has no symptoms of prostatism at present although in the past he's had some problems with prostatitis. I've asked him to let me know if there needs to be any change in the scheduling of his procedure. BH/dlc
Copy to Dr. Souviron.

7/13/98 Archie comes in after undergoing a urethroplasty last week. This was following trauma due to a foley catheter. The patient has done well. Foley catheter was removed today. He does have some swelling of his urinary meatus and glans penis, however, cosmetic result of the procedure is excellent. There is no evidence of wound breakdown. The urine today is grossly clear. He's seen a few drops of blood coming around the catheter and has had some mild incontinence particularly during bowel movements. I told him that this should resolve following removal of the catheter today.

Archie has done well following his procedure. I will see him in 4 weeks for a recheck. He'll let me know sooner if he has any difficulties. BH/dlc
Copy to Dr. Souviron

7/9/98 Mathieu flip flap urethroplasty. BH

JONES, JR., MR. ARCHIE EDWARD

AGE 55

DR. SOUVIRON

8/19/98 Archie comes in for follow-up after repair of a traumatic hypospadias recently. He's done well. He's having no voiding symptoms although his stream is a little difficult to direct it's getting better on a daily basis.

Urine is negative for sugar and albumin with a PH of 6. Microscopic showed a rare WBC only. Physical exam reveals a well healed glandular ventrum. There is no evidence of fistula or breakdown. The urinary meatus is adequate. Overall cosmetic appearance is excellent.

Archie is doing well. I will see him in six months. He did describe erectile dysfunction today. He was given a prescription for Viagra 50mg as well as some samples. He'll let me know if these are ineffective in which case we will increase the dose. I will otherwise plan to see him in six months. BH/dlc

2/17/99 Mr. Jones is here today for follow-up after a urethroplasty during the summer of 1998. He's done well following that procedure although he does have a little mild compromise of his urinary meatus. His says his stream is generally good although slightly compromised. The force and quality is good, however. There has been no hematuria, dysuria, or flank pain. He's worried because he was told he may not be emptying his bladder completely, however, sonographic post-void residual was obtained today and this value was low, 6.57cc. Urinalysis is negative for sugar and albumin with a PH of 6.5. Microscopic shows only amorphous crystal. The patient did try some Viagra following our last visit however this has not been effective for him. He has a history of hypogonadism and previously received Testosterone replacement therapy. He would like to resume that therapy if possible.

Physical exam reveals his meatus to be widely patent. The abdomen is benign and flanks aren't tender. Penis and scrotal contents reveal minimal compromise of the urinary meatus and rectal reveals a 1+ enlarged prostate which is smooth and free of nodules.

Mr. Jones is generally getting along well. We will resume his Testosterone replacement therapy. Today, he received 400mg of Delatestryl intramuscularly. We plan to continue these injections on a monthly basis and I will see him next month to determine if he's had a response. If he has we will simply continue them. If he's not had a response then we will explore other options. BH/dlc

JONES, JR., MR. ARCHIE EDWARD

AGE 48 (7/10/48)

DR. SOUVIRON

3/17/99 Archie comes in for follow-up of hypogonadism. Testosterone was administered at his last visit and he does report that it improved his energy level and libido. He has, however, been very dizzy and has not as of yet achieved a maximal effect from replacement therapy. In the past we have replaced his testosterone with very good results and have presently dose escalated him. He has good voiding quality. I performed a urethroplasty on him last year after trauma related to his total body burn. Urine today is negative for sugar and albumin with a PH of 6. Microscopic shows only amorphous crystal.

Mrs. Scott gave the patient 400mg of Delatestryl today IM in the right. His exam continues to reveal a clear chest. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. His rectal reveals a 1+ enlarged prostate which is smooth and free of nodules. Previous PSA's have been normal.

We will continue monthly testosterone replacement therapy on Mr. Jones. I will see him in 4 months. If he has any difficulties he'll give me ring. He will continue his follow-up as recommended with Drs. Souviron and Dr. Tracy Harvey. BH/dlc
Copy to Dr. Souviron

1/6/00 Archie comes in today complaining of some dysuria, urgency, and frequency. He also complains of perineal and testicular pain. The patient thinks he may have a urinary tract infection. There is a history of previous traumatic hypospadias. This has been repaired and cosmetically looks great. He has a widely patent urinary meatus but thinks that it may be somewhat smaller than it was prior to his previous injury and subsequent longterm catheterization. He denies any notable obstructive symptoms.

Urine is negative for sugar and albumin with a PH of 6.5. Microscopic shows only an occasional WBC. Physical revealed a benign neck. The chest is clear. The heart had a regular rate and rhythm with no murmur and the abdomen is benign. Penis and scrotal contents demonstrated no palpable abnormality. His repair looks great. Rectal reveals a 1+ enlarged prostate which is boggy and diffusely tender. Expressed secretions were not obtained due to the patient's general level of discomfort.

Mr. Jones appears to be suffering from a prostatitis syndrome. I'm going to empirically begin him on Levaquin on 500mg daily. A single tablet will be taken and I will follow-up with him in around 3 weeks. I anticipate that his symptoms will improve. I've asked him to call me if he has any problems prior to our scheduled appointment.
Copy to Dr. Souviron BH/dlc

JONES, JR., MR. ARCHIE EDWARD

AGE 50

DR. SOUVIRON

1/28/00 Archie comes in for follow-up of previous prostatitis which we treated with Levaquin at 500mg daily. He states that this is about the same as it was at that time. He has had some pain with ejaculation and has previously been noted to have a very low post-void residual. The patient does have a history of urinary meatal erosion which we treated with urethroplasty. The cosmetic result of that procedure is excellent. He does have a varying force and quality of stream but truly has no significant dysuria or highly bothersome obstructive symptoms. He is bothered significantly by decongestants which he has to take regularly due to his pulmonary problems following his burn. The present medication that he's using is Histavent.

Urine is negative for sugar and albumin with a PH of 7. Microscopic shows only an occasional WBC. Physical reveals a benign neck. The chest is clear. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. The patient is interested in restarting his previous testosterone supplements which we've prescribed for hypogonadism. This was done today with the patient receiving 400mg of Delatestryl in the left hip. His physical reveals a benign neck. The chest is clear. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. Notable body surface burns are present. Penis and scrotal contents show no abnormality and rectal reveals a 1+ enlarged gland which is smooth and nontender. Again, the urinary meatus is widely patent.

I think that Archie might improve with alpha blocker therapy. I believe a good deal of his symptoms is probably related to his longterm decongestant use. Medication like Flomax would probably be effective for him in relieving his voiding symptoms and yet not interfere with the beneficial effects alpha blocker therapy would provide from a pulmonary standpoint. I plan to see him in follow-up in 6-8 weeks. At that point I would like to see how he responds to Flomax. Presently he is utilizing Cardura which of course would have some antagonistic effect to his decongestants. We will try increasing the Cardura to 4mg daily from 2mg daily today. If this is effective then it may all that's required. If it's ineffective then we may consider a change to Flomax although the Cardura is presently being used to treat essential hypertension. This may require some coordination between Dr. Souviron and myself. We will see how he does with the higher dose of Cardura. He will call me if he has any problems in increasing his doseage to 4mg daily. BH/dlc
Copy to Dr. Souviron

JONES, JR., MR. ARCHIE EDWARDAGE 66 (1/23/20)DR. SOUVIRON

2/25/00 Mr. Jones comes in today for follow-up of prostatism. I placed him on Cardura at 4mg daily following his last visit. This appears to have potentially improved his voiding quality to some degree. He continues to have some problems with a splayed stream. He blames his previous urethroplasty for this although it seems to be widely patent. It's likely that a dilation will improve any splaying of his stream. His general force and quality of stream remains to be what he would consider mildly compromised but again this seems to have been improved by the increase in his Cardura dose. There has been no notable lightheadedness or orthostatic symptoms with his increased dose. A urine is negative for sugar and albumin with a PH of 5. Microscopic shows only amorphous crystal. He continues to use Testosterone replacement therapy for treatment of erectile difficulties. Physical continues to reveal a benign neck. The chest is clear today and the heart has a regular rate and rhythm. The abdomen is benign and the bladder is not palpable. The penis and scrotal contents are unchanged. Again the meatus is widely patent. Rectal reveals a 1+ enlarged prostate which is smooth and free of nodules.

I've asked Mr. Jones to come in for a cystoscopic exam during the next 3 weeks. I'm going to assess his urethroplasty and also particularly evaluate his prostatic urethra. He continues to have obstructive symptoms and I believe we need to rule out stricture disease in view of his history of longterm catheterization. Once that study is performed then it's likely that no further treatment will be required other than ongoing medical therapy. Certainly if a stricture was discovered we can perform a concomitant dilation. BH/dlc
Copy to Dr. Souviron

3/14/00 card mailed re/ remind appt on 3/10/00/gc

3/28/00 Archie comes in today for a cystoscopy and possible dilation. The patient is status post a urethroplasty for distal urethral erosion. He's done well following that procedure but has had a splayed stream and some obstructive symptoms. The cystoscopy to evaluate this.

Urine is negative for sugar and albumin with a Ph of 7. Microscopic shows only an occasional WBC.

Standard flexible video endoscopy is performed today with a 16 French flexible cystoscope. Visualization of the urethra shows a slight amount of stricture disease at the area of the flap distally. This is disrupted to some degree with the syringe used to inject the intraurethral Lidocaine. It is further opened by the cystoscope. Visualization of the more proximal urethra demonstrates it to be widely patent. There is no evidence of proximal pendulous or bulbar stricture. Prostatic urethra shows mild trilobar hyperplasia with a slight degree of outlet obstruction but nothing that is greatly significant or worrisome. The urinary bladder is inspected and the urothelium is grossly normal. There is no evidence of carcinoma in situ, papillary carcinoma, or

foreign body. Both ureteral orifices are orthotopic and neither shows any evidence of upper tract bleeding.

Following cystoscopy, a 4 French filiform was placed past the area of stenosis and the urethra was then dilated to 26 French. This was extremely well tolerated. I believe it will be of assistance to the patient. He did void prior to leaving the office and said his stream was more coherent and larger.

Archie may require this on an intermittent basis although it's difficult to know for sure whether this will be necessary. I've asked him to come in in six months for follow-up and to let me know sooner if he has any problems. Today's procedure was prophylaxed with Keflex. BH/dlc
Copy to Dr. Souvion

4/3/00 Alb:0. Sug:0. Mic: 2-5 WBC, occ RBC. Ph: 8.0. Mr. Jones states he had a temp of 102 this AM, "opening and stream is small"
Rx. Levaquin 500mg #2 1 po daily. Urine to lab for C&S. Ret. Tues. BH/ss

ANDERSON UROLOGY ASSOC., P.A.
112 ESSEX DRIVE
ANDERSON, S.C. 29621-3319

4/4/00 Eddie comes in today after complaining of dysuria yesterday. He also complains of perineal and scrotal pain. He continues to receive aggressive pulmonary therapy for treatment of his chronic chemical bronchitis. He's unsure whether his recent temperature which has been as high as 102 could be related to his pulmonary situation or to a urological problem. He does report significant slowing of his stream following some significant improvement after last week's dilation. The patient has a mild element of meatal stenosis.

Urine was checked yesterday and was negative for sugar and albumin. Ph was 8. Microscopic showed 2-5 WBC/hpf. The patient has taken a single Levaquin tablet. I have decided to continue this today but have switched him to Floxin at a dosage of 300mg PO b.i.d. A physical exam is performed and reveals a benign neck. The chest is clear. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. Penis and scrotal contents are palpably unchanged. The urinary meatus is slightly edematous and compromised. Rectal reveals a 1+ enlarged gland which is somewhat tender to exam. Certainly my fear would be that the patient might have experienced a bout of prostatitis in view of his fever, however, it would be unusual to have this and no notable pyuria.

Eddie will take the Floxin at 300mg PO b.i.d. as noted above. I will see him in follow-up in 3-4 weeks. I've asked him to call me if he has any problems prior to that time. I've asked him to let me know if his temperature increases to any significant extent. BH/dlc

4/25/00 DNKA - card mailed appt/gl
5/16/00 Floxin 300mg. po bid #40-Bib 226-0164/BH

ANDERSON UROLOGY ASSOC., P.A.
112 ESSEX DRIVE
ANDERSON, S.C. 29621-3319

ARCHIE E. JONES, JR.

~~CONFIDENTIAL~~ ACCT# 4857

6/16/00 Eddie comes in today complaining of difficulty urinating. The patient has a distal urethral stricture and we've noted this previously. He has received several cycles of antibiotics and continues to be followed for his pulmonary problems as well as the cutaneous problems that resulted following his burns. He also is receiving psychiatric therapy. Previous residual has been noted to be low. The patient does not complain of any overt symptoms of prostatitis today.

Urine is negative for sugar and albumin with a Ph of 6.5. Microscopic shows only an occasional WBC. The patient is concerned since he's thinks he's making less urine than he should be. I explained to him that this may a function of the time of year and an increase in insensible losses. Nonetheless, he is recalcitrant about this and is fixated on the volume of urine that he's making.

A physical today reveals a benign neck. The chest is clear. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. Penis and scrotal contents show a widely patent urinary meatus, however, the stenosis previously noted is just inside the meatus at the site of the previous urethroplasty. Scrotal contents are both normal. Rectal reveals a 1+ enlarged prostate which is smooth, nontender, and free of nodules today.

I've asked Eddie to undergo a comprehensive metabolic panel. This should allow us to assess his renal function. I've asked him to follow-up with me here in around 3 weeks. We will consider a cystoscopy and VIU in view of the patient's ongoing difficulties with the distal urethral stricture. The patient will call me if he has any questions or problems.
C. WILLIAM HINNANT, JR., MD/dlc

ANDERSON UROLOGY ASSOC., P.A.
112 ESSEX DRIVE
ANDERSON, S.C. 29621-3319

ARCHIE E. JONES, JR.

~~CONFIDENTIAL~~ ACCT# 4857

6/30/00 Eddie comes in for follow-up of urethral stricture disease. The patient continues to receive a complicated treatment regimen for his pulmonary disease and his anxiety and PTSD that he's suffered since his injury a couple of years ago. He also has suffered from bouts of prostatitis and was concerned recently about a diminishing volume of urine output. We checked a CMP and a CBC on him. His renal function is identical to that that we measured in mid-1998. LFT's and other parameters assessed in the CMP are all normal as well. A CBC is also unremarkable with a normal hemoglobin and hematocrit. Differential smear is not remarkable as well.

Eddie continues to have problems with spraying of his stream and some stranguria. We've dilated him successfully before, however, given his age he'd probably be better served by a VIU. Today, we have discussed this and have tentatively scheduled it for 8/10/00. Preop assessment is 8/7/00 at 9 a.m. I've instructed the patient to continue his psychiatric follow-up as well as his pulmonary follow-up. I believe this procedure can be performed under brief infusional anesthetic such as Propofol at the anesthesiologist's discretion. This will obviate the need to inhale the patient and risk aggravating his pulmonary problems.

C. WILLIAM HINNANT, JR., MD/dic

ADDENDUM: Urine today is negative for sugar and albumin with a Ph of 6.5. Post-void residual is assessed at 151.8cc today. This shows some progression and may also be a contributory factor to why the patient is noticing a lower voided volume. The patient will be following up with Dr. Mohan as per his instructions.

C. WILLIAM HINNANT, JR., MD/dic

Copy to Dr. Mohan

8/10/00 Cystoscopy, visual internal ;urethrotomy/BH

8/14/00 Foley catheter deflated and removed with ease. Return Sept. appt./BH(ss)

*Bib-Mall
Cardinal Rx.
Eddie Jones
226-0164
#30 X 6
9/1/00*



ANDERSON UROLOGY ASSOC., P.A.
112 ESSEX DRIVE
ANDERSON, S.C. 29621-3319

PAGE 14

JONES, JR., ARCHIE E.

~~DOB 7/20/72~~

ACCT# 4857

9/6/00 Eddie comes in for follow-up after a recent internal urethrotomy. He had a low grade stricture at the site of his previous urethroplasty. This was widely open. Today, he says his stream is good but that he still has some splaying and difficulty directing it. In talking to him this is not terribly bothersome, however, there is a mild compromise.

Physical exam of his penis today discloses a widely patent meatus. I've not watched the patient urinate.

Urine is negative for sugar and albumin with a Ph of 6. Microscopic shows only an occasional WBC. His chest is clear and his heart has a regular rate and rhythm with no murmur and abdomen is benign. Previous rectal is within normal limits.

I've asked Eddie to simply be patient and to wait about 2-3 months. I will see him in follow-up in about 8 weeks. We do need to check a serum PSA on him and assess whether he's having any significant obstructive symptoms at that time. The patient generally feels well, however and has no specific complaints today aside from the splaying of his stream.

He will return in 8 weeks. I do need to check a serum PSA in the near future. He did request a testosterone injection today and 400mg of Delatestryl were given intramuscularly in the left hip. He will let us know if he has any other questions or problems.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc

JONES, JR., ARCHIE E.

ACCT# 4857

9/26/00 Archie comes in today and demonstrates his voiding for me. He does have some splaying of his stream but his overall force and quality of stream seemed pretty good. He does have some mild compromise of the urethral meatus, however, this is fairly minimal and at least in looking at him he doesn't seem to be particularly uncomfortable with urination. We did proceed to dilate the patient's distal urethra today with VanBuren sounds. This was taken to a level of 26 French with no difficulty. The patient tolerated it extremely well. Urinalysis is negative for sugar and albumin with a Ph of 6.5. Microscopic shows only an occasional WBC.

I explained to Eddie today that his distal urethra seems widely patent and that his stream may simply be splaying due to the fibrotic nature of the tissue at the tip of his penis following previous urethroplasty. It may impossible to improve his stream any further and I've tried to make him realize this. I have asked him to follow-up with us here in around 2-3 months. He will call us if he has any problems prior to that time. I'm hopeful that today's dilation will improve his symptoms.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE EDWARD
C. William Hinnant, Jr., M.D.
3629288
08/10/00
08/10/00

OPERATIVE REPORT

DATE OF OPERATION: 08/10/00

PREOPERATIVE DIAGNOSIS:

1. Urethral stricture.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE PERFORMED:

1. Cystoscopy.
2. Visual internal urethrotomy.

SURGEON: C. William Hinnant, Jr., M.D.

ANESTHESIA: Spinal.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None apparent.

DRAINS: 22 French Silastic Foley catheter to gravity.

SPECIMENS: None.

STATEMENT OF MEDICAL NECESSITY: Mr. Jones is a 57-year-old gentleman who had experienced a substantial burn to most of his body, including his perineum around three years ago. He developed a traumatic hypospadias following prolonged Foley catheter drainage while in a burn unit. We subsequently repaired the traumatic hypospadias using a urethroplasty in 1998. He had done well for some time but earlier this year had developed some obstructive symptoms and splaying of his stream. We had dilated him twice in the office, however, this was uncomfortable for him and resulted in only temporary relief. He was brought to the Operating Room today for a visual internal urethrotomy.

OPERATIVE TECHNIQUE: Following informed consent, the patient was transported to the Operating Room and placed in the left lateral decubitus position where adequate spinal anesthesia was achieved. The patient could not undergo general anesthesia due to a history of chronic chemical bronchitis. He was moved to the dorsolithotomy position where his penis and scrotum were prepped and draped in the routine sterile fashion. Initially the urethra was cannulated with a 4 French ureteral catheter. This was somewhat difficult to pass due to the presence of the stricture, which was near the coronal sulcus. It was at the site of his previous flap mobilization for his hypospadias repair. The 4 French filiform was passed into the urinary bladder eventually and we subsequently dilated using a van Buren sound at the level of the fossa navicularis. A _____ urethrotome scope (21 French) was then passed

RECEIVED 08-24-2000

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE EDWARD
C. William Hinnant, Jr., M.D.
3629288
08/10/00
08/10/00

OPERATIVE REPORT

through the distal urethra under direct vision. The 4 French ureteral catheter could be seen as could the stricture at the level of the coronal sulcus. The blade was extended from the scope and a longitudinal urethrotomy performed at 12 o'clock. This was carried to the level of the urinary meatus. A mild amount of bleeding occurred. The urethra was then fully dilated to 30 French using van Buren sounds and endoscopic inspection thereafter disclosed an otherwise widely patent lower tract. The urinary bladder revealed normal urothelium with no evidence of papillary carcinoma, carcinoma in situ, or extrinsic compression. At that point the case was concluded. A 22 French Silastic Foley catheter was placed with no difficulty. The patient was taken to the Recovery Room in stable condition.

CWH:sps52-2138

cc: June V. Souviron, M.D.

C. William Hinnant, Jr., M.D.

COPY

RECEIVED 7-200

ANDERSON AREA MEDICAL CENTER
ANDERSON, S. C.
MEDICAL RECORD

PHYSICIAN'S COPY

JONES, ARCHIE
C. WILLIAM HINNANT JR., M.D.

08/10/2000
8/10/2000

HISTORY AND PHYSICAL

He is for procedure on Thursday.

Mr. Jones is a 57 year old gentleman who unfortunately experienced a 40% total body surface area burn around 3 years ago. He underwent extensive grafting for burn coverage and subsequently has suffered chronic inflammatory bronchitis related to the inhalation of a boiling liquid at the time of his burn. He also suffered from a traumatic hypospadias related to long term maintenance with a Foley catheter while hospitalized. We performed a Methiu urethroplasty on him in mid 1998, over 2 years ago. This resulted in a good cosmetic repair as well as a generally well maintained force and quality of urinary stream until recently. During recent follow-up in the office, he complained of some significant difficulty with a splayed urinary stream as well as significant hesitancy. The patient was examined cystoscopically and found to have a stricture at the site of his neourethral reconstruction. We initially managed this with dilation. However, despite repeated attempts at management along those lines, the patient continues to have some obstructive symptoms as well as difficulty directing the stream. It is for that reason that we bring him in today to undergo a planned visual internal urethrotomy. We simply plan to incise the stricture at 12:00 and then dilate the urethra to the greatest degree possible. A short term Foley catheter will be maintained thereafter.

PAST MEDICAL HISTORY: Generally the patient's medical history is remarkable for his significant total body surface area burn. Prior to that time he had generally been healthy aside from some problems with prostatitis, which had responded to antibiotic therapy. There is no known history of coronary artery disease, COPD, diabetes or other notable ongoing health problems aside from his problems with chemical bronchitis. He has intermittently received steroids for his pulmonary symptoms and has taken about 20 mg. of Prednisone as of late over the last several weeks. Additional medications include Paxil for anxiety and post-traumatic stress type symptoms. He also has used Atarax on occasion for itching. There are no known medicinal allergies.

PAST SURGICAL HISTORY: Is remarkable for his numerous burn-related procedures and his urethroplasty. He is a nonsmoker, nondrinker and previously was actively employed by the 3-M corporation as an engineer.

REVIEW OF SYSTEMS: Otherwise negative.

PHYSICAL EXAMINATION: In general, this is a pleasant, middle-aged gentleman in no distress. HEENT exam within normal limits. Neck supple. No venous distention, bruits or mass. Chest is basically clear. However, a few scant widely dispersed wheezes are noted. Abdomen is soft and nontender without mass, organomegaly or hernia. The bladder is not palpable and neither flank is tender. Penis and scrotal contents show no abnormality. Extremities showed no edema. Neurological exam is nonfocal. The patient does suffer from a broad-based burn which involves particularly the lower extremities and upper extremities in addition to his chest.

<Page> 1 of 2

RECEIVED AUG 23 2000

HISTORY AND PHYSICAL

JONES, ARCHIE
C. WILLIAM HINNANT JR., M.D.

IMPRESSION: Middle-age gentleman, status post hypospadias repair with distal urethral stricture.

PLAN: Visual internal urethrotomy.

CWH: smr

C. WILLIAM HINNANT JR., M.D.

CC: AHC

<Page> 2 of 2

RECEIVED AUG 23 2000

JONES, JR., ARCHIE E. ~~DOB: 7/28/43~~ ACCT# 4857

12/11/00 Eddie comes in for follow-up. He has a slight amount of distal urethral narrowing following previous hypospadias repair. He's voiding fairly comfortably but still has a splayed stream. Nothing seems to help this as much as we'd like. I think for that reason at this point it's simply best followed. His chief complaint today is erectile dysfunction. He's unable to get an adequate erection. His problems are compounded by significant psychological stress and difficulties in his relationship with his wife. The latter are bascially predicated on problems with an elderly relative and the general issues that have surrounded Eddie's injury. He is, however, recuperating and says his quality of life is much better than it used to be. In the past, he was able to achieve adequate erections however recently says that his erectile maintenance ability is very compromised. He denies recent loss of libido but does complain of stress. He denies visual symptoms any claudication or lightheadedness.

A urine is negative for sugar and albumin with a PH of 6. Microscopic shows only an occasional WBC. Physical reveals a clear chest. The heart has a regular rate and rhythm with no murmur and the abdomen is benign. Neither flank is tender. Penis and scrotal contents showed no gross abnormality.

I'm going to try Eddie a venous flow controller. This was dispensed today in hopes that it will improve his maintenance. He thinks that injections are uncomfortable and that Viagra may be unsafe for him. He's also not been satisfied with his response using the latter agent. We are going to see him in 6 weeks. He has some interest in a penile prosthesis and at some point this may be his only available option.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc
Copy to Dr. Souvion

JONES, JR., ARCHIE E.

~~DOB: 10/10/42~~ ACOT# 4857

1/24/01 Eddie comes in today for follow-up of distal urethral erosion related to previous trauma. Today, I watched the patient urinate and his stream is slightly splayed although it's an excellent stream with good flow. There is no evidence of fistula and the cosmetic result is excellent. Urine shows no evidence of sugar and albumin. Ph is 6. Microscopic shows only amorphous crystal. The patient continues to be treated for a post traumatic stress disorder but seems to be the best he's been in sometime now that he's started treatment with Dexedrine. He also has been diagnosed with ADHD.

The patient is a bit concerned about his splayed stream, however, I had a long discussion with him about this today and told him that I didn't think that this would improve to any greater degree. He has had no great problems with it and seems to be comfortable most of the time. He continues to be concerned about prostatism, however, PSA'S and DRE's have been significant only for BPH and his symptoms along those lines don't yet demand any treatment. I've asked him to simply follow-up with me here in 4-6 months. He did request a Testosterone injection today in hopes of improving his libido. 400mg were given intramuscularly in the left hip. The patient will receive 4 monthly injections and then sit down with me in 4 months to determine whether it's worth continuing these.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc

5/1/01 Cardura 4mg x1 refill -Bibo/BH

JONES, JR., ARCHIE E.

ACCT# 4857

5/9/01 Eddie comes in for follow-up of urethral stricture disease. He's undergone a hypospadias repair secondary to traumatic hypospadias related to long-term catheterization. His stream is still somewhat splayed but he says his force and quality of stream is good. He continues to undergo chronic pulmonary and psychiatric counseling. He denies recent history of urgency or frequency. There has been no hematuria. Appetite is good and weight is stable. Urine is negative for sugar and albumin with a Ph of 6. Microscopic shows only an occasional WBC. Physical revealed a benign neck. The chest was clear. The heart had a regular rate and rhythm with no murmur and the abdomen was benign. Neither flank was tender. The penis and scrotal contents showed no abnormality. The meatus is widely patent. Rectal reveals a 1+ enlarged gland which is smooth and free of nodules.

I ordered a serum PSA on the patient today and will be reviewing this as soon as it's available. I've also advised him to continue hormone replacement therapy using Testosterone at 400mg IM each month. This injection was given today in the right hip. We will see if this improves his ongoing difficulties with libido and erectile function. If it's going well for him then there would be no need to change this regimen. We will continue his injections on a monthly basis and I will see him in 3-4 months to see how his ongoing response has been.

C. WILLIAM HINNANT, JR., MD, DABU, FCLM/dlc

JONES, JR., ARCHIE E.

~~DOB: 12/14/45~~

ACCT# 4857

9/30/03 Eddie came in for follow up after not being seen in some time. He is taking Flomax from Dr. Souviron and says that his force and quality of his stream is much slower than it has been in the past. I previously performed a urethroplasty on the patient after he experienced catheter related trauma while hospitalized in Charleston after his serious burn. He says his force and quality of stream is slow and that he has a good deal of hesitancy and pushing to urinate. There has been no gross hematuria and he denies any fever or chills. Appetite has been good and weight is stable. He continues to use numerous medications primarily for management of his pulmonary difficulties related to prior inhalation of hot oil.

Urine today shows trace albumin, no sugar. PH: 6.5. Microscopic shows a rare WBC. Sonographic residual is assessed and is elevated at 94.1cc. Brief upper tract imaging shows no abnormality. Physical reveals changes consistent with prior cutaneous burns. HEENT is unremarkable. Neck supple, no venous distention, bruit, or mass. Chest clear. Heart had a regular rate and rhythm with no murmur. Abdomen is benign. Neither flank is tender. Penis and scrotal contents show well preserved urinary meatus which does not appear that we ever operated on it. Rectal revealed a 2+ enlarged prostate which was smooth and free of nodules.

The patient's symptoms are bothersome and he desires other options of treatment of prostatism. I asked him to return in 10 days for a urinary flow rate and flexible cystoscopic exam. If his difficulties are all prostatic in origin, then TUMT would be a good option for him. He will let us know if he has problems or questions prior to that appointment.

C. WILLIAM HINNANT, JR., MD,JD/gl

Copy to Dr. Souviron

JONES, JR., ARCHIE E.

~~DOB: 7/20/42~~ ACCT# 4857

10/9/03 Archie came in today for follow-up of difficulty with urination. The patient's history is noted in the chart. Urinary flow rate was initially obtained and was better than expected. A maximal flow of 38.8cc/sec was obtained with an average value of 23.2 and a voided volume of 462cc. This quickly tapered off, however and showed some prolongation at the end of the voiding phase. Post-void residual has previously been noted to be elevated. A flexible cystoscopic exam was then performed and revealed a widely patent urethra to the level of the external sphincter where coaptation was normal. The prostatic urethra did show trilobar hyperplasia with some mild to moderate outlet obstruction. Within the urinary bladder the urothelium showed no evidence of papillary carcinoma, carcinoma in situ, or extrinsic compression. Mild trabeculation was present. The ureteral orifices were orthotopic and neither showed any evidence of upper tract bleeding.

It appears that Archie had some mild outlet obstruction and rather bothersome symptoms despite his good flow rate. I think he would be best treated with TUMT. We elected to proceed in that direction later this month. He will let us know if he has any problems or questions prior to that time. Today's procedure was prophylaxed with fluoroquinolone antibiotics.

Alb: 0 Sug: 0 Mic: Ph: 7.0.

C. WILLIAM HINNANT, JR., MD, JD/dlc

JONES, JR., ARCHIE E.

DOB: [REDACTED] ACCT# 4857

10/27/03 Archie came in today for TUMT. After informed consent was obtained, sedation was achieved with a single oral Tylox tablet and 10mg of Valium, orally. The patient was then taken to the treatment room and placed in the supine position. His bladder was catheterized with a treatment catheter and a rectal thermosensing unit was placed. A rapid ramp-up technique was used to administer transurethral microwave thermotherapy using the Prostotron treatment device. A 30 minute treatment was performed with a total energy delivery of 105kJ. Average microwave power was 58W. The patient tolerated treatment well. At its conclusion, he was recovered for a brief period in the office. All treatment catheters were removed and a single foley catheter was placed to gravity drainage. The patient subsequently was allowed to leave the office with prescriptions for Darvocet N 100 for pain control and Bactrim DS at 1 PO b.i.d. I asked him to follow-up with us here on Wednesday for catheter removal. He will call us sooner if he has any problems or questions.

C. WILLIAM HINNANT, JR., MD, JD/dlc

JONES, EDDIE

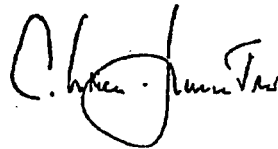
~~EDDIE JONES~~ ACCT# 4857

6/28/05 Eddie comes in today for follow-up. The patient was recently treated for prostatitis with Cipro and also given a prescription for Levitra for treatment of erectile dysfunction. He's just started the Cipro as of late and says his symptoms are somewhat improved although he's having some mild dysuria. There has been no incontinence and he denies any gross hematuria, flank symptoms, fever or chills. Appetite is good and weight is stable. General level of function is high despite his history of burns. He thinks he's emptying his bladder well. He has not yet tried the Levitra.

Urine today is negative for sugar and albumin with a PH of 6. Microscopic shows an occasional WBC. Physical reveals a benign HEENT. Neck is supple with no venous distention, bruit, or mass. The chest is clear. The heart had a regular rate and rhythm with no murmur. The abdomen is benign. Neither flank is tender. Penis and scrotal contents showed no abnormality and rectal reveals a 1+ enlarged prostate that was smooth and nontender today. Post-void residual was assessed and was low at 33.11cc.

The patient seems to be improved but I told him to complete his cycle of antibiotics. Follow-up will be in November. He will call us if he has any problems or questions prior to that time. I asked him to let me know if the Levitra was effective such that I could give him another prescription.

C. WILLIAM HINNANT, JR., MD, JD/dlc



JONES, ARCHIE

~~XXXXXXXXXX~~

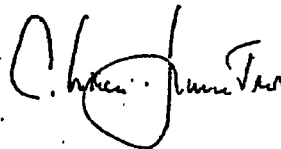
ACCT# 4857

11/8/05 Eddie comes in today for follow-up. The patient is status post TUMT and also has undergone a meatoplasty for urethral erosion after prior severe burns and prolonged catheterization. He now is over 2 years status post TUMT and says that his voiding quality has worsened somewhat as of late. Dr. June Souviron, his personal physician, has recently restarted Flomax at 0.4mg daily. The patient says this is addressing his voiding symptoms and that he's generally comfortable. He has borderline erectile dysfunction but does not wish to undergo medical therapy for this upon questioning today. He denies recent gross hematuria, dysuria, incontinence, stranguria, or hesitancy. There have been no flank symptoms. Prior PSA's have been within the normal range and a follow-up screening PSA is ordered today.

Urine today is negative for sugar and albumin with a Ph of 6. Microscopic shows an occasional WBC. Physical reveals a benign HEENT. Neck is supple with no venous distention, bruit, or mass. The chest is clear. The heart has a regular rate and rhythm with no murmur. The abdomen is benign. Neither flank is tender. Penis and scrotal contents showed no immediate abnormality and rectal reveals a 1+ enlarged prostate that is smooth and free of nodules of induration. Extremities showed no edema. Neurological is nonfocal.

Eddie is holding his own. We will continue the Flomax for now. The PSA drawn today will be reviewed as soon as it's available. Follow-up will be in 6 months. If his symptoms worsen we would consider treatment with transurethral needle ablation.

C. WILLIAM HINNANT, JR., MD, JD/dlc



JONES, ARCHIE

~~DOB: 7/28/48~~

ACCT# 4857

6/14/06 Archie comes in for follow-up of BPH. He also is status post uerthral trauma with a history of prior urethroplasty. The latter has healed nicely. He also complains of erectile dysfunction as well as variable libido. The latter may be related to some psychological issues that have been problematic since his injury several years ago while working. He does say that he occasionally has some mild hesitancy and occasionally will have some nocturia. There has been no recent incontinence. Serum PSA late last year was normal at .61 ng/cc and flow data have generally been borderline in character. The patient has undergone a prior TUMT. In regard to his erectile difficulties, he's failed to respond to any PDE5 inhibitors. It appears that he would be a good candidate for injection therapy and has actually done the latter in the past.

Sonographic residual is assessed today and is a little high at 88.12cc. A urine shows trace albuminuria with no sugar. Ph 6. Microscopic shows a rare WBC. Physical reveals a benign HEENT. Neck is supple with no venous distention, bruit, or mass. The chest is clear. The heart had a regular rate and rhythm with no murmur. The abdomen is benign. Neither flank is tender. Penis and scrotal contents showed no immediate abnormality and rectal reveals a 1+ enlarged prostate that is smooth and free of nodules or induration. Extremities showed no edema. Neurological is nonfocal. The patient has severe burns over much of his body.

The patient's erectile difficulties are new and his voiding symptoms seem stable. He's failed to respond to most treatments prescribed in regard to his voiding issues and I don't think that any new treatment should be planned at the present time based on the minimal nature of his symptoms. In regard to his erectile dysfunction, however, I do think he would be a good candidate for Trimix. He previously used PGE1 but says that it caused burning with injection. For that reason we prescribed Trimix today and asked him to come in next week for a test dose. If he responds favorably to test dosing then I would recommend that he utilize Trimix for treatment of his sexual dysfunction. He will call if he has any problems or questions prior to that appointment.

C. WILLIAM HINNANT, JR., MD, JD/dlc

C. William Hinnant, Jr.

JONES, ARCHIE

ACCT# 4857

6/26/06 Eddie comes in today for a penile injection. The patient has a history of erectile dysfunction.

We are now dosing the patient with Trimix. Today, he received a dose of Trimix 30/1/10. .5cc were given in the left corpora cavernosa. This was well tolerated. A latency period of around 10 min. followed and the patient was re-examined. He developed an erection of 3 to 4+ turgidity with 3+ rigidity. This appeared adequate for sexual intercourse.

The patient has syringes at his home and will do injection therapy there. He was asked to give me a call if he had any questions. I'm hopeful that this dose of medicine will work well and be well tolerated. He was advised as to consideration of priapism and frequency of injection. Follow-up will be here in 4 months.
C. WILLIAM HINNANTM, JR., MD, JD/dlc

C. William Hinnant, Jr.

ANDERSON UROLOGY ASSOCIATES, P.A.

C. WILLIAM HINNANT, Jr., M.D.

1411 North Main Street
Anderson, South Carolina 29621

Telephone: (864) 226-6131

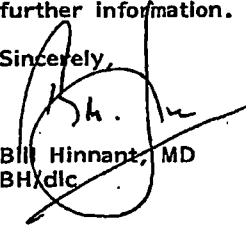
June 23, 1998

Peg Stutsman, RN
Liberty Mutual Ins. Comp.
775 Spartan Blvd.
Suite 200
Spartanburg, SC 29304

Dear Ms. Stutsman,

I'm in receipt of your fax of 6/23/98. Mr. Jones was seen in the office today and has a traumatic hypospadias related to longterm catheterization while he was hospitalized for grafting of his recent burns obtained during the course of his employment with the 3M Corporation. The patient seems to have done well following his burn coverage, and is undergoing rehabilitation. He was prescribed a burn garment and is wearing this in the office today. He has no specific voiding dysfunction other than difficulty in directing his urinary stream and a wide gaping urinary meatus which extends from the glans penis to the coronal sulcus. We see this fairly commonly in people who have been catheterized for long periods primarily due to erosion of the ventral glans penis and distal penile shaft. This results in inability of the patient to direct his urinary stream and also in what most would consider a cosmetically unappealing penis. In short, the patient has a traumatic hypospadias and desires its repair using a urethroplasty. This procedure is a fairly minor procedure and can be performed as an outpatient. We have tentatively scheduled it for 7/9/98 at Anderson Area Medical Center. The patient will continue his rehabilitation locally and has an appointment to see Dr. Tracy Harvey in Charleston, SC for continued treatment of his burns during the next 2-3 weeks. In short, I can say definitively that the traumatic hypospadias is related to the patient's burn injury particularly his longterm catheterization while he was being treated in Charleston. The patient and I both feel it an absolute medical necessity that this problem be corrected surgically. Please contact me if I can provide further information. With best regards.

Sincerely,


Bill Hinnant, MD
BHxdlc



October 8, 2001

Charles W. Hinnant
112 Essex Drive
Anderson, SC 29621

RE: CLAIMANT : Archie Jones
EMPLOYER : 3M
DOI : 6/3/97
CLAIM NO. : WC555-248068
OUR FILE NO. : 531-4400

Dear Dr. Hinnant:

I am a Nurse Case Manager with Crawford & Company Healthcare Management and have been assisting Mr. Jones during his recovery from his workers' compensation injury.

Mr. Jones has been receiving treatment from you for his urological difficulties, which reportedly were caused, from his injury.

The Worker's Compensation Insurance Carrier, Liberty Mutual has requested your documentation of the claimant's current status. Prognosis and long term treatment plan.

If you have any questions regarding the above information, please do not hesitate to contact me at 864-228-9679.

Your report should be mailed to:

Mary Cocke, RN, CCM
PO Box 80430
Simpsonville, SC 29680

Archie Jones
June 5, 2001
Page 2 of 2

Thank you for your time and consideration regarding the above information.

Sincerely,
Crawford & Company
Healthcare Management

Mary Cocke RN

Mary Cocke, RN, CCM
Medical Services Consultant

MC/pls

C: Karen Gamlin
Liberty Mutual
PO Box 31204
Tampa, FL 33631

ANDERSON UROLOGY ASSOCIATES, P.A.

C. WILLIAM HINNANT, Jr., M.D.

112 Essex Drive

Anderson, South Carolina 29621

Telephone: (864) 226-6131

October 19, 2001

Mary Cocke, RN, CCM
P. O. Box 80430
Simpsonville, SC 29680

Dear Ms. Cocke,

In response to your letter of 10/8/01, this update concerns your claimant, Mr. Archie Jones (Claim # WC555-248068, Your file # 531-4400). As you correctly note, the patient has received urological treatment here. As you are well aware, he suffered a work related accident in the past which led to a significant total body surface area burn. The patient had an indwelling foley catheter for sometime which led to dramatic erosion of his distal urethra and also to a urethral stricture. The urethra has been repaired and he has undergone dilation on occasion for the stricture although the latter is mild and only requires a couple of visits each year. There is no question that this initial injury and his subsequent requirement for treatment were proximally and factorially caused by his work related injury. The patient's long-term prognosis is good and at this point his long-term treatment plan would include visits on a biannual basis for potential dilation of his stricture and periodic urinalysis. It's very unlikely that he would require any aggressive therapy for this problem in the near future that would entail significant cost.

The patient does suffer from some symptoms that are related to prostatism, however, at present these are mild. Should they worsen there is certainly some possibility that they might require treatment in the future, however, this particular problem would not necessarily bear any causal relationship to the injury necessitating his Workman's Compensation Claim.

I hope that this clarifies the patient's present situation. Please contact me at the above address if there are any questions.

Sincerely,

C. William Hinnant, Jr., MD
CWH/dlc

ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE OPS 676-2
C. WILLIAM HINNANT, JR., M.D.

07/08/98
07/09/98

PHYSICIAN'S COPY

HISTORY AND PHYSICAL

Mr. Jones is a 54 year old gentleman who was initially seen in our practice over three years ago for problems relating to mild prostatism, recurring episodes of prostatitis and erectile dysfunction. These problems have generally been treated medically and he had responded well to various treatments offered. The patient, thereafter, was lost to follow-up during a short period. He unfortunately experienced a 40% total body surface area burn over one year ago. This occurred during the course of his employment with the 3M Corporation and evidently resulted from a liquid gas explosion. The patient was unconscious for several weeks following his initial burn and subsequently underwent significant grafting and burn coverage at the Medical University of South Carolina. During that period he was catheterized with an indwelling Foley catheter. When he later regained consciousness he continued to undergo rehabilitation and minor surgical procedures for contracture releases, etc., for some time thereafter. All in all, he was catheterized for around 3 1/2 to 4 months. During that period he developed a traumatic hypospadias which basically at this point is a precoronal hypospadias. The patient's recuperation following his burn has been remarkable. He is wearing a burn garment and has excellent use of his extremities. He received only a minor burn to his face, which has not left him disfigured in any way. There is a mild contracture present in the region of the left eye lid and Dr. Tracy Harvey plans to perform a release and repair on this during the next several weeks.

The patient recently saw me regarding inability to direct his urinary stream. He has to more or less stand over the toilet in order to direct his urine into it. Today he is brought in as an outpatient to undergo a urethroplasty. We plan either a GAP procedure versus a flip-flap urethroplasty, depending again on the degree of redundancy on the ventral surface of the penis.

PAST MEDICAL HISTORY: In general, Mr. Jones has been a healthy person. He has had some problems with prostatitis in the past, as well as erectile dysfunction. However, these have seemingly not been a problem following his burn. There is no history of coronary artery disease, COPD, diabetes or any other notable on-going problems. He has been on long term steroids and will receive a steroid pulse just prior to this procedure. He has been maintained on Paxil specifically for some anxiety and post-traumatic stress type symptoms. He has also used Atarax on occasion for itching. There are no known medicinal allergies.

Continued
CWH:ljw

Page 2
HISTORY AND PHYSICAL

JONES, ARCHIE
C. WILLIAM HINNANT, JR., M.D.

PAST SURGICAL HISTORY: Aside from the many procedures he has undergone following his burn, basically negative. The patient anticipates returning to work for 3M as an engineer in the near future. He does not smoke or use alcohol to excess.

REVIEW OF SYSTEMS: Otherwise negative.

PHYSICAL EXAMINATION: In general, this is a pleasant, middle aged gentleman in no active distress. He is wearing a burn garment and a sling on one arm. A mild contracture is noted involving the left brow. HEENT exam is otherwise within normal limits. Neck is supple without venous distention, bruits or mass. Chest is clear to auscultation. Heart had a regular rate and rhythm with no murmur. Abdomen was soft, nontender without mass, organomegaly or hernia. The penis and scrotal contents demonstrate the hypospadias mentioned above. The rectal exam reveals a minimally enlarged, smooth prostate, which is free of nodules. Extremities showed no edema. Neurological exam is nonfocal.

The patient does have numerous diffuse sites of burn injury, particularly involving his trunk and lower extremities. These are less notable above the waist and don't involve his genitalia or groin.

IMPRESSION: 54 year old gentleman status post serious 40% TBSA burn. He now has a traumatic hypospadias related to long term catheterization.

PLAN: Urethroplasty.

CWH:ljw
cc: Dr. June Souviron

C. WILLIAM HINNANT, JR., M.D.

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ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE
C. WILLIAM HINNANT, M.D.
3066193
7/09/98
7/10/98

OPERATIVE REPORT

DATE: 7/09/98

PREOPERATIVE DIAGNOSIS: Traumatic hypospadias secondary to catheterization.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE: Mathieu flip flap urethroplasty.

SURGEON: Bill Hinnant, M.D.

ANESTHESIA: Spinal.

ESTIMATED BLOOD LOSS: 100 ccs.

COMPLICATIONS: None apparent.

DRAINS: 18 French silastic Foley catheter to gravity.

SPECIMENS: None.

STATEMENT OF MEDICAL NECESSITY: Mr. Jones was a 54 year old gentleman who had suffered a 40% total body surface area burn. During his recuperation he had been catheterized for around 4 months. During that period he developed a traumatic hypospadias which resulted in the patient being unable to direct his urinary stream into the toilet. He had to stand over the toilet and had a splayed very difficult to control urinary stream. For that reason he was brought to the operating room at the present time to undergo a urethroplasty.

OPERATIVE TECHNIQUE: Following informed consent, the patient was transported to the operating room and placed in the supine position. Spinal anesthesia was achieved with the patient in the sitting position. He was seen in the supine position where his lower abdomen, penis and scrotum were prepped and draped in the routine sterile fashion. Initially a marking pin was used to demarcate Firlit's skirts. A pedicle was established just proximal to the patient's urinary meatus and a standard paramental flap was developed. The proximal skin edges were taken down in a circumcising fashion using cautery and the pedicle flap was developed with care to preserve its underlying blood supply. Bilateral glandular wings were then developed by sharp incision of the ventral urethral plate. The medial

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ANDERSON AREA MEDICAL CENTER
ANDERSON, S.C.
MEDICAL RECORD

JONES, ARCHIE
C. WILLIAM HINNANT, M.D.
3066193
7/09/98
7/10/98

OPERATIVE REPORT

Page Two

aspect of the urethral plate was then reapproximated to the paramental flap advancing the patient's urethra to the distal tip of the penis. The lateral glandular wings were then mobilized to the midline where they were approximated with interrupted suture of 2-0 vicryl. This brought the glands back together and reconstructed the median Rafe. Some redundant foreskin was then trimmed and buyers patches were developed. A standard circumcising closure was performed with interrupted suture of 5-0 chromic catgut. The patient had a Foley catheter that was inserted at the beginning of the procedure and this was left in place at its conclusion. A sterile dressing of Coban and Telfa was placed.

Mr. Jones tolerated this procedure well. He was moved from the operating table in stable condition and taken to the recovery room without apparent complication.

CH/43ms

C. WILLIAM HINNANT, M.D.

ANDERSON AREA MEDICAL CENTER

RADIOLOGY CONSULT REPORT

Radiology Report

Attending MD: HINNANT JR., C W
REQUEST DATE/TIME: 07-07-1998 9:46 AM
ORDERING PHYS : HINNANT JR., C W
ORDER PHYS PH#: (803) 226-6131

JONES, ARCHIE EDWARD
MR# : 000066441
IDX Acc # : 188081
Acct# : 3066193
Pt Location : OS
Pt. Status : O

Sex: M Age: 54 Years DOB: ~~07-20-1943~~

Exam: (AH) 210103 COMPLETED: 07-07-1998 2:29 PM
CHEST: PA: SINGLE VI

Clinical History: PROCEDURE: URETHROPLASTY

Diagnosis: URETHROPLASTY

JONES

CHEST, SINGLE VIEW

CLINICAL HISTORY: Preoperative evaluation and chronic lung disease.

Heart size and pulmonary vascularity are normal. The lungs are clear. The mediastinal and skeletal structures are unremarkable. There has been no change from 3-23-98.

Reading Physicians:

Carl David Geier M.D. /signed by/ CARL DAVID GEIER M.D.

Transcribed on: 07-08-1998 1:41 PM by Linda Harper

Finalized on: 07-08-1998 4:22 PM by Carl David Geier M.D.

Page: 1

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archibald 55 yrs ♂
Diagnosis - 3M

Date 4/20/99 allergies: NKDA Notes Should Be Signed by Physician P88 B/P 130/90 ↓↑

cc: ↑ anxiety -

HPI: Recent ↑ in bronchial secretions → quin Claritin and beginning Vertigo, anxiety, SOB, sleep disturbance. D/C'd Ativan on his own → ↑ anxiety - hot oil burn 2 yrs ago trapped in a room inhaling vaporized oil -

Risk Factors: sister by virgin 2 trauma - son age 34 died last yr of subarachnoid hemorrhage

Current meds: Ativan 10mg 2x, Duragesic, benigulain, Cardura, Paxil 10mg, Colace, desiquin, Albuterol inhaler, Atrovent inhaler, Derovant inhaler, Flavert inh, Flavertapin ^{noed}
med/surg hx: burned 40% - 2 yrs ago -

ψ hx - on Paxil since burn ⁺/₋ regress -

F ψ hx - sister OD'd → suicide

Social Hx:

lives w: wife

Education: did well - skipped grades - lost interest in high school - later went to college - & back

PROGRESS NOTES

Cont'd

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archibald Jones

cat's

Date	Notes Should Be Signed by Physician
	development: met milestones early
	ETOH: $\emptyset$
	substance abuse: $\emptyset$
	peers: perfectionist & "hard to live with"
	support system - $\oplus$
	Review of Systems
	neuro: ^{looking R/T nerve regeneration} myopia & visual aura OB/Gyn - N/A
	cardio: 2 ^o burns -
	GI: $\emptyset$
	uro: prostate problems R/T bike riding
	endocrine $\emptyset$
	respiratory - multiple - 2 ^o burns
	Hearing - $\oplus$ ear ringing - long hrs work & heavy equipment
	Vision - eyes burned & oil fire - $\emptyset$ glasses - blurred
	"floaters"
	^{a burn was having trouble sleeping} Sleep: $\oplus$ now due to Atarax -
	Appetite: $\emptyset$ meat in past - good - slowly
	$\downarrow$ meat - carbos craving -
	MSE:
	eye contact: good
	speech: expansive
	mood: subtle humor
	affect: full R/A - ? feigned humor -
	thinking: disorganized, forgetful

PROGRESS NOTES

cat's

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archai Jones
cont'd

Date	Notes Should Be Signed by Physician
	A/V H - hears bumping sounds while watching TV not from the T.V. -
	SI/HI - denied
	Oriented: X.3
	Appearance:
	① about self - good person -
	② about self - physical things, mechanical -
	③ about self - inability to go outdoors
	goals: none - he is functional
	Appearance - adequate hygiene, appears
	stated age - dressed in overalls and
	spare shirt -
	↓ memory, scattered -
	hrs of working hours. overstimulated brain -

PROGRESS NOTES

Archie Jones

Date	Notes Should Be Signed by Physician
4/20/75	Revised he impressed $\bar{c}$ $\uparrow$ he terms. Reports rec. thoughts $\uparrow$ anxiety ($\bar{c}$ new situat. of $\uparrow$ stimulus) episodic anxiety attacks $\uparrow$ sleep latency $\uparrow$ distractible. Denies previous $\emptyset$ ALVH $\emptyset$ S/HI
	MSE $\oplus$ eye contact nl psychomotor activity. Speech rapid & clear. Mood expressive Affect congruent Associations loose. Able to redirect. $\rightarrow$ rapid return to $\uparrow$ speech & loose assoc. $\emptyset$ D/O thought content or percept. AXO x 3 $\emptyset$ S/HI
	Di: ① Hypoman due to med. / prob. $\uparrow$ near asphyxiated $\uparrow$ parox. ② PTSD from ③ R/O Bipolar
	Ph: ① Nymex 300 qhs $\rightarrow$ TID am 3 days $\oplus$ Period present ② Mellaril 100 ③ dipaxil 5mg x 4 doses then stop ④ PRN 1 week

A23931

PROGRESS NOTES

C.B.M.

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
4/21/99	phone call - pt % ↑↑ drawdown → slept all day - speech slightly slurred - ? confused about meds - nurse inform Dr. Richards Campbell Attempted to call - left message - V.O. D/C Neurontin, need to see tomorrow. Dr. Richards/Campbell

PROGRESS NOTES

Greenville Psychiatry, P.A.

9-A Caledon Court

Greenville, South Carolina 29615

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
4/23/98	phone call - nurse at 3M, Sue reports first dose of Neurontin pt was "more lucid" and "slowed down" - but did have sedation - ? Compliance = directions - she ^{FM} also reports pt D/C'd Neurontin and restarted Paxil and Atarax - V.O. Do not restart Paxil. Dr. R. Richards / Campbell message left on answering machine.
4/26/99	Pt reports "I've been so sick - bronchitis" Pt did not restart Paxil - reports he is feeling better - Advised pt Dr. Richards would like to see him and his wife on Friday at MIPH - directions given. Campbell / Jell

PROGRESS NOTES

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 Greenville, South Carolina 29615
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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
4/30	Seen c spouse. Had ↑↑ good response to Neurontin → next day in "lets find" → sedated & confused. Also has ↓ & O/C pers. problems. → Hrs excellent days & "confused" days & clear problems & provocations. M. reports good med compliance. Pulse oxim. ≥ 95% Spinal pressure done psc on Tuesday (3 days ago). ↑ polite. ⊕ are correct. Speech rapid but clear. Moral asitated & anxious. Assault loose → able to redirect. ⊕ A/V/H A+Qx3 ⊕ S/H/T. Discussed c Dr. Merck → MRI R/O major injury, phone call occupational therapy nurse. (rich heavy notes) Pr: Hypon due to brain injury, (prev) Ph: ① MRI ② Neurontin 600 hs x 3 day then BID ③ FU 2 week

Consider re-eval & test

PROGRESS NOTES

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Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
5/11/99	Neuro 100 BID, $\emptyset$ SE ok this dr. month. Pleural $\bar{c}$ respase ↑ energy, ↑ ability to bear ↓ racing thoughts. Onset of heavy metal per occupational health nurse. Speech 21 rate, & clear. Mood, built Allent bright. Affect tight $\emptyset$ No full gal DAVH @ 50-60, Normal 20 min. 45 sec. Dx: Bipolar due to TBI Rx: ① 1st ↑ problems ↑ dose neuro 100 TID ② MRI pool ③ In 4-6 weeks consult neuro & consult ④ FU / 6-8 weeks _____ <i>BL</i>

PROGRESS NOTES

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

①

Patient Name: Archie "Ed" Jones

Date	Dr. Clark 2256286	Notes Should Be Signed by Physician
5/15/99	Per Dr. Richards clinical for MRI	R/O focal/structural injury secondary to asphyxia (hypoxemia) and secondary mental status changes suggestive of mania - would like/suggest good view of temporal and frontal lobes.
	Dr. Clark informed. Ed Smith	
5/25/99	Attempted to return call - left message.	Emergency
5/27/99	phone message left for Reg at Liberty	Received 1-800-806-5907 ext 240 - MRI report received. Emergency
6/1/99	Phone call - reports 4-100 kbb. & other problems	Will report 100/200. Call if problems. Keep FU.
		③

PROGRESS NOTES

Arthur "Ed" Jones

Date	Notes Should Be Signed by Physician
6/22/99	Verbal 200/200 ØSE ØJaw Reports ↓ memory ↑ irritability ⊕ slowed down "gushy" of life not good" ↑ losses due to ↓ life capacity. ↓ concentration of racing thoughts & psychoses Speech not quite clear. Mood irritable & nervous. Thinking dis Ø ALVH Dx: Bipolar Depressed due to TBI Plan: Zolof 25, Can Reval used procedures → watch monitor Casich Therp., FU ✓ 2 weeks
6/30/99	attempted to return, call - busy - family not get

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Ed Jones

Date	Notes Should Be Signed by Physician
6/30/99	phone call - pt reports sedation - "my mind is not sedated" - "I'm just so tired" - ⊕ energy - daytime drowsiness - Pt Reports gradual onset p start of Zolof - Pt reports sleeping well, good appetite & ↓ in food craving cont & ↑ irritability but it is less than last spot. - no change in mood - ⊕ ↓↓ memory forgetfulness - ie. word loss - unable to be supportive of wife during anniversary of son's death. - "Road rage and I'm the only one on the road." Wife inform Dr Richards. Eugene H. [Signature] V.O. D/C Zolof. See M.O at MIPN on 7/2/99 at 12⁰⁰ Eugene H. [Signature] pt informed -

PROGRESS NOTES

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 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Ed Jones

Date	Notes Should Be Signed by Physician
7/2/99	Neuritin 100/200 ZolPt 25mg Stopped 2^o ↑ sleep Reports that ZolPt ↓ irritability → release & restart. Reports ↑ stress related to pressures @ work "Went 40 hr." Speech rep. d. Mood irritability Affect 1/2 expressive Tense 1 & D/O Thought content or perception A+Ox3 & S/H/T Dx: Bi-polar mixed due to TBI Ph: ① D/C atax ② ↑ Neuritin 100/100/200 (↑ problems in pm) ③ FU phone call 5 days. → IP ↑ problems consider hyper or stimulat. ④ FU ✓ 4 weeks B.M.
7/7/99	Phone call - 1/2 ↑ tired. Coaxial improved "I feel stress" ↑ tired. Will restart atax FU phone call 2 weeks. B.M.

PROGRESS NOTES

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 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Ed Jones

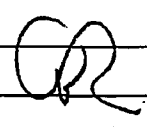
W-299-2014

Date	Notes Should Be Signed by Physician
7/19/99	<u>h-224 2669</u> phone call - ↑ sedation X / ↑ hmk - concentration "OK" - memory ↓ - some "Paranoia" + "I feel strange" - p. Restarting Atorax - yesterday omitted afternoon dose of Neurontin & reports able to put lawn mower together, cut grass and woke up "Clear" - H ↓ concentration - H memory loss -
	V.O. omit midday Neurontin - Call in 2d. <i>Dr R. Richards</i> <i>Campbell J. J. J.</i> attempted to call X3 - left message on home #. <i>Campbell J. J. J.</i>
7/20/99	Attempted to call - F/H - <i>Campbell J. J. J.</i> h# & w# left message
7/22/99	Pt reports ↑ sedation today in the afternoon - "mind is clear, memory improved" - has difficulty identifying fatigue v.s. sedation - Reports being "worn out" by end of week - Reports ↑ in inflammation in lumbar spine - Will inform Dr. Richards. <i>Campbell J. J. J.</i>

PROGRESS NOTES

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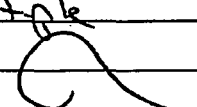
Patient Name: Ced Jones

Date	Notes Should Be Signed by Physician
7/27/99	Neuro 100am/200hs P-84 B/P 140/80 ↓ 112/70 ↑ ~~Proloft 25mg~~ Atarax 25 Qhs ↓ in daytime sedation, ↓ in irritability "road rage" speech rate NMB - expressive - cont. 2 short term memory loss - speech improved but cont. time periods of "exhausted" still to see ↑ physical stamina & clear thoughts ↓ road rage "not as much" "hard to get motivated" ↓ other symptoms of depression ↑ med. kcal Dec 13-14 M. & 2 due to TBI ADD due to TBI Pls. Trial doc for 5mg Qm. Recheck usual procedures ⊕ Consent Also ↑ atax 10 BID. FU phase 2 days - soon R recall FU G-Swed.
	

PROGRESS NOTES

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Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Ed Jones

Date	Notes Should Be Signed by Physician
7/29/99	phone call - "busy last few days" - ears ringing from 7/24 - 7/27 ^{forget} respiratory distress - memory is better, & sedative, good concentration easily disturbed - ↓ appetite - slight sleep disturbance/latency - can't do computer games as usual - not reeled up - "feel crisper" - can remember phone #s - "I've lost that sedative feeling - % ongoing ear ringing @ ear - bump, feeling better - Emergency Dept
	Dr. Richards notified of pt status - <u>Emergency Dept</u>
7/30/99	Pt % ↑↑ ears ringing, "don't feel well"; "ocular part of migraine - lightening bolt" took Motrin last p.m. - pt ↑↑ concerned.
h-2242669	Dr. Richards paged.
w-2362014	V.O. Hold Dexedrine
	PT informed EFT Dr. Richards <u>Emergency Dept</u>
7/30-7/31	Attempted to call multiple times. Unable to reach 

PROGRESS NOTES

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

864-
H-224-2669
W-236-2014

Date	Notes Should Be Signed by Physician
8/5/99	phone call - @ ear ringing - ↑↑ distraction - PCP → gave him disorientation - has not taken it - Pt reports ↑ he took Dexamethasone - concentration is good - ↑ anxiety - ↑ fatigue - please have M.D. call - cyl removed from behind @ ear - no % discomfort - will inform Dr. Richards. Cory L. G. R.

8/6/99	Phone call. "I'm anxious" neuron in 100/200 at 10 hr Reports return of rapid speech speech associated with anxiety. Will ↑ neuron 200 BID. IR ↑ sedation or no response, consider anxiety. Keep PCP.

8/19/99	phone call - % ↑↑ ringing in ears - sensory letter order - mixing up words - memory loss - RespTx has been d/c'd - 2° M.D. change. ↑ congestion - coughed → H/A - "ps pulmonary" Retain necessary. Dr. Richards please review 2 op.

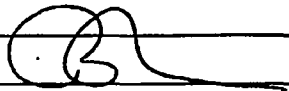
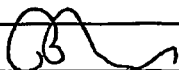
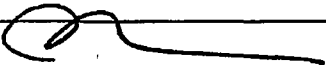
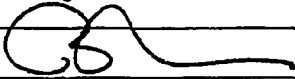
PROGRESS NOTES

Patient Name: Archie Jones

PROGRESS NOTES

Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
9/2/89	Attempted to return call. Left message. 
9/3/89	Attempted to return call. Left message. 
9/4/89	Attempted to return call. Left message. 
9/22/89	Newborn 200 B10 } ØSE After 10 hrs Reports ↑↑↑ stress @ work. ⊕ conflict @ work. "I got written warning" → transfer to mech Speech clear. Mood level A/P Bell range. Think clear. ØAlvit ↑supp ØS/HT A/P No change. Rev Gweel 

PROGRESS NOTES

Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Anne Jones

Date	Notes Should Be Signed by Physician
1/4/00	Neurontin 200 BID Reports 1 mo hx ↑ flashbacks & vivid dreams? delayed onset 4-10 causal & der. accident helps "get off stress" → "almost hopeless" ⊕ try 1 Addx 3 ⊕ SLIT Dx: Bipolar mixed due to TBI Cogn. O/O NOS due to TBI R/O Depression R/O PTSD, delayed onset Ph: Cont. neuro ⊕ Support therapy RTC 2-4 weeks → Consider antidepressant <i>[Signature]</i>
	Note: Request specialty therapy → main issues due to burn. Also cognitive & behavior interventions for depression ↓ PTSD <i>[Signature]</i>

Greenville Psychiatry, P.A.
9-A Caledon Court
Greenville, South Carolina 29615
Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archi Eddies Jones

Date	Notes Should Be Signed by Physician
1-12-00	phone call - pt reports recent illness 2° inactivity R/T foot surgery → lung congestion, otitis, prostate inflammation - Reports recent med A per pulmonologist - Pt ↑ exposure, ↑ talkative - reports ↑↑ fatigue + ↑↑ weakness - meds reported: Fludacort D/A → (+) hallucinations → D/C Alaxay qhs - D/C Shangylin 300 BID Jessalyn pearls 2° cough → present Atrament nasal spray Sib vent Derivent BID Coloce Pirilosa qam → "red spot on throat" Neurotri 200 qam qhs 100 q p.m. Dura Juss Cardura Favagun 500 po qid 1-6-00 X 3 wks ASA qd
	pt also asking for therapist clarification - please call Cheryl Terhune 1-800-532-7706 - cont'd -

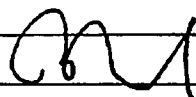
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 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archi Eddin Jones

Date	Notes Should Be Signed by Physician
Cont'd -	↑ Tegaserod R/T decreased sm's B/D. V.O. ↑ Neurontin 200 TID - Dr. R. Richards pt notified per answering machine. <i>[Signature]</i>
1/25/00	Neurontin 200 BID Ø SE Hes to eat by perls & other meal changes Discuss ↑ stress 2° illness → Episodes ↑ anxious, ⊕ response to therapy + speech apical meal crises Allt consent. Thyroid clear & ALVH Ø 5/11/00 Dr. B. Rich. M.D. due to TBI Ph: See plan RTC 1mo <i>[Signature]</i>
1/25/00	Not ⊕ Sleep spec. Tx perls, <i>[Signature]</i>

Greenville Psychiatry, P.A.
 9-A Caledon Court
 Greenville, South Carolina 29615
 Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
2/22/01	Neurontin 300 BID OSE Discussed ↑ stress @ work. Also coordinating MD appts. "I have rage" ↑ suppurative Speech rapid & clear. Mood/Affect irritable. Association loose O/O thought content OAVit O S/HI Dx: Bipolar mixed due to TBI Sleep apnea PTSD Plan: ↑ Neurontin 400 BID RTC Imo.
	

Telephone: (864) 271-5056 FAX: 271-8043

Patient Name: Archie Ed Jones

Date	Notes Should Be Signed by Physician
2/29/00	phone call - pt reports "had the worst" yesterday "↓ blood sugar and energy" - Pt ⁵⁶ SOB. Last pm energy, ↑ dry mouth, slept ↑ soundly. coordination "a little better" - denies change in mental status - concentration is better - more optimistic. Sleep study and pulmonary function studies recently done - restarted Resp Tx bi-weekly - rode bike on Sun - Advised pt to call pulm. M.D. ✓ on results of recent studies → more csgt sooner if hes - Write unit report Dr. Richards Cung
3/1/00	left phone message for pt to report above to PCP and pulmonologist per Dr. Richards. Pt also here for Tx and advised. Cung

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
4/15/00	Neuro 400 B/p Can't see any pulmonary problems. → pressure 20 QD. Pt reports age ↓ ability to read or watch TV + subjective ↓ short term memory.
	⊕ eye checked. Speech not clear & later may affect anxious ⊕ tension & disorganized. ⊕ ALVH ⊕ S/H AFO x 3 unable to complete go-no-go "I'm undecided" 11 animals 30 sec, 10 others 30 sec short term memory 10/3
	A/P new 4 test → eval cogn & suggestion for new 4 rehabilit it indicates RTC time BM
4/25/00	CSE from Mr. Rich. May need to consider deplete or atypical

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
5/14/00	Neuro 4 to 10 Prehension 15 GD → slow top ↑ tall ↑ ↑ anxious ↑ ↑ ↑ "I have no structure" ↓ ↓ ↓ tolerance → ↑ ↑ ↑ "inherent" Gd ↑ stress rel to disability Also ? ↑ ↑ ↑ due to prehension Speech rapid Mood irritable A/R ↑ ↑ ↑ ⊕ circumstances → loose → O/O thought content ⊕ A/H A/O × 3 ⊕ S/H/E Dx: B-pts due to TBI ↑ ↑ ↑ due to prehension Ph ① Liver panel & CBC TSH ② Phn all p lchs → deph 250 / 500 & D/C non ③ Gd. Thry ④ RTC 3-4 wks.
5/17/00	pt requested minor to "look at" ⊕ leg 2" all this a.m. → golf ball size area noted on ⊕ lateral knee area = 1 1/2" black area under ⊕ ankle area - Dr. Richards informed

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Patient Name: Archie E Jones

Date	Notes Should Be Signed by Physician
5/17/00	Pt directed to arrange to see PCP today - could per pt. request phone call to Dr. [unclear] the will see pt this p.m. <i>[Signature]</i>
5/22/00	phone call to Anderson Med Center for lab - - TSH done - they will fax - Dr. Richards referred - TSH. <i>[Signature]</i>
5/22/00	Phn call - Labs look fine will stop nortin begin dequate 250/500 ✓ labs 1 week Reval usual progress. Keep FU
5/22/00	Referral for neuro consult made 2 Cindy at Beach Rehab - will fax order - gave demographics - they will mail packet to M.D of pt - they will schedule. <i>[Signature]</i>

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
6/6/00	phone call to Roger C Ponce to inquire if I test; scheduled - it was scheduled today per staff 2 pt - 7/10/00 at 10 ⁰⁰ , 7/13 at 8 ³⁰ a.m., 7/19 at 10 - Campbell
	Per Dr. R pt advised Dr Richards would review other meds vs. UPA 7 hr tomorrow during apt. Campbell
6/7/00	Attempted to call. No answer. ? Dr. reports he stopped anticoagulant. Will call RCP → discuss Depakote.
Lato entry for 6/6/00	phone call to Dandy Rogers with 6/8/00 Liberty Mutual 843-762-4632 or 9094 - left apt dates and time (on vac mail) of neuro psych test; Campbell
6/8/00	phone call to Dr. Dominion office - med. assist, reports chart at N.D's home office - with Ramin = M.O D D/c anticoagulant Tx? @ is it OK to use Depakote - will call within week. Campbell

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
6/8/00 1427	phone message - med assist from Dr. Souverin's office reports Dr. Souverin states pt on no anti coagulants, except ASA that he takes, that she knows of. Depakote OK to prescribe. <i>Cary [signature]</i>
	V.O. D/C Neurax. Begin Depakote 250/300 ✓ levels in 1 wk. Dr. R Richards <i>Cary [signature]</i>
	Pt informed - Pt reports going to Chas. Sc 6/12 for aggr R/T surgery, swelling graft site (R) ankle - Usual precatious nerves. Pt inattentive at times - Will mail lab orders. <i>Cary [signature]</i>
	Dr Richards informed of pt's trip to Charlotte to see M.D. re: graft site. V.O. Advise pt to delay starting Depakote until p seeing M.D. Will be happy to call M.D. if needed. Dr. Robert Richards <i>Cary [signature]</i>
	pt informed - Will RF Neurax. <i>Cary [signature]</i>

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
4/14/00	Neurot. w/o B.D. Reaches 1500 (top tier) Reports ↑ mood lability. ? episode of road rage "Carb had killed him" Access to loaded guns. Avoids being around people. 20 yrs / rage Denies precip. flashbacks to him just, but ALYN. "Carb control my thoughts" ↑ tith. ⊕ rapid ⊕ loose ↑ social. Adox 3. ↓ concern ⊕ sustained atk. Unable to complete go-no-go. De. Bipolar mixed Due to TBI R/O Carb. 0/0 " " " M. ⊕ Begin deplete 250/500. Ch. c. surgery. Pres. usual present
4/14/00	② Lab 3 week ③ Cal. Sign. Thym. ④ Neuro 4 consult per ⑤ RTC 2 weeks -

[Handwritten signature]

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Patient Name: Archie Eddie Jones

Date	Notes Should Be Signed by Physician
	224-2669
6/20/00	phone call - pt ↑ distraught - "this medicine isn't working - I can't take this" - ↑↑ anxiety "I can't function" - reports stomach burning - "lungs chest about to explode" - ↑↑ respiratory secretions, ↑ intubation, ↑↑ lungs (more than before) - ⊕ sedated - pt reports numerous ⊖ responses to Dypkote - med teaching attempted but pt unable to tolerate - pt also reports upcoming reconstructive surgery "as soon as I get Prednisone down to 5mg a day" but denies home visitation schedule. PT requests Dr. Richards call - going to another medical apt. this p.m. - Eugene [signature]
6/20/00	Phne Discussed above - will take nortin 100/200 tabs → 100 in am. med ✓ 6/21. Does S/H/T "Would call"
	[signature]

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
6/21/00	Depakote 250/sq level good Reports slower thinking but ↑ intense anxiety. → nervous 100/200 "calmed down immediately" but ↑ restlessness. Speech in 1st order. Mood level. A/P + content Assoc ↑. High E decreased Cycling of A/P + A/C x 3 & S/H A/P ↓ depakote 250 BID Nervous 200 BID ✓ labs 3 days @ G/H p/hr RTC 1 week

6/21/00	Nervous 100 + 120 ti BID RE 1

6/22/00	Attempted to call pt — left message to call off. <i>Completed</i>

6/22/00	Attempted to call Mary Cooke, nurse (workman's 1155 comp) — left message. <i>Completed</i>

	phone call — pt. does not feel comfortable about writing giving info to Mrs. Cooke. → cont.

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
	cont'd - pt reports. Prolineone has been D/c'd - asking if he needs to cont. 2 Depakote. <i>Conquered</i>
6/23/00	Per Dr. Richardson ① M.D. nurse will not talk to case mgr. a talking 2 Mr. Jones ② Cont. Depakote + Neurontin until next visit. - lab in a.m. <i>Conquered</i>
sketo	Depakote 1000 38.2. $\nearrow$ ↑ dose until next visit

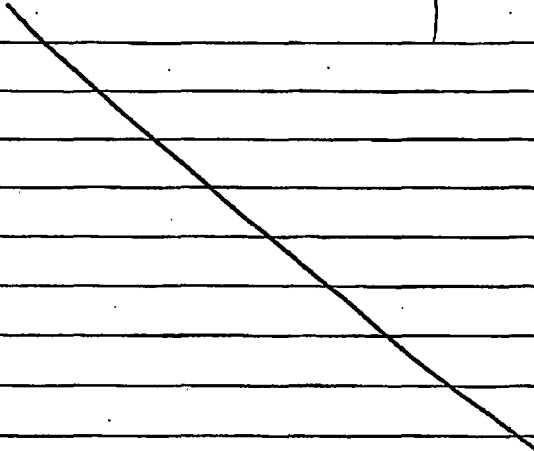
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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
6/27/00	Depakote 250 BID } ↑ sedation Neurontin 200 BID } AP productive ↓ racing thoughts "not as bad" Sleep fine. Epilepsy "unless provoked" Concern about ↓ motor, "overwhelmed" Cal ↑ sleep ⊕ eye contact. Speech n/c ↓ den. Mod depressed. Allt build Thin, pale. ALH A40x3 ØS/HI Depakote 38.2 ALP? need for Depakote 2° ALT studies. Also? ↑ depression due to ↓ steroids. → will ↓ Depakote 250. Phas ✓ Tweak RSC Imo
7/15/00	Attempted to return call, left message
7/16/00	Attempted to return call, left message

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
	cont'd - pt reports Prozac has been D/C'd - asking if he needs to cont. = Depakote. Campbell JGH
6/23/00	Per Dr. Richardson ① M.D. & nurse will not talk to case mgr. a talk j. Mr. Jones ② Cont. Depakote & Neurontin until next appt. - lab work. Campbell JGH
6/24/00	Depakote 38.2. $\nearrow$ dose until next visit ②
	

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
7/17/00	Attempt to return call. Left message
7/18/00	Case consulted - Ms. Richey ⊕ Saw improvement on dose depakot & continue keep Rx
7/27/00	Depakot 250 bc } ↑ Sleep bkg. @ CRAP Numb 200 BID } ⊕ response ↓ anxiety ↑ concentration ↑ productivity "The lights are on" Speech ml (slr) Mood / affect bright Think clear / S/HI A/P No change RTC 1 mo
8/15/00	Nik Ms. Richey. May do better on depakot 250/250

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Patient Name: Archie Jones

Date	Notes Should Be Signed by Physician
8/22/00	Depakote 250hs } ~~OSE~~ Neurontin 200/200 } Reports ↑ SOB + cough Tx Dr. M... ⊕ episodic ↑ weight ⊕ Pruritus → overwhelmed easily. ⊕ Recy thoughts "at times" Trage Speech at rate + clear. Mood low Affect full range ⊕ psych → loose ⊕ No thought control ⊕ Alvt Adx 3 ~~SHI~~ D. B. - S/P TBI Plan: ↑ Depak 375hs RTC 6 wks ✓ last 1 week
8/30/00	phone call - pt reports recurring severe head ache since 8/22/00 ↑ UPA - headache wakes him up in a.m. - ⊕ nausea - pt asking what med he can take for H/A? or what to do? will review 2 X coverage and call him back - Tang ~~del~~
	V.O. 1 Depakote 250mg qhs. - tylenol prn avoid ASA - status ✓ Mon 9/5 sooner -

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
8/30/07	if H/A persists see PCP. V.O. Dr. Any Jones Eugene Jones
	Pt notified per answering machine as directed! Eugene Jones
	(1)
9/14/07	Phone call - 1 hr ↓ dose to 250 → +/- ↓ HA "when I take my med" HA may be due to "↑ lung problems" has also started CPAP. → Describes +/- mild depression. Able to experience pleasure. → "Sands break! ↓ sleep" "going up & down" note: recently started surgery → ↑ HA & SE. Discussed options → will be to ↑ dose to 375. If ↑ HA will return to PCP & ↓ dose back to 250. Keep FU B

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Patient Name: Edna Jones

Date	Notes Should Be Signed by Physician
9/28/00	Dopamine 375 } <u>OSE</u> Nervous 200/200 } +L Tremor Pain 200/200 Reports 2 weeks for ↑↑ anxiety Worse in "situations" & bedtime ① Unable to feel pleasure + - cries easily ② delayed sleep phase. Speech clear Mood anxious & depressed Affect less. Assoc. less. Think ch ③ ALVH 4x0x3 & 5/4x5 D. B. 10/10 5/10 TBI Ph. ↑ Dopamine 500 hrs. IR ↑ HA Call RTC 1mo. ✓ last + TSH @ next visit B.I.L
10/2/00	phone message - pt reports since Dopamine ↑ 1643 "not doing well" - ? in the L all week - end - V.O. ↓ Dopamine 375mg qhs Dr Robert Richards Emergency Pt informed per emergency notification requested - please call and confirm understand

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Patient Name: Edwin Jones

Date	Notes Should Be Signed by Physician
10/3/00	224-269
1438	Pt confirms seeing ↓ VPA message correctly - "It didn't help" → renewed need for ↓ blood level - pt reports ⊕ tremors + inability to make decisions - he reports being worse immediately = ↑ VPA - requests M.D. to call - has appt. in Tx, Pat. Physician on 10/5. <i>Campbell</i>
10/3/00	Phone call - discussed chue & Mr. Tris ↑↑ supportive. → discussed options → begin a mid-day dose of nortrin 100mg. If no improvement will call → see @ end of the week. Does SHH.
	BL

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Patient Name: Edie Jones

Date 10/24/00 Notes Should Be Signed by Physician

10/24/00 12:45h }
Neigman 200/200 } OSE
Prentiss 20 }
"My mind is clear" Grand
about episodic mood reactivity
associated stress. "I can't focus"
↓ executive function
Speech n. Rk under. Phd / APP
Wright Thm, ch. ZAVH OSHIT
Dr. B. p. Nos APP
Ph. S. p. R. C. Lm. Thm
Deep study pen

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Patient Name: Caddie Jones

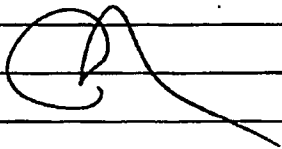
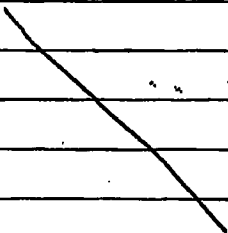
Date	Notes Should Be Signed by Physician	h-224-2669
10/31/00 1743	attempted to call - busy. Temporarily	
11/1/00 1505	phone call - pt reports ↑ anxiety X ↑ work - "I'm going backwards" - dizzy - "passing out" when using inhalers since Monday - P is 130 at rest - easily frustrated - ↑↑ fatigue - sleeping day and night - pt unclear about reporting to pulmonary - "shaking and jerky" - denies fever - easily startled - M.D. please call. "I can't get enough to eat" → labes done 10/30 at Dr. Med - Temporarily	
11/1/00	Phone call - reports ↑↑ anxiety, ↓ changes in moods, ↑ use of inhalers. ↑↑ SOB & ↑ chest pain will try ↑ nebulizer 200/100/200. If no response or ↑ problems, consider ↓ dose ativan. Keep PCU. Call @ 9:00 PM	

Elde Tris

Date	Notes Should Be Signed by Physician
11/5/00	Neurology 200/100/200 } Ø SE Dephase 375 } Prechore 20 } Reports ↑↑ anxiety → ↑ physiologic symptoms. ↑ anger / conflict wife. Speech nt clear & slow Mood anxious & irritable All + level. ⊕ trig. / Ø ALVH Adex-3 Ø S/HI Dr. Biral. NOS S/P TAT Sleep Apn Ceph Ph. ① Ativan 0.5 TID & 0.5hs prn ② Tylenol 100 QID ③ RCT 1-2 week

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
11/27/00	Referred 20 Depressed 3/15 Attn. 5 TIO 4 hrs pm Reports anxiety "Not as much as a issue" ↑↑ stress & marriage "Wife reports that I am very mean... I don't see it" Sleep 7-8 hrs Speech not clear & slow Mood anxious & irritable Affect Content ⊕ tense ADO x3 ØS/HE ↑ Speech Rx: Zolpidem 125 mg qd Sleep Aids CPO Plan ↑ Attn 1 TIO & 1 pm hr RTC 2 week
	
	

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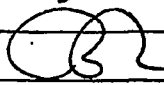
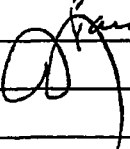
Patient Name: Ellie Jones

Date	Notes Should Be Signed by Physician
12/12/00	Rx: 10 Depakel 375hs Alim. 5 TID + 10 pm } ~~QSG~~ Alim 1 TID } Admex Wife reports ↑ sensitivity to criticism, ↑ irritability, "explodes" ① Conceptional disorganized, looks intensely angry, but "don't feel any" Speech clear. Mood / Affect level 1 Think of ALVIT Adx x 3 @ 5/4/1 Dr. B. per NOS S/P TBI Ph: ① ↓ Alim. 5 TID x 3 days ↓ Alim. 5 BID x 3 days ↓ Alim. 5 Qd x 3 days then stop ② Risperidone 5mg TID Per usual presc ③ RTC 2 wks

OBVIOUS NOTES

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
12/28/00	Risperidone 10mg Depakote 375mg Pt. reports "I feel the same" Wife reports "much better" Still feels anger, but M. control Speech dec. More irritable & Ed. All but anger. Thinking of SHT. EPS. TD Dr. B. N. S. S/P TBI Ph. Add. Risperidone 10mg Q RTC 2-4 hrs 
12/28/00	Phone call: c/o FE distress & general malaise addition of Celexa, "killing his stomach"; otherwise no problems; P. D/C Celexa call Dr. Richards next week to follow-up if another antidepressant indicated 
1/1	

W-41 (Rev. 10/99) Form 1000-1000-1000-1000

PROGRESS NOTES

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Robert W. Richards, M.D.
Vladimir Maletic, M.D.
Laureen J. Noll, M.D.
Edmund C. Parsons, M.D.
Amy E. Jones, M.D.

Lynne E. Furry, LISW
Patricia C. Riordan, LMSW
Lynn C. Parsons, L.P.C.
Keith Mundis, L.P.C.

November 1, 2000

RE: Archie E. Jones — DOB: ~~2-30-1933~~

Please be advised that I have been treating Mr. Jones for Bipolar Disorder and PTSD since January 2000.

This case is very complicated by residual medical difficulties resulting from an industrial accident which rendered Mr. Jones unable to work or participate in previously enjoyed activities.

Therapy has focused on coping skills and anger management. Mr. Jones participates regularly except when his health precludes same. He utilizes therapy to express emotions and prevent relapse of depression.

While it is most difficult to set and attain goals in treatment, therapy has proved useful in limiting crises, emergent visits with Dr. Richards, phone contacts between sessions and by increasing Mr. Jones' awareness of his mood disorder and management thereof. Mr. Jones has not required psychiatric hospitalization during the course of his treatment.

Should you require any additional information, please feel free to contact me.



Patricia Riordan, LMSW

File # [REDACTED]
File

RECEIVED
DEC 15 1999
COLUMBIA SC

Feb 07 01 03:10P

P. 2

DEA # BR3636202

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ROBERT W. RICHARDS, M.D.
9-A CALEDON COURT
GREENVILLE, SC 29615
864-271-5056 FAX: 864-271-8043

NAME Archie Jones DATE 2/5/01

ADDRESS _____

☒ (Please Print) Monthly Update

No change since statement
dated 1/3/01 except
pt has started on low
dose dextrodine for
ADD like symptoms.

☐ LARS
☒ RFA
TIME'S PFA NR

DISPENSE AS WRITTEN

SUBSTITUTION PERMITTED

21-MAR-00

04-100529-025-7-10532_0002

DEA # BR3636202

GREENVILLE PSYCHIATRY, P.A.
ROBERT W. RICHARDS, M.D.
9-A CALEDON COURT
GREENVILLE, SC 29615
864-271-9038 FAX: 864-271-8043

Archie Jones

DATE 1/13/01

(Please Print)

Monthly Update

Patient has started
Risperidone 5mg TID
less than an optimal
response

Patient continues to have
difficulties associated
with medical problems
relating to lungs requiring
steroids which cause
worsening mood
lability

☐ LABS

DISPENSE AS WRITTEN

M.D.

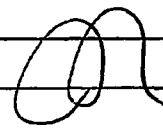
SUBSTITUTION PERMITTED

M.D.

04-106528025-7-14648_8002

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Patient Name: Ellie Jones

Date	Notes Should Be Signed by Physician
1/22/01	Risperidone .5 TID } Out SSN Depakote 375 hr Prozac 15
	Day well. ↓ conflict @ home ↓ rec. thought ↓ anxiety ↓ mood stability. (Cocaine) ↓ ↓ ↓ concentration → ↓ executive ↓ rec. comp. ↓ remember TV → Doc for S, In 7/99 good course. Started 2° m... in the ears LHA - related to doc for
	MSF Speech nt. asked for Mood/Alert bright. Thru cl ALVH AUC x3 5/14
	Dr. Branch Nos AND S/P TBI Re: Retelling doc for S RTC 2week
	

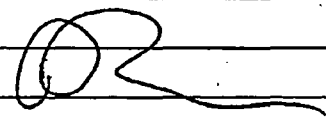
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Patient Name: Eddie Jones

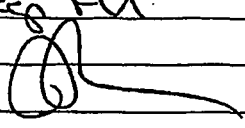
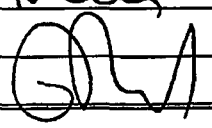
Date	Notes Should Be Signed by Physician
2/6/01	Discharge 5:10 } Out-sun Discharge 3:55 hr } Discharge 10 ① reports ① response. ↓ ADD ↑ active. Speech not clear & clear. Maud/Allyt bright Think clear. ①/4/4 Atox 3 ①/5/4/4 AP No change RTC Galt Call @ 9:00 am GM
2/6/01	Phone call - Reports ↑↑ Rtg "all day" ↑↑ reports ↑↑ pulmonary congestion Stop line @ hr. ① Maud 1st 1st Will ✓ ① pulmonologist or PCP R/O med. R no problems. Call G

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Patient Name: Eddie Jones

Date	Notes Should Be Signed by Physician
3/16/01	Dex 5mg Risperidone .5TID Depakote 300 Prozac 10 15mg (↑ noted) h/h good response to dex 5mg → response ↓ mood ↓ energy ↓ headache top, CHD going Hs had complex med. Wn → no problems Speech in pt & clear. Mnd level All-1 agreed. Think clear & organized. CA/VH ALO x3 (S/HI) Dr. B. get Wgs ADD sp TBT Ph. ↓ disench .25, .25, .5h Watch for ↑ energy & ↓ irritability. Phos / 2 weeks → Keep Rx 2-4ul Caser ↑ Dex 5mg
	

Eddie Tres

Date	Notes Should Be Signed by Physician
3/15/61	Cal. Immutal. "no interest in anything" ~~Answer~~ S/PTBI. Will ↑ dex spm 10 sm. Real usual present. Keep FU 
3/21/61	Dex Spm 10 Risperidol .5710 Depakote 375 Prednisone 10 Reports Regretful sleep → ↑ Irritable "Man" Immutal. Interest in school. "Don't feel like associ- ate people. Speech not good & dead. Moral irritability. Allert told Assoc. trigal & pmon. & S/PTBI Adex-3 & S/PTBI Dex: Risperidol NO3 ADD S/PTBI Phn: ① ~~Colony~~ 12.5 sm he present not real. Real usual present ② R/T 2 weeks, tired ③ ~~loss~~ 

A23931

PROGRESS NOTES