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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

WCC File No. 0717624

Hector G. Fragosa, Employee/Claimant, ... Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier,
..... Respondents.

RECORD ON APPEAL

Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1527 Blanding Street
Post Office Box 50349
Columbia, SC 29250
(803) 779-4000
stephen@samuelslawfirm.net

Michael W. Burkett
WILLSON JONES CARTER & BAXLEY, P.A.
4500 Fort Jackson Boulevard
Columbia, SC 29209
(803) 227-2886
Mwburkett@wjlaw.net

Jeff C. Chandler
CHANDLER LAW FIRM
Bank of America Building
2501 North Oak Street
Myrtle Beach, SC 29577
(843) 448-4357
jeffcchandler@aol.com

ATTORNEY FOR RESPONDENTS

ATTORNEYS FOR APPELLANT

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SC Court of Appeals

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Mwburkett@wjlaw.net

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CHANDLER LAW FIRM
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(843) 448-4357
jeffcchandler@aol.com

ATTORNEY FOR RESPONDENTS

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DECISION AND ORDER OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0717624

Hector G. Fragosa,
Employee,
Claimant,
vs.
Kade Construction, LLC,
Employer,
and
Key Risk Management Services, Inc.,
Carrier,
Defendants.

DECISION AND ORDER

HEARING:

Held in Conway, South Carolina on June 28, 2011.

APPEARANCES:

Claimant represented by Jeffrey C. Chandler,
Esquire of Myrtle Beach, South Carolina.

Defendants represented by Michael W. Burkett,
Esquire of Willson Jones Carter & Baxley, P.A.,
Columbia, South Carolina.

PURPOSE OF HEARING:

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

DECISION AND ORDER:

By: Avery B. Wilkerson, Jr., Commissioner

FILED:

November 21, 2011

I. APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence at the time of the hearing:

Claimant's APA Submissions

- APA #1: Records of MUSC Medical Center, dated 11/1/2007 – 12/1/2007, consisting of pages 1 – 419.
- APA #2: Records of MUSC Therapeutic Services, dated 11/23/2007 – 12/1/2007, consisting of pages 420 – 578.
- APA #3: Records of MUSC Department of Orthopaedic Surgery, dated 11/1/2007 – 12/30/2009, consisting of pages 579 – 651.
- APA #4: Records of MUSC Neurology, dated 10/30/2008 – 11/4/2008, consisting of pages 652 – 655.
- APA #5: Records of MUSC Otolaryngology – Head and Neck Surgery, dated 1/12/2009 – 4/13/2009, consisting of pages 656 – 666.
- APA #6: Records of Strand Regional Specialty Associates, LLC, dated 8/29/2008 – 1/19/2011, consisting of pages 667 – 729.
- APA #7: Records of Atlantic Physical Therapy & Rehabilitation, Inc., dated 12/16/2008 – 8/31/2009, consisting of pages 730 – 844.
- APA Exh. A: Deposition of George M. Sandoz, M.D., dated August 6, 2010, consisting of pages 845 – 867.
- APA Exh. B: Psychological and Vocational Evaluation performed by Robert E. Brabham, MRC, CRC, dated November 2, 2010, consisting of pages 868 – 881.
- APA Exh. C: Letter from Jeffrey C. Chandler to Dr. Sandoz, dated March 10, 2011, consisting of page 882.

II. STIPULATIONS

Counsel for the respective parties stipulated at the time of the hearing to the following issues:

1. The purpose of the hearing is to determine the issues as set forth in the Forms 50

and 51 and any other issues which may timely come before the Commission;

2. The Claimant's accident occurred on November 1, 2007;
3. The Claimant's average weekly wage was \$400.00 with a corresponding compensation rate of \$266.68;
4. Notices were timely and properly served upon all parties of interest;
5. Venue, set in Horry County, is proper as agreed by all parties;
6. The South Carolina Workers' Compensation Commission has jurisdiction over the parties and issues involved;
7. The issues for determination are to what extent, if any, the Claimant is entitled to additional compensation benefits for permanent total disability to the injured body parts, and whether the Claimant sustained a physical brain injury as contemplated by § 42-9-10.

Without objection, the Commission's file was made a part of the record in this matter with the exception of any self-serving declaration or unstipulated medical reports.

III. STATEMENT OF THE CASE

The Claimant contends he sustained a work-related injury to his brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay on November 1, 2007. The Claimant filed a Form 50 on April 8, 2011 requesting compensation for past medical care, future medical treatment, and permanent total disability, and seeking lifetime benefits for physical brain damage.

On April 19, 2011, Defendants timely filed a Form 51 admitting that the Claimant sustained a work injury by accident arising out of or in the course of his employment on November 1, 2007, but denying that the Claimant sustained compensable injuries to the extent alleged in the Claimant's Form 50. Defendants also sought credit for temporary total benefits paid in excess of the award and sought to stop payment of the Claimant's benefits pursuant to the Form 21 filed by the Defendants on March 25, 2011. A hearing was held by the undersigned Commissioner in

Conway, South Carolina on June 28, 2011 to determine the issues raised in the Forms 50, 51 and 21.

It is the Claimant's position in this matter that the Claimant is entitled to additional medical care as a result of his admitted work accident and that he is totally and permanently disabled based on the totality of his injuries. The Claimant also seeks lifetime benefits claiming that he suffered a physical brain injury pursuant to S.C. Code Ann. § 42-9-10.

It is the Defendants' position in this matter that the Claimant is not totally and permanently disabled, and that the Defendants are entitled to stop payment of the Claimant's benefits because the Claimant has reached maximum medical improvement. Defendants contend that the Claimant did not suffer a physical brain injury as defined by S.C. Code Ann. § 42-9-10, and that any alleged injury to the Claimant's brain properly falls under Regulation 67-1101 of the South Carolina Workers' Compensation Commission. The Defendants contend the Claimant is therefore not entitled to lifetime benefits and is not totally and permanently disabled.

IV. EVIDENCE OF THE CASE

The Workers' Compensation Commission's file and Commissioner's notes were made a part of the record of the case.

The Claimant testified at the hearing in this matter, and his testimony allowed the Commissioner to observe the Claimant, to ask questions to the Claimant and to judge the Claimant's credibility as a witness. The Claimant testified that he is thirty (30) years old. The Claimant testified that he is unmarried and has no children, that he was born on October 4, 1980, and that his education background consists of completing middle school in his home country of Mexico. The Claimant testified that he came to the United States in the year of 2002 or 2003, and he speaks very little English. The Claimant's prior work history includes security work, retail sales

and construction. At the hearing, the Claimant described the occurrence of his work injury and the course of his medical treatment. In addition, the Claimant testified regarding his symptoms and the difficulties he still experiences as a result of his injury. The Claimant testified that he has headaches at least once a week and has short term memory problems and dizziness, but he testified that he is still able to drive a car. The Claimant testified that he did not have any brain problems prior to his 2007.

The medical records from the Medical University of South Carolina (MUSC) Medical Center indicate that the Claimant's injuries included subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypotension, a scalp laceration, C7 and T1 spinous process fractures, right rib fractures, bilateral transverse fractures, a right big toe fracture, a right fifth toe fracture, a fracture of the skull, a tracheostomy, an endoscopic gastrostomy and an amputation of the second through the fifth toes of the right foot. A CT scan of the Claimant's head performed on the date of the accident revealed a fracture of the skull with a small extraoccipitoparietal hematoma and the possibility of a small epidural hematoma.

The medical records from MUSC Therapeutic Services indicate that the Claimant was transferred and admitted for physical therapy on November 23, 2007. The Claimant underwent physical therapy for his toe amputation and was discharged home from MUSC Medical Center by Dr. Christian T. Minshall on December 1, 2007.

The Claimant was readmitted to MUSC Medical Center on December 12, 2007 for an infection to the amputation site at the second through fifth toes of his right foot. The Claimant underwent wound dehiscence and was discharged on December 15, 2007. The MUSC records indicate that the Claimant continued to have follow-up visits at MUSC Medical Center until February 8, 2010.

Dr. Christopher Merrell of MUSC Department of Orthopaedic Surgery saw the Claimant on February 4, 2009 and treated the Claimant for pain in his cervical spine. Dr. Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641). Dr. Merrell completed a Form 14B on February 8, 2010 and indicated that the Claimant had sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury and that the Claimant reached maximum medical improvement on December 30, 2009. Id. at 651.

Dr. Shane Wolfe of MUSC Department of Orthopaedic Surgery treated the Claimant from December 1, 2008 until June 29, 2009 for pain in the Claimant's left shoulder and right foot. Dr. Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. Id. at 629. Dr. Wolfe completed a Form 14B on February 24, 2010 in which he indicated the Claimant sustained a one percent (1%) impairment to the left upper extremity and could return to work without restriction. Id. at 649. Dr. Wolfe completed another Form 14B on April 8, 2010 in which he indicated that the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity. Id. at 650. Dr. Wolfe further indicated that the Claimant had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries. Id.

Dr. Wolfe referred the Claimant to Atlantic Physical Therapy & Rehabilitation, Inc. for physical therapy. The Claimant regularly underwent physical therapy for his cervical and left shoulder pain from December 16, 2008 until August 31, 2009. (Claimant's APA #7).

Dr. Mark Wagner, a Clinical Neuropsychologist, saw the Claimant on October 30, 2008

and completed an independent medical evaluation. Dr. Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

Dr. Mark Hoy of MUSC Department of Otolaryngology – Head and Neck Surgery treated the Claimant from December 1, 2008 until April 13, 2009 for ear pain associated with the Claimant's closed head injury. Despite the Claimant's continued complaints of ear pain, Dr. Hoy noted most of the Claimant's tests to be normal and opined in a Form 14B on March 16, 2010 that the Claimant reached maximum medical improvement with regard to his ear pain on April 13, 2009 and that the Claimant would not need future medical care with regard to his ear pain. (Claimant's APA #5, pg. 666). Dr. Hoy did not give the Claimant any impairment rating in the Form 14B, but placed a question mark ("??") in the blank space where the impairment rating is to be written. Id.

Dr. George M. Sandoz of Strand Regional Specialty Associates, LLC initially treated the Claimant for dizziness and headaches from August 29, 2008 to August 12, 2009. Dr. Sandoz also noted that the Claimant had some damage to his right inner ear which had caused some loss of hearing and mastoiditis. (Deposition of George M. Sandoz, Claimant's APA Exhibit A, pg. 852-853, pg. 865-866). Dr. Sandoz described mastoiditis as an inflammation of the mastoid, which is a part of the skull, not of the brain. Id. at 865-866. On August 20, 2009, Dr. Sandoz drafted a letter stating that the Claimant had a forty-six percent (46%) impairment to the whole body for a traumatic brain injury. (Claimant's APA #6, pg. 716). Dr. Sandoz went on to state in this letter that the Claimant is totally and permanently disabled. Id. Dr. Sandoz reaffirmed this position in his August 6, 2010 deposition, stating that the Claimant is not able to return to any kind of former

employment due to an inability to follow commands and to the inner ear injury which causes the Claimant to be unsteady and dizzy. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, pg. 863). Dr. Sandoz also stated in his deposition that the Claimant suffered some damage and injury to the function of the brain. Id. at 859.

Despite Dr. Sandoz's opinion that the Claimant suffered a traumatic brain injury, Dr. Sandoz stated at his deposition that "There's no evidence of any damage on the brain that we can go and see." Id. at 859. The Claimant's medical record is void of any neurological medical treatment from August 12, 2009 through August 6, 2010, the date of Dr. Sandoz's deposition. Dr. Sandoz did not treat the Claimant from August 12, 2009 until November 12, 2010. Despite the Claimant's lack of treatment for over a year and Dr. Sandoz's statement that there was no visible physical damage to the Claimant's brain, Dr. Sandoz concluded the Claimant was totally and permanently disabled on account of a physical brain injury in a letter dated March 17, 2011. (Claimant's APA Exhibit C, pg. 882). This letter was sent by the Claimant's attorney to Dr. Sandoz with the option of circling either "YES" or "NO" with respect to the Claimant's suffering a physical brain injury which renders him totally and permanently disabled. Id.

The Claimant was seen on October 27, 2010 for a Psychological and Vocational Evaluation by Robert E. Brabham, MRC, CRC. In Dr. Brabham's November 2, 2010 report, he concluded that the Claimant has a physical brain injury and must be expected to permanently remain unable to engage in full-time gainful employment. (Claimant's APA Exhibit B). Dr. Brabham diagnosed the Claimant with cognitive disorder secondary to "(physical) traumatic brain injury." Id. at 879. Dr. Brabham further concluded that the Claimant's brain injury and restrictions were the result of his November 1, 2007 work-related injury.

A record such as was necessary for a decision was made of the proceeding and after careful

consideration and study of all the evidence, the following findings of fact are accordingly made.

V. FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.
2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was \$400.00, with an applicable compensation rate was \$266.68.
3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.
4. That this is a closed head injury.
5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.
6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his February 8, 2010 Form 14B.
7. That the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a

combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis

“and that’s why he’s dizzy.” (Deposition of George M. Sandoz, M.D., Claimant’s APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant’s toe amputation. (Claimant’s APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant’s left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant’s APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant’s behalf.

18. That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers’ Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply.

VI. CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant’s multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers’

Compensation Act.

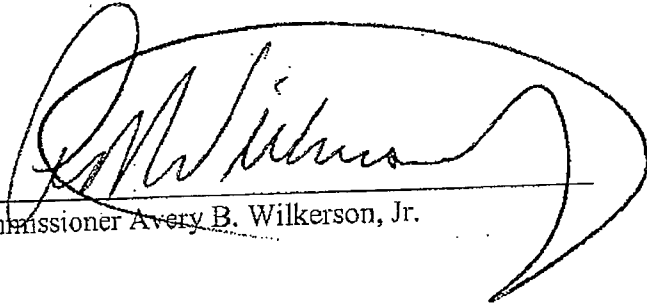
VII. ORDER/AWARD

IT IS HEREBY ORDERED that the Defendants shall pay the Claimant compensation benefits for permanent total disability as set forth in the Conclusions of Law above.

IT IS SO ORDERED.

ORDER REQUESTED ON JULY 20, 2011.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

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

November 21, 2011

By: Elaine Boyd, Administrative Assistant to Commissioner Wilkerson

**APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 0717624**

Hector G. Fragosa,
Employee/Claimant,
Appellant

vs.

Kade Construction, LLC
Employer,

and

Key Risk Management Services, Inc.,
Carrier,
Defendants,
Respondents.

Appellate Panel Review held in Columbia, South Carolina on March 19, 2012 per
Notices timely and properly served on all parties of interest.

Appellate Panel Decision and Order filed 5/23, 2012.

Appearances: Claimant/Appellant represented by Stephen B. Samuels, Esquire, of the
Samuels Law Firm, 1527 Blanding Street, Columbia, SC 29201

Defendants/Respondents represented by Michael W. Burkett, Esquire, of
Willson, Jones, Carter & Baxley, 4500 Ft. Jackson Blvd., Columbia, SC
29209.

STATEMENT OF THE CASE

The parties were heard by Commissioner Avery B. Wilkerson on June 28, 2011 in Conway, South Carolina. As a result of said hearing, Commissioner Wilkerson issued an Order dated November 21, 2011, from which the Claimant appealed.

The Hearing Commissioner's Decision and Order set forth the following Findings of Fact:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.

2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was \$400.00, with an applicable compensation rate was \$266.68.

3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.

4. That this is a closed head injury.

5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.

6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his

February 8, 2010 Form 14B.

7. That the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis, "and that's why he's dizzy." (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. (Claimant's APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant's behalf.

18. That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply.

The Hearing Commissioner's Decision and Order also set forth the following Conclusions of Law:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

Within the statutory period, counsel for the Claimant filed an Application for Review in the case setting forth the following assignments of error:

1. Whether the Single Commissioner erred as a matter of fact and law in finding: "That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply."
2. Whether the Single Commissioner erred as a matter of fact and law in finding that a neuropsychologist was qualified to give an opinion as to whether "functional studies, such as EEGs, CTs and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury'" when a neuropsychologist's expertise does not extend to reading and interpreting EEGs, CTs and MRIs.
3. Whether the Single Commissioner erred as a matter of fact and law in arbitrarily disregarding the unrefuted expert medical opinion of Dr. Sandoz that Claimant had suffered a physical brain injury.
4. Whether the Single Commissioner erred as a matter of fact and law in giving any weight to Dr. Wagner's opinion where the opinion was not stated to a reasonable degree of medical certainty.
5. Whether the Single Commissioner erred as a matter of law in failing to make specific and detailed findings of fact sufficient for appellate review.
6. Whether the Single Commissioner erred as a matter of fact and law in failing to award lifetime compensation to Claimant in that he was totally disabled and had suffered physical brain injury.

Copies of the above assignments of error were furnished to all interested parties prior to oral argument presented before the Appellate Panel on March 19, 2012.

Pursuant to S.C. Code Ann. § 42-17-50 (1985), the Appellate Panel reviewed the Award and weighed the evidence in the record as presented at the initial hearing. The Panel also

considered all issues raised in the brief of the Appellant and Respondents. The Panel makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.
2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was \$400.00, with an applicable compensation rate was \$266.68.
3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.
4. That this is a closed head injury.
5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.
6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his February 8, 2010 Form 14B.
7. That the Claimant sustained a forty percent (40%) impairment rating to the right

lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, we find that the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CT's and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis "and that's why he's dizzy." (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. (Claimant's APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant's behalf.

18. That, based on the greater weight of the evidence, we find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10, and physical brain damage does not apply.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-50, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain

injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

After careful review in the present case, the Appellate Panel of the South Carolina Workers' Compensation Commission has determined the Order of the Hearing Commissioner is hereby AFFIRMED IN FULL. The Findings of Fact and Conclusions of Law found in the Hearing Commissioner's Decision and Order, and as specified above, are hereby AFFIRMED IN FULL.

ORDER

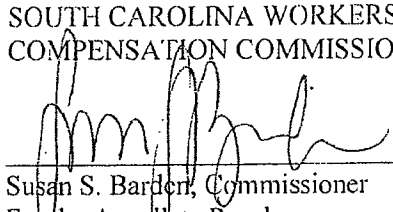
IT IS HEREBY ORDERED that the Order of the Single Commissioner from which this appeal has been taken is hereby AFFIRMED IN FULL.

IT IS AFFIRMED that the Defendants shall pay the Claimant compensation benefits for permanent total disability as set forth in the Conclusions of Law above.

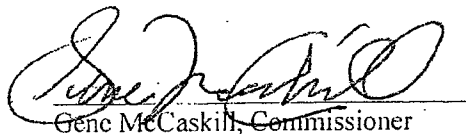
IT IS AFFIRMED that the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

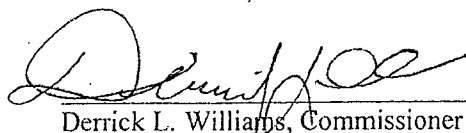
IT IS SO ORDERED.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION


Susan S. Barden, Commissioner
For the Appellate Panel

Concur:


Gene McCaskill, Commissioner


Derrick L. Williams, Commissioner

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 State mail addressed to the attorney or attorneys for said parties.

This 23 day of May, 2012
By Valerie D. Decker

Administrative Assistant to the Commissioner

Michael W. Burkett
Jeff C. Chandler
Stephen B. Samuels



Claimant's Name: Hector G. Fragosa SSN: _____ Employer's Name: Kade Construction, LLC
Address: [REDACTED] Address: 1607 James Island Ave. N.
City: Myrtle Beach State: SC Zip: 29577 City: N. Myrtle Beach State: SC Zip: 29582
Home Phone: () - Work Phone: () - Insurance Carrier: Key Risk Management Services
Preparer's Name: Stephen B. Samuels Law Firm: Samuels Law Firm Preparer's Phone #: (803) 779 - 4000

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☒ claimant ☐ employer (check one) Date of injury: 11/01/2007 (m/d/yyyy)

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).

Please see Attachment to Form 30.

(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 Michael W. Burkett, Esquire, Willson Jones
Name

Carter & Baxley, P.A., 4500 Fort Jackson Boulevard, Columbia, South Carolina 29209
Address

on the 5th day of December, 2011 by ☒ first class mail ☐ personal service ☐ certified mail.

[Signature]
Preparer's Signature

Attorney for Claimant
Title

December 5, 2011
Date

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.

ATTACHMENT TO FORM 30

Hector G. Fragosa, Employee, vs. Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier.

WCC FILE NO. 0717624

Grounds of Appeal:

1. Whether the Single Commissioner erred as a matter of fact and law in finding: "That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply."
2. Whether the Single Commissioner erred as a matter of fact and law in finding that a neuropsychologist was qualified to give an opinion as to whether "functional studies, such as EEGs, CTs and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury'" when a neuropsychologist's expertise does not extend to reading and interpreting EEGs, CTs and MRIs.
3. Whether the Single Commissioner erred as a matter of fact and law in arbitrarily disregarding the unrefuted expert medical opinion of Dr. Sandoz that Claimant had suffered a physical brain injury.
4. Whether the Single Commissioner erred as a matter of fact and law in giving any weight to Dr. Wagner's opinion when the opinion was not stated to a reasonable degree of medical certainty.
5. Whether the Single Commissioner erred as a matter of law in failing to make specific and detailed findings of fact sufficient for appellate review.
6. Whether the Single Commissioner erred as a matter of fact and law in failing to award lifetime compensation to Claimant in that he was totally disabled and had suffered physical brain injury.



WCC File #: 717624
Carrier File #: 1000021953
Carrier Code #: Unassigned
Employer FEIN #: Unassigned

Claimant's Name: Hector Gomez Fragoso SSN: _____
Address: _____
City: Myrtle Beach State: SC Zip: 29577
Home Phone: _____ Work Phone: () -
Preparer's Name: Jeff Chandler Law Firm: Chandler Law Firm

Employer's Name: Kade Construction, LLC
Address: 1607 James Island Ave, N.
City: N. Myrtle Beach State: SC Zip: 29582
Insurance Carrier: Key Risk Insurance Company
Preparer's Phone #: (843) 448 - 4357

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 workers' compensation benefits is made based on the following grounds:

Date of Injury or Illness: 11-01-07

☒ Injury ☐ Illness ☐ Repetitive Trauma

- 1a. The claimant sustained an injury to Brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay on 11-01-2007 in Marion county, state of South Carolina.
1b. Body part(s) affected are: Brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, and psychological overlay.
Briefly describe how the accident occurred. Claimant sustained injury when a roof truss being carried by a crane snapped in half and fell on top of the Claimant.
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 11-01-07 in the following manner: Verbally

☒ 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: Claimant will require lifetime medical care to control his disability.

☒ 7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:
From the date of injury until returning to full duty.

☒ 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

☒ (3) Wage Loss

☒ Partial

☒ Partial

☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

Amputation of 2nd through 5th toes on claimant's right foot and scalp scar.

10a. At the time of the injury, the Claimant was paid weekly wages of \$400.00, and demands accounting of days worked and wages earned as provided by law. From the date of injury until returning to full duty.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

11a. Further grounds or unusual aspects of claim: Any and all grounds available under the Act including proration of lump sum Award when deemed necessary under James v Anne's Inc. Additionally, this is a lifetime brain damage case.

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: MUSC-- 171 Ashley Ave. Charleston, SC 29425. Strand Regional Specialty Associates -- 8170 Rourke Street Myrtle Beach, SC 29572 -- Atlantic Physical Therapy -- 3650 Coalition Drive, Myrtle Beach, SC 29578

11c. To the best of your knowledge, did you have any prior permanent disability?
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.

☒ 13b. I am requesting a hearing. A \$25 fee is required.

☐ 14. Estimated time needed for hearing: 60-90 minutes as my clients requires the use of a translator.

I verify the contents of this form are accurate and true to the best of my knowledge.

Attorney for the Plaintiff

Title

Jeffchandler@aol.com

Email

04-08-2011

Date

Preparer's Signature

Refer to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

WCC Form # 50

Revised 9/07

South Carolina Workers' Compensation Commission

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

WCC File # 0717624

Carrier File # 1000021953

Carrier Code #

Employer FEIN

Hector G. Fragosa

Claimant's Name

SSN

Address

City

State

Zip

Home Phone

Work Phone

Michael W. Burkett

Preparer's Name

Kade Construction, LLC

Employer's Name

1607 James Island Ave N, N. Myrtle Beach, SC 29582

Address

City

State

Zip

Key Risk Management Services, Inc.

Insurance Carrier

(803) 227-2886

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:

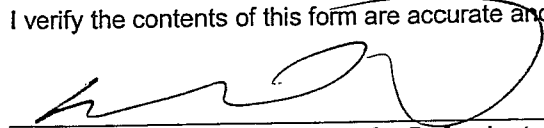
1. It is (admitted) (denied) that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: It is admitted the Claimant sustained a work injury on the date alleged; however, it is denied he sustained compensable injuries to the extent alleged in the Form 50.
2. It is (admitted) (denied) that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See number 1 above.
3. It is (admitted) (denied) that the relationship of employer and employee existed at the time in question. The reasons for denial are: See number 1 above.
4. It is (admitted) (denied) 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: See number 1 above.
5. It is (admitted) (denied) that notice of injury was given the employer. The reasons for denial are: See number 1 above.
6. It is (admitted) (denied) that the employee needs or is entitled to additional medical care as a result of injury. The reasons for denial are: See number 1 above. Claimant has reached maximum medical improvement and no further medical care will tend to lessen any period of disability.
7. It is (admitted) (denied) that the employee is entitled to temporary total disability for the period(s) of: See numbers 1 and 6 above.
8. It is (admitted) (denied) that the employee is permanently disabled. The reasons for denial are: See numbers 1, 6, and 7 above.
9. It is (admitted) (denied) that the employee has a serious disfigurement. See numbers 1, 6, 7 and 8 above.
10. It is contended that an average weekly wage of \$ 400.00 applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: Defendants reserve the right to amend and to assert defenses as they become aware of them.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Jeffrey C. Chandler, Esquire,
Name

PO Drawer 1889, Myrtle Beach, SC 29578-1889 and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202
Address

on the 19th day of April, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

I verify the contents of this form are accurate and true to the best of my knowledge.


Preparer's Signature, Attorney for Defendants

Michael W. Burkett

Willson Jones Carter & Baxley, P.A.

4500 Fort Jackson Boulevard

Columbia, SC 29209


Kellie J. Bobo, Certifier

April 19, 2011

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.



Claimant's Name: Hector Fragoso
Address: [REDACTED]
City: Myrtle Beach State: SC Zip: 29577
Home Phone: (843) 241-8478 Work Phone: ()
Preparer's Name: Jeff Chandler

Employer's Name: Kade Construction, LLC
Address: 1607 James Island Ave N
City: N. Myrtle Beach State: SC Zip: 29582
Carrier: Key Risk Management Services, Inc.
Preparer's Phone #: (803) 227-2886

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$266.68 2. AWW: \$400.00 Date of Injury: 11/01/07
3. Type of injury and body part(s): Brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay.
4. Facts in controversy: 1.) Claimant contends that he is entitled to lifetime benefits under 42-9-10 as a result of the physical brain damage that has rendered him totally and permanently disabled.
5. Legal issues involved: 42-9-10; 42-9-20; 42-9-30; 42-15-60; 42-9-301; 67-1101
6. Unusual aspects: Claimant will require a translator for testimony.
7. Witnesses (designate if expert):* Claimant
8. Exhibits: Deposition Transcript of Dr. George Sandoz-- Psychological and Vocational evaluation--
Medical Questionnaire from Dr. George Sandoz.
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance):
See attached Notice of APA Submissions.
10. Name, address, and specialty, if any, of the treating physician: Dr. George Sandoz - 8171 Rourk Street Myrtle Beach, SC 29572
Neurologist.
11. Impairment rating(s); body part(s); physician and date of opinion: Claimant was assigned a 1% impairment rating to his left shoulder by Dr. Shane Wolfe on 02-24-2010, 40% to the right lower extremity by Dr. Shane Wolfe on 04-08-2010, 11% to the cervical spine by Dr. Christopher Merrill on 02-28-10, and was assigned a 46% whole person rating by Dr. George Sandoz on 08-20-2009.
12. I am amending my Form 50/51 in the following manner: Hearing loss for Right Ear due to Mastoiditis.

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature: [Signature]

Email: Jeffcandler@aol.com

Date of hearing: 05/11/11

Time needed for hearing: 1 Hour

On behalf of ☒ Claimant ☐ Employer

STATE OF SOUTH CAROLINA)

COUNTY OF HORRY)

HECTOR GOMEZ FRAGOSO,)

Employee/Claimant,)

vs.)

KADE CONSTRUCTION,)

Employer,)

KEY RISK INSURANCE COMPANY,)

Carrier.)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION
COMMISSION

W.C.C. FILE NUMBER: 0717624

TRIAL BRIEF
(SYNOPSIS OF CONTESTED ISSUES)

Total and Permanent Disability

The Claimant alleges that he is totally and permanently disabled based on the following:

(1) 46% impairment to the whole body for traumatic brain injury with associated dizziness and headaches. "He is totally and permanently disabled" by Dr. George Sandoz (APA #6, p. 716).

(2) Dr. Sandoz testified in his deposition:

QUESTION: Based on the condition that he has now and the limitation that he has, do you believe that he can return to any kind of former construction related employment?

ANSWER: "No, I don't think he will be able to. The reason being is because - - not only because of the traumatic injury, I don't think he's able to follow any type of commands, but the most significant change is the inner ear injury that he suffered which is making him unsteady."

(Deposition of Dr. Sandoz, Exhibit A, p. 8)

(3) 11% Whole Person impairment related to cervical spine by Dr. Christopher Merrell.

(APA #3, P. 651)

(4) 40% Right Lower Extremity impairment and 1% Left Shoulder impairment by Dr.

Shane Wolfe. (APA #3, p. 650)

(5) Right Inner Ear Damage – Loss of Hearing and Mastoiditis. (Deposition of Dr. George

Sandoz, p. 7-8, p. 20-21)

(6) MUSC Discharge Summary

Discharge Diagnosis(es):

- 1.) Subdural and Epidural Hematomas
- 2.) Bilateral Frontal Contusions
- 3.) Respiratory Failure
- 4.) Hypotension that was treated with intravenous fluid
- 5.) Scalp laceration with large complex, status post repair
- 6.) C7 and T1 spinous process fractures
- 7.) Right rib fractures which included 7, 8, 9, 10
- 8.) Bilateral transverse process fractures of L1 and L2, Right L3
- 9.) Right big toe fracture
- 10.) Right fifth toe fracture
- 11.) Fracture of skull. Midline to sagittal through frontal and parietal
- 12.) Placement of percutaneous endoscopic gastrostomy
- 13.) Tracheostomy
- 14.) Status post amputation of 2nd through 5th toes

(APA #1, p. 417-419)

(7) Dr. Robert E. Brabham concludes that Mr. Fragoso has a physical brain injury and must be expected to permanently remain, unable to engage in full-time gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in November 2007. (APA Exhibit B)

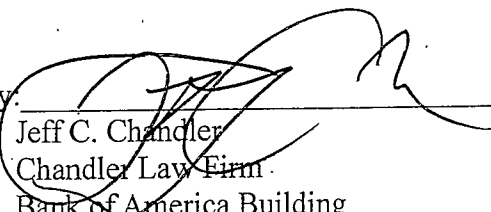
Lifetime Benefits for Physical Brain Damage

The Claimant is seeking an award of lifetime weekly benefits, because he is totally and permanently disabled and has suffered physical brain damage based on the following:

(1) Dr. George Sandoz, the authorized treating Neurologist, says on a questionnaire that Mr.

Fragoso has suffered physical brain damage that has rendered him totally and permanently disabled. He issued this opinion to a reasonable degree of medical certainty. (APA Exhibit C, p. 882)

- (2) In his deposition, Dr. Sandoz stated clearly and unequivocally that the Claimant sustained an injury to the brain and not a concussion. He stated, "There's been some damage and injury to the function of the brain." (Deposition of Dr. Sandoz, Exhibit A, p. 14)
- (3) The Defendants' IME Neuropsychologist, Dr. Mark Wagner, determined that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain. (APA #4, p. 655)
- (4) CT Head/Brain (APA #1, p. 655)
- (5) Dr. Brabham, in his psychological and vocational evaluation, diagnosed "cognitive disorder, secondary to (physical) traumatic brain injury. (APA Exhibit B, p. 12)

By: 

Jeff C. Chandler

Chandler Law Firm

Bank of America Building

2501 Oak Street

Myrtle Beach, South Carolina 29578

(843)448-4357

STATE OF SOUTH CAROLINA)
COUNTY OF RICHLAND)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION

Hector G. Fragosa,)
Claimant/Appellant,)

WCC FILE NO. 0717624

-vs-

BRIEF OF CLAIMANT/APPELLANT

Kade Construction, LLC,)
Employer,)

and)

Key Risk Management Services, Inc.,)

Carrier,)
Defendants/Respondents.)

The Claimant, by and through his undersigned attorney, hereby submits his Appellant's Brief to the Full Commission.

ISSUES ON APPEAL

1. Whether the Single Commissioner erred as a matter of fact and law in finding: "That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply."
2. Whether the Single Commissioner erred as a matter of fact and law in finding that a neuropsychologist was qualified to give an opinion as to whether "functional studies, such as EEGs, CTs and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury'" when a neuropsychologist's expertise does not extend to reading and interpreting EEGs, CTs and MRIs.
3. Whether the Single Commissioner erred as a matter of fact and law in arbitrarily disregarding the unrefuted expert medical opinion of Dr. Sandoz

that Claimant had suffered a physical brain injury.

4. Whether the Single Commissioner erred as a matter of fact and law in giving any weight to Dr. Wagner's opinion when the opinion was not stated to a reasonable degree of medical certainty.
5. Whether the Single Commissioner erred as a matter of law in failing to make specific and detailed findings of fact sufficient for appellate review.
6. Whether the Single Commissioner erred as a matter of fact and law in failing to award lifetime compensation to Claimant in that he was totally disabled and had suffered physical brain injury.

STATEMENT OF THE CASE

This is an appeal from a hearing set on both the Form 21 and Form 50. The primary issue in dispute was whether the Hector Fragoso, the Claimant, was permanently and totally disabled with physical brain damage. The Single Commissioner erroneously held Fragoso, "has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act." He found "Under 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled."

Fragoso is 30 years old and originally from Mexico where he obtained the equivalent of a middle school education. He does not speak English and testified through a Spanish interpreter.

On November 1, 2007, Fragoso was working on a construction project for the Employer in Marion, South Carolina. Fragoso was on the roof of a garage. He was hit in the head with part of a construction crane which fell onto him knocking him off the roof and onto the ground.

He was transported to MUSC by helicopter. Fragoso was hospitalized for one month following his accident – the first two weeks of which he was in a coma. He has no memory of the

accident.

Fragoso suffered numerous injuries, to wit (drawn from the discharge summary at MUSC):

1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. CT and T1 spinous process fractures.
7. Right rib fractures which include 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.
10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes. [APA p. 591].

The specific diagnoses related to his traumatic brain injury are (1) skull fracture; (2) open complex scalp wound with epidural and subdural hematoma; and (3) bilateral frontal contusions. [APA 653].

The Employer accepted Fragoso's claim and began providing benefits, including treatment from a neurologist, Dr. George Sandoz. Dr. Sandoz made numerous statements throughout his medical records confirming the physical brain injury.

On October 10, 2008 – nearly a year after the accident – Fragosa presented to Dr. Sandoz “with the complaint of dizziness [and] spells that suggest that the patient is having seizures . . . From the evidence of the brain, this was reviewed by me and it suggest that there is a **right temporal lobe injury**. [APA p. 693 (emphasis added)]

Several weeks later on October 24, 2008, Dr. Sandoz reported, “This has been worked up and has shown no evidence of any seizure and nor any evidence of any damage of the brain. **Despite**

that review of the MRI shows some mild abnormality in the temporal lobe. [APA p. 696 (emphasis added)].

On November 25, 2008, Dr. Sandoz noted, "The patient is a very complex white male who appears to have **traumatic brain injury**." [APA p. 699 (emphasis added)].

On January 6, 2009, Dr. Sandoz recorded, "The patient presented here status **post work-related injury where he had a traumatic brain injury** with the description that the patient suffer. At this moment, the **headaches appear to be chronic, posttraumatic in nature**. [APA p. 701 (emphasis added)].

Six months later on June 2, 2009, Doctor Sandoz continued with the diagnosis of: "**Intracranial injury** of other and unspecified nature." [APA p. 710]. The next day he wrote a letter confirming the brain injury and assigning a 20% impairment rating per the 6th Edition of the AMA Guide: "seen by MUSC Orthopaedics for cervical and lumbar injury as well for a **traumatic brain injury**. . . . From the traumatic brain injury, the patient's impairment rating is of 20% as noted on the table 13-8." [APA p. 711].

On a followup visit on July 7, 2009, Dr. Sandoz noted the specific problems resulting from the brain injury: "The patient is a 28-year old male with traumatic brain injury, headache, dizziness, difficulty with complex tasks." [APA p. 713].

On August 20, 2009, Dr. Sandoz wrote a detailed explanation of Fragoso's impairment and total disability as it relates specifically to the brain injury:

Mr. Fragoso is a patient of mine who I have seen since 09/16/2008 secondary to a **traumatic brain injury** on 11/01/2007. He ____ for a **traumatic brain injury**. **At this moment from the injury that the patient has suffered, he is totally and permanently disabled**. After evaluation of the AMA Guidelines, he is totally and permanently disabled. After the evaluation of the AMA Guidelines, Guides to

Evaluation of the Permanent Impairment Rating, fifth edition as in table 13-5, the patient has 29% of the whole person. Superimposed to this is associated with the headaches that the patient has presented and this correlates to 2% impairment of the whole body. From the standpoint of the dizziness, the patient has 10% impairment of the whole person. Utilizing a combined value chart, this is a 46% impairment of the whole body. This does not attend to the damage that the patient has suffered from his neck and back as well for his foot. [APA p. 716 (emphasis added)]

Table 13-5 is the chart for "Clinical Dementia Rating." [AMA Guides to Permanent Impairment (5th Edition), page 320. The 29% whole person rating for the brain injury reflects an "impairment [which] requires direction of some activities of daily living." Id.

Dr. Sandoz was deposed on August 6, 2010. He confirmed, "This is not a concussion, this is an injury suffered to the brain. . . . That's why traumatic brain injury is the preferred term. . . . [The difference is the] concussion should resolve. . . . [we call it a traumatic brain injury "Because there's been some damage and injury to the function of the brain." [George Sandoz, M.D., dep. Tr. Page 14, lines 12-24].

On March 10, 2011, Dr. Sandoz removed all doubt regarding his opinions by answering "YES" to the question "to a reasonable degree of medical certainty whether Mr. Fragoso has suffered physical brain damage that has rendered him totally and permanently disabled." [APA p. 882].

Defense counsel arranged an IME with Dr. Mark Wagner, a neuropsychologist. The evaluation took place on October 30, 2008. Dr. Wagner's report is replete with observations of physical brain injury – both the fact of the physical brain injury and the cognitive deficits resulting from that injury. He notes:

[Mr. Fragosa] had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the brain. . . . He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive

syndrome.¹ The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. [APA p. 614].

Included in the above description was the incidental statement that: "Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury." [APA p. 614].

The Single Commissioner issued an Order on November 21, 2011, ordering "that the Defendants shall pay the Claimant compensation benefits for permanent total disability as set forth in the Conclusions of Law above." [Order, p. 12]. The Commissioner essentially added up all the impairment ratings from Fragosa's multiple injuries, found they exceeded 500 weeks, and therefore ordered 500 weeks compensation to be paid. He made no findings regarding post-MMI medical treatment.

The Single Commissioner erroneously held Fragoso, "has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act." He found as a fact that "based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under 42-9-30 and 42-9-10 and physical brain damage does not apply."

This appeal followed.

¹Post-concussion syndrome is a set of symptoms that a person may experience for weeks, months, or occasionally up to a year or more after a concussion—a mild form of traumatic brain injury. The condition can cause a variety of symptoms: physical, such as headache; cognitive, such as difficulty concentrating; and emotional and behavioral, such as irritability. Continuing symptoms confirm the presence of physical brain damage.

ARGUMENT

1. The evidence overwhelmingly supports a finding that Fragosa suffered physical brain damage.

Hector Fragosa was hit in the head with a crane which knocked him off a roof onto the ground. He suffered a skull fracture with subdural and epidural hematomas along with frontal lobe contusions – all of which were confirmed with MRI and CT scans. He remained in a coma for 15 days following his accident.² Since then, he has suffered from proven cognitive deficits, balance problems, dizziness, seizures, and difficulty with complex tasks. Both his treating neurologist and the Defendants' neuropsychological IME confirm the permanency of the cognitive deficits. The authorized treating neurologist has repeatedly and explicitly stated to a reasonable degree of medical certainty that Fragosa is permanently and totally disabled due to physical brain injury.

Despite the overwhelming evidence, the Single Commissioner found as a fact that “based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers’ Compensation Act.” The Order never goes into any specifics as to what evidence he might have been relying on. The only finding of fact which could even remotely support such a conclusion is Finding of Fact 12: “That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable ‘demonstrating structural resolution of the work-related injury.’” [Order, page 10].

²The CDC developed a definition of traumatic injury for the Department of Defense and Veterans Administration. Under the CDC’s definition, a loss of consciousness longer than 24 hours is classified as a *severe* traumatic brain injury. See Department of Defense and Department of Veterans Affairs (2008). “Traumatic Brain Injury Task Force” <http://www.cdc.gov/nchs/data/icd9/Sep08TBI.pdf>

This isolated statement in Dr. Wagner's report is *not* evidence that Fragosa did not suffer physical brain damage. Dr. Wagner himself confirms the presence and effect of the physical brain damage in the very same paragraph of his report, noting:

[Mr. Fragosa] had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the brain. Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury. He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive syndrome. The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. [APA p. 614].

While Dr. Wagner remains true to his reputation as an exceptionally conservative neuropsychologist by minimizing the sequelae of the brain injury, his report consistently notes the "persisting cognitive complaints" and "abnormal findings" shown by neuropsychological testing.

Dr. Wagner is a neuropsychologist. Neuropsychologists are qualified to testify as experts on physical brain damage *as shown* by neuropsychological testing. In this case, Dr. Wagner's testing confirmed the existence of cognitive deficits due to "structural change to the brain." The comment about the imaging studies "demonstrating structural resolution of the work-related injury" is not an opinion about physical brain damage, nor could it be as Dr. Wagner is not qualified to interpret or opine on imaging studies. Dr. Wagner never explicitly opined on physical brain damage one way or the other (nor did he ever state his opinions to a reasonable degree of medical or neuropsychological certainty). The only inference which can be drawn from his report is that Fragosa suffers persistent cognitive deficits due to the brain injury.

The doctor who is qualified to interpret and opine on imaging studies is Dr. Sandoz, the

authorized treating neurologist. Throughout his reports, Dr. Sandoz opined Sandoz had suffered physical brain damage. He assigned a 46% whole person impairment rating under the 5th Edition of the AMA Guides and a 20% whole person impairment under the 6th Edition. These ratings were strictly for the damage to the brain.³

The Defendants argument is that the hematomas shown on the CT scans have resolved. Defense counsel used the analogy of "Well, I hit my arm at my house the other day and I have a hematoma on my arm and it is going to resolve." [Tr. page 20, lines 10-15]. This is an interesting analogy – and it would have some superficial appeal if Fragosa's brain (like counsel's arm) had fully healed with no residual deficits. Tragically, it did not. Counsel retains full use of his arm; Hector Fragosa lost as much as 46% of the use of his brain.

Dr. Sandoz explained the distinction in his deposition testimony:

- Q. Now, we've arrived at this because of what you called traumatic brain injury, correct?
- A. That's correct.
- Q. As far as physical findings on his brain, if you were to look at scans, is it fair to say there is no physical damage to the brain *that we can see*; is that right?
- A. There's no evidence of any damage on the brain *that we can go and see*, that's correct.
- Q. Okay. So what we're dealing with here are these – the traumatic brain injury, and sometimes I like to call it because I don't know what else to call it, but I see it often, is the post concussive syndrome –
- A. Got it.
- Q. Injury suffered to the brain.
- A. That's why traumatic brain injury is the preferred term.
- Q. What's the difference between the jar that a brain takes in a concussion and what he may have had?
- A. The concussion should resolve.
- Q. Okay. So we're looking at – so we call it traumatic brain injury because it's a longer period of time?
- A. Because there's been some damage and injury to the function of the brain,

³Fragosa's other doctors assigned ratings of 11% to the spine (Dr. Merrell), 1% to the left shoulder (Dr. Wolfe), and 40% to the right foot (Dr. Wolfe).

[George Sandoz, M.D., dep. Tr. Page 13, line 21-page 14, line 24 (emphasis added)].

Hematomas are like tsunamis. The blood is absorbed back into the body, just as the tidal wave retreats back to the ocean. But just like a tsunami, the hematoma leaves destruction in its wake. The tidal wave is gone – you can no longer see it – the damage remains.

It is not at all unusual for a physical brain injury not to be visible on conventional CT and MRI scans - even once the initial bleed reabsorbs. Most brain injuries involve widespread microscopic damage to neurons and axons within the cerebrum. To actually see it, more sophisticated imaging is required – such as PET scans and 3.0 Tesla MRI scans. Otherwise, the evidence of physical brain injury is shown by evidence of continuing symptoms and functional deficits – all of which were confirmed here by Drs. Wagner and Sandoz.

The question and answer relied on by Defendants had a qualifier. Counsel did not ask Dr. Sandoz *whether* Fragosa had suffered physical damage to his brain; counsel asked *if you could see* any evidence of physical damage to the brain on the later MRI and CT scans. [George Sandoz, M.D., dep. Tr. Page 13, line 24-page 14, line 4]. When Dr. Sandoz was asked the ultimate question, he confirmed that it was his opinion to a reasonable degree of medical certainty that Fragosa is permanently and totally disabled due to physical brain injury. [APA p. 882]. The opinion of Dr. Sandoz is the sole statement on physical brain damage tendered by an expert qualified to give such an opinion.

As the evidence of physical brain damage is overwhelming, the Appellate Panel should reverse the Single Commissioner and find as a fact that Fragosa suffered physical brain damage. As such, he is entitled to lifetime compensation and medical treatment.

2. **The IME Report from Dr. Wagner cannot be used to support a finding of no physical brain damage as a neuropsychologist is not qualified to give an opinion based on imaging studies.**

The Single Commissioner's reliance on Dr. Wagner's statement regarding imaging studies having been read as unremarkable is legal error. Dr. Wagner never rendered an opinion – or “concluded” as the Order puts it – that Fragosa had not suffered physical brain damage or even that the brain damage had somehow been cured with no deficits. At most, he merely commented that the later imaging studies were read as unremarkable.

As a neuropsychologist, Dr. Wagner is qualified to give an opinion as to the existence, extent and severity of a traumatic brain injury – subject to the limitation that his opinion be based on the neuropsychological testing he is qualified to administer and interpret. He is not a medical doctor or radiologist; he cannot interpret imaging studies.

More importantly, Dr. Wagner's opinion supports the conclusion that Fragosa suffered a physical brain injury. Dr. Wagner's testing revealed cognitive deficits. He attributed the deficits to the brain injury; not to medication, not to psychological issues, not to any other cause – only the brain injury.

A further concern over Dr. Wagner's opinion is that it is not stated to a reasonable degree of medical certainty (or even neuropsychological certainty). A traumatic brain injury is a medically complex case – defined as “sophisticated cases requiring highly scientific procedures or techniques for diagnosis or treatment excluding MRIs, CAT scans, x-rays, or other similar diagnostic techniques.” S.C. Code Ann. § 42-1-160 (2007). Such cases must be proven by medical evidence.

The term *medical evidence* is defined as “expert opinion or testimony stated to a reasonable degree of medical certainty, documents, records, or other material that is offered by a licensed and qualified

medical physician.” Id. An IME by definition must be explicitly stated to a reasonable degree of medical certainty. Michau v. Georgetown County, 27064 (SCSC). As Dr. Wagner’s report is not so stated, his opinions are incompetent (as they would be on this issue in any case) and were improperly relied on as evidence against physical brain injury.

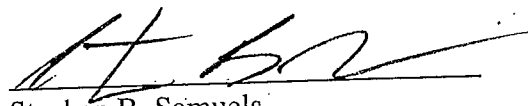
3. The Single Commissioner should have addressed and ordered additional medical treatment.

Defendants admit Fregosa requires additional medical treatment to lessen his period of disability. This specific issue was not addressed by the Single Commissioner in his Order one way or the other. Claimant requests that the Appellate Panel modify the Order to provide future medical treatment or note that the issue is being held in abeyance and is not part of the hearing or this appeal.

CONCLUSION

For the foregoing reasons, the Appellate Panel should reverse the findings of the Single Commissioner and enter an Order finding Claimant suffered physical brain damage, is not subject to the five hundred week limitation, and shall receive disability and medical benefits for life.

Respectfully Submitted



Stephen B. Samuels
SAMUELS LAW FIRM, LLC
1527 Blanding Street
P.O. Box 50349
Columbia, SC 29250
(803) 779-4000

Attorneys for Claimant

Jeff C. Chandler
CHANDLER LAW
Bank of America Building
2501 Oak Street
Myrtle Beach, SC 29578
(843) 448-4357

Columbia, South Carolina
January 26, 2012

SAMUELS LAW FIRM, LLC
1527 BLANDING STREET
P.O. Box 50349
COLUMBIA, SC 29250
(803) 779-4000 ♦ FAX (803) 779-4004

CERTIFICATE OF SERVICE

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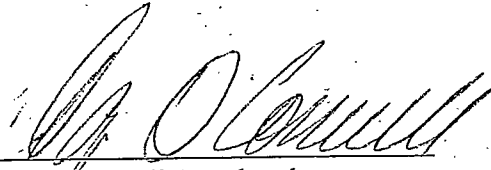
W.C.C. File Number: 0717624

This is to certify that I, Angi O'Connell, paralegal to attorney Stephen B. Samuels, have served a copy of the following described document by mailing a copy of same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

Document served: **BRIEF OF CLAIMANT/APPELLANT**

Person(s) served: The Honorable Virginia Crocker
Judicial Director
S. C. Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

Michael W. Burkett, Esquire
Attorney for Defendants
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, South Carolina 29209


Angi O'Connell, Paralegal

January 26, 2012

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

W.C.C. FILE #0717624

HECTOR GOMEZ FRAGOSO)

CLAIMANT,

VS.

KADE CONSTRUCTION
EMPLOYER,

AND

KEY RISK INSURANCE
CARRIER.

SC WORKERS' COMPENSATION COMMISSION

HEARING OF

HECTOR GOMEZ FRAGOSO

VS

KADE CONSTRUCTION, LLC

This is the Transcript of the South Carolina Workers' Compensation Hearing of Hector Gomez Fragoso versus Kade Construction, LLC, taken before Gloria Davis, a Court Reporter and Notary Public in and for the State of South Carolina, commencing at the hour of 10:13 A.M., Tuesday, June 28, 2011, at Horry County Court House, 1301 Second Avenue, Conway, South Carolina.

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APPEARANCES

FOR THE CLAIMANT:
Jeffrey C. Chandler, Esquire
Chandler Law Firm
2501 Oak Street
P.O. Drawer 1889
Myrtle Beach SC 29578-1889

FOR THE EMPLOYER/CARRIER:
Michael W. Burkett, Esquire
Willson Jones Carter & Baxley
4500 Fort Jackson Boulevard
Columbia, SC 29209

ALSO PRESENT:

*Reporter's Note: -- Indicates incomplete thought or sentence, trailing off or interruption by speakers.

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I N D E X

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STIPULATIONS

Commissioner Wilkerson: Today's date is June the 28th, 2011. We're here in reference to Workers' Comp File Number 0717624. The Claimant is Hector G. -- is it -- how do you pronounce it?

Mr. Chandler: Fragoso.

Commissioner Wilkerson: Fragoso, okay. --

Fragoso. His Attorney is Jeff Chandler. The Employer is Kade Construction, LLC. The carrier is Key Risk Insurance Company of South Carolina and their Attorney is Michael W. Burkett or Burkett. The date of accident is 11/1 of 2007. The average weekly wage is four hundred dollars (\$400.00), thus the compensation rate is two sixty-six, sixty-eight (\$266.68). My understanding is this was initially set on a Form -- excuse me -- initially set for -- to determine if Employer/Carrier may stop payment and, if so, to determine if the Claimant is entitled to any future benefits, the carrier also requests credit for temporary total benefits paid in excess of award. That's when we were originally going to have the case on 5/11/2011, but we're also today are on the 50 and 51 is my understanding; is that correct, gentlemen? I think we pushed it back for

1 that reason.

2 Mr. Chandler: That's correct.

3 Commissioner Wilkerson: Is that correct? Okay.

4 Thank you. Are there any objections to APA's,
5 jurisdiction, venue or any other items from --
6 Michael, since you were the original moving party
7 I'll ask you that first?

8 Mr. Burkett: No, sir. I do -- or will make when
9 I -- when it's my turn to go I will make a comment
10 or two (2) on the synopsis of the issues that Mr.
11 Chandler handed up.

12 Commissioner Wilkerson: Yes, this is not
13 evidence.

14 Mr. Burkett: Right.

15 Commissioner Wilkerson: This is -- yes, this -- I
16 understand.

17 Mr. Burkett: Just a couple of arguments on it.

18 Commissioner Wilkerson: I don't have a problem
19 with that. Thank you.

20 Mr. Burkett: But, otherwise, no -- no objections,
21 Your Honor.

22 Commissioner Wilkerson: Okay. Jeff, anything
23 from you?

24 Mr. Chandler: I don't, Your Honor.

25 Commissioner Wilkerson: And that would -- let me

1 ask you, and that would encompass the 21 as well
2 as the 50/51 when I -- when I mentioned that. You
3 were just the initial moving party --

4 Mr. Burkett: Yes, sir.

5 Commissioner Wilkerson: -- as far as any
6 objections. Okay. Okay, thank you. No
7 objections. Since there are no objections, the
8 Commission's file becomes a part of the record
9 with the exception of self-serving declarations
10 and unstipulated medical reports. Do you all
11 prefer which one of you goes first? It would
12 probably be better --

13 Mr. Burkett: Jeff can go first.

14 Commissioner Wilkerson: -- yes, I would agree,
15 even though -- I would agree with that, so Jeff?

16 Mr. Chandler: I'll be happy to.

17 Commissioner Wilkerson: Sure, absolutely. If you
18 need -- you can stand up or sit down; whatever is
19 comfortable for you.

20 Mr. Chandler: Thank you, Your Honor. I'm here on
21 behalf of Mr. Fragoso here today arguing for
22 lifetime benefits for him under 42-9-10. We
23 believe that he's totally and permanently disabled
24 as a result of a combination of injuries to
25 include physical brain damage. And I think the

1 evidence is going to be proper -- properly before
2 you so that you can make that ruling. We have a
3 treating Neurologist that substantiates that he's
4 got permanent physical brain damage. And I want
5 to point you to some of the APA submissions. And
6 I know they're voluminous but I just wanted to
7 make sure that you have a -- a clear picture and I
8 provided that synopsis of the contested issues.
9 Dr. Sandoz was deposed. On page 14 of his
10 deposition he clearly states that there's been
11 damage and injury to the function of the brain.
12 Further, Dr. Sandoz was asked in a questionnaire
13 about whether he suffered physical brain damage
14 and he was provided CT scans to review; that's
15 page 882, APA Exhibit C. And he gives his opinion
16 to a reasonable degree of medical certainty that
17 he has suffered physical brain damage and that
18 physical brain damage has rendered him totally and
19 permanently disabled. And, Your Honor, I point
20 your attention to the MUSC discharge summary.
21 This guy had subdural epidural hematomas,
22 bilateral frontal contusions, respiratory failure,
23 hypotension that was treated intravenously with
24 fluids, a large scalp laceration, C-7 through T-1
25 spinous process fractures, rib fractures that

1 included 7, 8, 9, and 10, bilateral transverse
2 process fractures L-1, L-2, right L-3, right big
3 toe fracture, right fifth (5th) toe fracture,
4 fracture of the skull, midline to sagittal through
5 the frontal and the parietal, placement of a
6 percutaneous endoscopic gastrostomy; so they had
7 to feed him with a tube for weeks, a tracheotomy,
8 and his -- his foot was amputated from toes 2
9 through 5, okay?

10 Commissioner Wilkerson: Which foot? Both or --

11 Mr. Chandler: That is his right foot.

12 Commissioner Wilkerson: -- okay. That's fine.

13 Mr. Chandler: The only Vocational Expert that's
14 rendered an opinion says that he's totally and
15 permanently disabled as a result of physical brain
16 damage coupled with his other injuries; the
17 treating Neurologist says this. Even the IME
18 doctor, Dr. Wagner -- and I'll point you to the
19 APA's from Dr. Wagner, page 655, APA Number 4. He
20 determined that the Claimant had a skull fracture
21 with acute underlying minor structural change to
22 the brain. Now, Michael is going to tell you that
23 that resolved post -- I guess discharged from the
24 hospital. But I don't think 42-9-10 -- number one
25 (1), The language of the Statue says, "suffered

1 physical brain damage". So, I -- I think that
2 it's clear that he suffered it. I guess maybe the
3 carrier and Michael believe that maybe he isn't
4 presently suffering from permanent physical brain
5 damage.

6 Commissioner Wilkerson: Yes --

7 Mr. Chandler: And maybe that's --

8 Commissioner Wilkerson: -- address --

9 Mr. Chandler: -- maybe that's the argument.

10 Commissioner Wilkerson: -- okay. Address that
11 with me a little bit. More so along the lines of
12 if brain damage did occur and it has resolved;
13 just --

14 Mr. Chandler: Well, I mean, I -- I think that's
15 often the case --

16 Commissioner Wilkerson: -- just for the record.

17 Mr. Chandler: -- sure. I think that's often the
18 case where someone has a frontal lobe contusion,
19 maybe the brain bleed absorbs back into the --

20 Commissioner Wilkerson: I agree.

21 Mr. Chandler: -- into the brain, into the body.

22 Commissioner Wilkerson: Right.

23 Mr. Chandler: But they're left with the cognitive
24 deficits. And it's clear in this case that he's
25 got the residual cognitive deficits.

1 Commissioner Wilkerson: He still has them?

2 Mr. Chandler: Still has them to --

3 Commissioner Wilkerson: Okay.

4 Mr. Chandler: -- this day.

5 Commissioner Wilkerson: Okay.

6 Mr. Chandler: He's got memory deficits. He's got
7 dizziness. He's got chronic headaches. And --
8 and that's -- he's got visual disturbances. So,
9 he -- he's got all the cognitive deficits; those
10 are supported by the Vocational Experts and his
11 treating Neurologist, and he's getting medicine
12 management for those things.

13 Commissioner Wilkerson: So, what you're saying is
14 the brain damage that was there, the damage itself
15 may have resolved -- I don't know -- but the
16 outcome is because of what happened he still has
17 these prolonged effects on --

18 Mr. Chandler: Certainly.

19 Commissioner Wilkerson: -- on the -- okay. I'm
20 fine with that.

21 Mr. Chandler: And -- and in addition to that, an
22 interesting finding that you can see presently on
23 an MRI is what Dr. Sandoz says is severe
24 mastoiditis. And he -- if you look at --

25 Commissioner Wilkerson: What's that? I don't

1 know.

2 Mr. Chandler: -- it's because of the trauma to
3 the brain.

4 Commissioner Wilkerson: Okay.

5 Mr. Chandler: Let me just point you to Sandoz's
6 deposition testimony with respect to the
7 mastoiditis. The deposition of Sandoz page 7 and
8 8 and also at pages 20 and 21.

9 Commissioner Wilkerson: Okay. And it's in here?
10 It's in the record, right?

11 Mr. Chandler: Right. And that's what has caused
12 a loss of hearing, okay? He got struck on the
13 left side of his head. And I'm going to show you
14 the skull fracture when we go on the -- on the
15 record --

16 Commissioner Wilkerson: Sure.

17 Mr. Chandler: -- with the Claimant. But Sandoz
18 says that because of this trauma that he ha to the
19 left side of the head it -- it refers over to the
20 right side.

21 Commissioner Wilkerson: Okay.

22 Mr. Chandler: That's why he had this hearing loss
23 on the right side.

24 Commissioner Wilkerson: Okay.

25 Mr. Chandler: So, I -- I believe the evidence is

1 clear for you; I don't think it could be much
2 clearer. And you've got a guy who was a
3 construction worker who cannot go back to any kind
4 of gainful employment. Even if we didn't have the
5 brain injury it's clear that he's totally disabled
6 as a result of the combination of injuries that we
7 can present to you. But there -- the evidence
8 couldn't be clearer in my opinion that we've got a
9 physical brain damage case and we've got a
10 lifetime case, okay?

11 Commissioner Wilkerson: Okay. Thank you.
12 Michael, I know you got a little different take on
13 it, so.

14 Mr. Burkett: Yes, sir, I do. I -- I think --

15 Commissioner Wilkerson: Do you want to address
16 this first? This --

17 Mr. Burkett: I -- I'll give it -- it's just one
18 (1) little correction I want to make in there --

19 Commissioner Wilkerson: -- okay.

20 Mr. Burkett: -- and Jeff kind of touched on it.
21 But --

22 Commissioner Wilkerson: And this is not evidence.
23 This is just to help me --

24 Mr. Burkett: -- that's right.

25 Commissioner Wilkerson: -- follow through? Okay.

1 That's fine.

2 Mr. Burkett: And this is ninety-nine percent
3 (99%) accurate. I think that the best way to look
4 at this is you have the question of physical brain
5 injury, which is what the Statue requires, versus
6 just an injury to the brain, which is covered in
7 Regulation 67-11-01. The law covers both of them.
8 And I think the best example is if we take an
9 injured worker who has his legs amputated, he's
10 confined to a wheelchair for the rest of his life.
11 Well, assume he can't go back to work. The most
12 he's going to get is five hundred (500) weeks.
13 He's got his two (2) body parts, he has no legs;
14 he cannot walk. Now take someone who is a
15 paraplegic. No functional use of the legs, can't
16 work anymore, confined to a wheelchair, but their
17 outcomes are different. The law gives one (1) of
18 them lifetime benefits and the law gives the other
19 one (1) five hundred (500) weeks because the law
20 presupposes additional more complicated problems
21 when you're a paraplegic as opposed to having your
22 legs amputated. The law presupposes additional
23 problems, significant problems, when you have a
24 physical injury to your brain, something we can
25 see, a physical damage to the brain as opposed to

1 what the law covers in the regulations, which says
2 he can get an award between twenty-five (25) and
3 two hundred and fifty (250) weeks. Now, Dr.
4 Sandoz unequivocally on page 13 of his deposition

5 --

6 Commissioner Wilkerson: Let me ask you a question
7 along those lines and I may get a response from
8 both. Are you saying that someone in an
9 automobile wreck who hits their head on the
10 dashboard or the window may initially have damage
11 to the brain but it may not be a brain damage
12 case; is that fair?

13 Mr. Burkett: I think you -- I think you -- I
14 think the law is very --

15 Commissioner Wilkerson: Based on the medicals,
16 right?

17 Mr. Burkett: -- you have to have physical brain
18 damage.

19 Commissioner Wilkerson: Okay. I'm fine with
20 that.

21 Mr. Burkett: A physical finding of the brain.

22 Commissioner Wilkerson: Okay. I'm fine with
23 that.

24 Mr. Burkett: A physical finding of the brain.

25 Commissioner Wilkerson: Okay.

1 Mr. Burkett: Now, Dr. Sandoz in his deposition,
2 on page 13, line 24, here's the question, "As far
3 as physical findings on his brain" --
4 Commissioner Wilkerson: Wait a minute, which --
5 is it -- show me -- tell me where.
6 Mr. Burkett: -- I'm sorry, page 13 of Dr. Sandoz.
7 Commissioner Wilkerson: Well, no, but I'm talking
8 about -- is it on here? You -- or --
9 Mr. Burkett: No, sir.
10 Commissioner Wilkerson: -- I'm sorry. Page 13 of
11 --
12 Mr. Burkett: Page 13 of the deposition --
13 Commissioner Wilkerson: -- of the deposition.
14 Okay. I'm sorry.
15 Mr. Burkett: -- of Dr. Sandoz.
16 Commissioner Wilkerson: Dr. Sandoz. I'm fine.
17 Go ahead.
18 Mr. Burkett: The question was, "As far as
19 physical findings on his brain, if you were to
20 look at the scans is it fair to say there is no
21 physical damage to the brain that we can see; is
22 that right"? And the answer, "There is no
23 evidence of any damage on the brain that we can go
24 and see; that's correct". All right. Now, after
25 this was done in August of 2010, within the last

1 two (2) or three (3) months, the date of it is --
2 I think it's the last page of the APA submissions.
3 They went and got a questionnaire from Dr. Sandoz,
4 March 10th, 2011; and he simply circled yes or no
5 on -- was there physical brain damage? Was there
6 physical brain damage? His answer is yes. It
7 doesn't say what CT scans he reviewed; it doesn't
8 say anything. So, we've -- we've rung the bell
9 and now we're trying to un-ring the bell. So,
10 Sandoz is talking out of both sides of his mouth
11 when he says --

12 Commissioner Wilkerson: Well, what -- let me ask
13 you a question on that. His deposition was taken
14 --

15 Mr. Burkett: -- August of 2010.

16 Commissioner Wilkerson: -- so about ten (10)
17 months ago --

18 Mr. Burkett: Yes, sir.

19 Commissioner Wilkerson: -- or eleven (11) months
20 ago. So, could there be, don't know until the
21 evidence is presented that's in here, could there
22 have been a progression or I've seen several times
23 where there's a progression for the worse; I've
24 also seen times where it's gotten better. So, my
25 question is, we don't know what Sandoz -- we know

1 what he said in August, nine (9) or eleven (11)
2 months ago -- ten (10) or eleven (11) months ago,
3 but now we've got a check off list.

4 Mr. Burkett: There's no evidence of any
5 progression because according to this letter that
6 was sent with the questionnaire he was sent the CT
7 scans. The Claimant has not had any CT scans in
8 2009 or 2010.

9 Commissioner Wilkerson: I'm fine with that.

10 Mr. Burkett: Now, keep this in mind too. The
11 argument here is that Mr. Fragoso has such a
12 significant level of physical brain damage, or has
13 physical brain damage, and he's entitled to
14 lifetime medical benefits -- I mean, I'm sorry,
15 lifetime indemnity benefits; just like I said the
16 law presupposes these additional problems.

17 Between August 2009 -- I'm sorry -- August 2000 --
18 yes, August 2009 --

19 Commissioner Wilkerson: Yes.

20 Mr. Burkett: -- and August 2010, there wasn't a
21 single appointment with the Neurologist, a single
22 prescription that he was asking to be refilled, no
23 visits whatsoever. It wasn't until after Dr.
24 Sandoz's deposition that suddenly Mr. Fragoso
25 started to go back and see him on a fairly regular

1 basis; which was fine, he's the authorized
2 treating doctor. But for somebody who has a
3 physical brain damage and can't function, and
4 needs lifetime indemnity benefits, there's no
5 neurological treatment between August 2010. -- I
6 mean August 2009 and August 2010. Now, this is
7 where it also gets important. There's a
8 Vocational Report, which is Tab -- I'm sorry --
9 page 868 of -- this is Tab B, page 868, of the
10 Claimant's APA submissions. And Dr. Brabham goes
11 into all sorts of conclusions about what the
12 medical issues are and things like that but he
13 makes one (1) important note that everybody gets
14 -- seems to pick up on on page 874, and I'll --
15 I'll -- when you get there. And -- and Jeff kind
16 of read it and this is the medical synopsis form,
17 too. But on page 874 --

18 Commissioner Wilkerson: Wait a minute. Let me
19 get there.

20 Mr. Burkett: -- okay. And I'm -- I'm going to be
21 on the -- the fifth (5th) paragraph down.

22 Commissioner Wilkerson: Eight seventy-four (874)?

23 Mr. Burkett: Yes, sir.

24 Commissioner Wilkerson: Fifth (5th) paragraph

25 down. It starts with on -- let's see, 1, 2, 3, 4

1 -- on 10/30/08, or is it the one (1) above that?
2 Mr. Burkett: Yes, sir. 10/30/08.
3 Commissioner Wilkerson: Okay. I'm fine.
4 Mr. Burkett: All right. This is Dr. Brabham's
5 take on this case. And he says, "Dr. Wagner --
6 Mark Wagner noted, "post concussive syndrome,
7 mild chronic pain disorders, situation depression,
8 very serious work related injury result in trauma
9 to his body and skull. Skull fracture with acute
10 underlying minor structural changes to the
11 brain"". And he just stops -- he just stops right
12 there; he stops the recitation of what Dr. Wagner
13 says because they know they need a finding of
14 physical brain damage. But here's what Dr. Wagner
15 really said. He said that but if you read the
16 next sentence of his report, which is --
17 Commissioner, I'll give you the -- the main stack.
18 It'll make it easier for you.
19 Commissioner Wilkerson: Please.
20 Mr. Burkett: On page 655.
21 Commissioner Wilkerson: 655, got it. Okay.
22 Mr. Burkett: All right. And where it says
23 discussions.
24 Commissioner Wilkerson: Wait a minute; let me
25 make my notes. Discussions, right.

1 Mr. Burkett: Here is the complete context that
2 everyone seems to want to leave out because it's
3 the most important detail; it's the one (1) thing
4 they need legally to get to what they need to get.
5 And it says, "He had a skull fracture with acute
6 underlying minor structural change to the brain.
7 Follow-up structural and functional studies EEG,
8 CT, MRI have been read as unremarkable and
9 demonstrating structural resolution of a work
10 related injury". So, the structural changes that
11 Jeff is going to point out to you the day of the
12 accident CT scans are his -- are the hematomas?
13 Well, I hit my arm at my house the other day and I
14 have a hematoma on my arm and it is going to
15 resolve.

16 Commissioner Wilkerson: Now, this -- this report
17 that's marked confidential, that report is done by
18 Dr. Wagner; is that correct?

19 Mr. Burkett: Yes, sir. Wagner is the -- is --

20 Commissioner Wilkerson: It's at the bottom.

21 Okay. I'm fine.

22 Mr. Burkett: -- is a Neurologist at MUSC.

23 Commissioner Wilkerson: And that was done on
24 11/4/08?

25 Mr. Burkett: Yes, sir.

1 Commissioner Wilkerson: Okay.

2 Mr. Burkett: Almost exactly a year after the
3 accident.

4 Commissioner Wilkerson: Okay. I'm fine with
5 that. Okay.

6 Mr. Burkett: All right. Now -- but once again
7 and -- you'll -- they all want to seem to leave
8 out that second opinion; Dr. Brabham, you know,
9 and what have you. After he was discharged from
10 the hospital you'll see -- for example on page
11 629, he's gotten normal studies. Page 641, he's
12 got a normal CT scan. Once again, the law makes
13 the allowance to get -- have an injury to the
14 brain without having physical brain damage, and
15 that's -- that's the argument here.

16 Commissioner Wilkerson: I understand.

17 Mr. Burkett: But we have this allegation of
18 physical brain damage that for the rest of his
19 life he needs indemnity benefits and it's -- and
20 it -- it's so horrific that -- that we need to
21 fall under that category. Yet there's been no
22 motion to appoint a guardian ad litem for Mr.
23 Fragoso. He's here today to testify on his own
24 behalf, to his own -- for his own benefit. I
25 don't doubt that he has had a -- he -- he got hurt

1 and he had a horrific injury, but he does not have
2 a physical brain damage that entitles him to
3 lifetime indemnity benefits.

4 Commissioner Wilkerson: Okay. Any --

5 Mr. Chandler: Unlike that hematoma that's going
6 to resolve on Michael's arm and that's not going
7 to cause him any lasting deficits, Mr. Fragoso
8 because of that skull fracture and the physical
9 brain damage that he suffered and is still
10 suffering from will have lifetime cognitive
11 deficits that has been un-refuted by a
12 Neuropsychologist, a Neurologist, a Neurosurgeon,
13 or any other kind of doctor. The evidence is
14 clear that he's got a physical brain damage and
15 that he's entitled to lifetime benefits.

16 Commissioner Wilkerson: -- and, gentlemen, that's
17 why we're here today.

18 Mr. Burkett: And just very briefly. The --
19 there's no -- I -- I'm not sitting here saying he
20 shouldn't get an award under 67-11-01 for an
21 injury to his brain; I'm okay with that.

22 Commissioner Wilkerson: Yes, that's what I took
23 it as, so.

24 Mr. Burkett: The one (1) -- the one (1) thing I
25 didn't address was the mastoiditis. You'll see

1 Dr. Sandoz gives a great explanation of this. The
2 mastoid is a -- is a structural part of the skull,
3 itself.

4 Commissioner Wilkerson: Okay.

5 Mr. Burkett: It's an area of the skull. It's the
6 -- it's the -- it's a process. It's a -- and so,
7 it's not part of the brain and it's -- that's
8 where the -- the hearing loss is coming because of
9 the mastoiditis, because of the fluid built up in
10 that -- in that bony process is what that is.

11 It's just a -- it's a part of the -- it's a
12 portion of the skull is what the mastoid is.

13 Commissioner Wilkerson: Okay. All right, thank
14 you. Anything else before we start taking
15 testimony?

16 Mr. Chandler: No, Your Honor.

17 Commissioner Wilkerson: Okay. Thank you.

18 Mr. Chandler: Do you have a --

19 Commissioner Wilkerson: Yes. Let me -- can we go
20 off the record just real quick?

21 Mr. Chandler: -- yes, sir.

22 Mr. Burkett: Yes, sir.

23 (Off The Record)

24 Commissioner Wilkerson: We're officially back on
25 the record. We went off the record to handle a

1 Motion Hearing real quick. Jeff, are we now ready
2 to hear from your client?

3 Mr. Chandler: Yes, Your Honor.

4 Commissioner Wilkerson: Okay. So, what we'll do
5 is we'll swear the Court Reporter in first -- no
6 -- is that backwards?

7 Court Reporter: The Interpreter.

8 Commissioner Wilkerson: The Interpreter, I'm
9 sorry. It's been a long week.

10 Court Reporter: The Court Reporter is going to
11 swear the Interpreter in.

12 Commissioner Wilkerson: Sir, I am sorry. It's
13 been a long week and it's only Tuesday.

14 Mr. Lailson: It's only Tuesday.

15 Commissioner Wilkerson: Is it or is it Friday?
16 I'm sorry. So, we'll --

17 Court Reporter: Do you want me to do it? Would
18 you raise your right hand, please?

19 Commissioner Wilkerson: -- yes. Would you raise
20 your right hand, Mr. Interpreter? Thank you. And
21 then we'll get you to swear the Claimant in.

22 Thanks.

23 Whereupon;

24 JAIME LAILSON, being duly sworn to translate from
25 English to Spanish the questions posed by counsel and

1 from Spanish to English the answers given by the
2 witness.

3 Court Reporter: Please state your full name for
4 the record.

5 Interpreter: Jaime Lailson.

6 Court Reporter: Please help me swear him in; ask
7 him to raise his right hand.

8 Whereupon;

9 HECTOR GOMEZ FRAGOSO, being duly sworn and
10 cautioned to speak the truth, the whole truth, and
11 nothing but the truth, testified as follows:

12 Court Reporter: Please state your full name for
13 the record.

14 Witness: Hector Gomez Fragoso.

15 Court Reporter: Thank you, sir

16 Mr. Burkett: Commissioner, we've -- we've
17 discussed who -- Jeff, is going to -- I have --
18 with my blessing, is going to lead for a lot of it
19 just to get us through it.

20 Commissioner Wilkerson: That's fine.

21 Mr. Burkett: And I told him he would hear from me
22 the moment I thought that the leading was
23 inappropriate.

24 Commissioner Wilkerson: That's fine. I was going
25 to ask could he do that as well so, Mr. Chandler.

1 Mr. Chandler: Thank you, Your Honor.

2 DIRECT EXAMINATION

3 By Mr. Chandler:

4 Q. Good afternoon, Mr. Fragoso. Are you thirty-one (31)
5 years old today?

6 A. No.

7 Q. How old are you?

8 A. Twenty-nine (29).

9 Q. Okay. Thank you. Mr. Fragoso, you're not married; is
10 that right?

11 A. Yes.

12 Q. You don't have any children; is that right?

13 A. No.

14 Q. You're from Mexico; is that correct?

15 A. Yes.

16 Q. And you went through middle school in your home
17 country; is that right?

18 A. Yes.

19 Q. And you came to the United States somewhere in around
20 2002 or 2003?

21 A. Yes.

22 Q. And in Mexico after you finished school you worked in
23 some jobs that involved security work?

24 A. Yes.

25 Q. And you worked in what I understand to be a retail type

1 of job in a perfume shop?

2 A. Yes.

3 Q. Are those the only types of jobs you that you held
4 working in Mexico?

5 A. Yes.

6 Q. And since coming to the United States I understand the
7 only type of work that you've been involved in is
8 construction; is that right?

9 A. I don't know if -- I worked five (5) to six (6) months
10 at a shop where they used to do kitchen counters;
11 that's all.

12 Q. Okay.

13 A. I don't know if that is the same as construction what I
14 do.

15 Q. Is that the only other type of work that he's done
16 since coming to the United States?

17 A. Yes.

18 Q. Okay. Did Mr. -- did you have any kind of problem, Mr.
19 Fragoso, with respect to your -- your head, your brain,
20 prior to 11/1/2007?

21 Interpreter: Excuse me. What year?

22 Mr. Chandler: 2007.

23 A. No.

24 Q. We're here about an accident that happened on November
25 the 1st of 2007. You were working on a construction

1 project over in Marion, South Carolina; is that right?

2 A. Yes.

3 Q. Do you have any specific memory of the accident that
4 you were involved in?

5 A. No.

6 Q. When is your first memory following the accident?

7 A. When I woke up from the hospital.

8 Q. Okay.

9 Mr. Chandler: Now, Commissioner, if we can start
10 -- so we don't have to start and stop during the
11 testimony, I'm going to ask you put on the record
12 the scarring that Mr. Fragoso has -- has suffered
13 as result of this; if you don't mind.

14 Commissioner Wilkerson: No, that's fine.

15 Mr. Chandler: And -- and --

16 Commissioner Wilkerson: And let -- and let me ask
17 you a question just because of the confines I have
18 here. Would it be best if you were to walk over
19 and let Michael come up and you describe it?

20 Mr. Chandler: -- if -- if you don't mind, can I
21 get him to come down in front of you?

22 Commissioner Wilkerson: Oh, I'm fine with that.
23 However you want me to do it, that's fine.

24 Mr. Chandler: Jaime, if you could ask that Mr.

25 Fragoso to step out of the witness box. And I'll

1 lay some foundation.

2 Commissioner Wilkerson: That's fine. I just --

3 Mr. Chandler: I just wanted to -- instead of
4 starting and stopping and going through his
5 different body parts.

6 Commissioner Wilkerson: -- okay. That's fine.

7 Mr. Chandler: Okay. And if you will, go ahead
8 and take off --

9 Commissioner Wilkerson: -- do you need to come
10 up?

11 Mr. Chandler: -- your shoe. Go ahead and
12 instruct him to take off his shoe and his sock.

13 Mr. Burkett: Here you go.

14 Mr. Chandler: Yes, I'll -- I'll get it.

15 Commissioner Wilkerson: Yes, you probably better
16 get him a chair because I'm not sure --

17 Mr. Burkett: Here you go.

18 Commissioner Wilkerson: -- I'm not sure I'm going
19 to be able to lean far enough over.

20 Q. Okay. Mr. Fragoso, as a result of this accident I
21 understand that you have numerous scars; some of those
22 scars came from the actual trauma when you sustained
23 the injury and some were the result of surgery?

24 A. Yes.

25 Q. Okay. And I -- I want to start at your head and I'm

1 going to work my way down to your feet.

2 A. Yes.

3 Q. Okay. Now, specifically, Mr. Fragoso, I understand as
4 a result of the trauma that you've had to the head that
5 you have a scar that still remains from what looks like
6 your temple -- on your forehead that looks like it
7 extends back in a zigzag fashion almost to the crown of
8 your head; is that right?

9 A. Yes.

10 Mr. Chandler: And, Commissioner --

11 Commissioner Wilkerson: I'd concur.

12 Mr. Chandler: -- if you can eyeball what you
13 believe that is in --

14 Commissioner Wilkerson: Gosh.

15 Mr. Chandler: -- inches? If you want to
16 stipulate I -- I --

17 Commissioner Wilkerson: Let's see.

18 Mr. Chandler: -- it looks to me like it's at
19 least six inches (6").

20 Commissioner Wilkerson: I'd say it's more than
21 that.

22 Mr. Burkett: I think it's about seven (7).

23 Commissioner Wilkerson: I think it's -- yes.

24 Seven is fine. At least -- let's say at least
25 seven inches (7"), I -- because it -- the way it

1 angles.

2 Mr. Chandler: Right.

3 Commissioner Wilkerson: I'm just trying to look
4 at a six-inch (6") ruler and try to -- it's at
5 least six inches (6"); it could be eight (8).

6 Mr. Chandler: Okay.

7 Commissioner Wilkerson: Okay.

8 Q. Mr. Fragoso, do you also have an area on your throat
9 where you had a -- a tracheotomy?

10 Mr. Chandler: Ask him to please -- please answer
11 the question.

12 A. Yes.

13 Commissioner Wilkerson: Can -- I say if you can
14 rotate back because it's -- with -- with the --
15 okay, I'm fine with that. It's hard to see with
16 the --

17 Mr. Chandler: And to me, Your Honor, that looks
18 like a keloid scar.

19 Commissioner Wilkerson: -- it looks like it's
20 raised on the outside from what I can tell.

21 Mr. Chandler: And it looks like there are also
22 keloid scars that are adjacent to the main scar.

23 Commissioner Wilkerson: Probably where they
24 attached the -- yes. So, that would be -- I'm
25 going to say keloid scarring in that area where

1 the tracheotomy was done.

2 Q. Do you have additional scars across your chest to your
3 abdominal area?

4 A. Yes.

5 Q. Please show the Commissioner where else you have
6 scarring?

7 Commissioner Wilkerson: But those -- those
8 wouldn't be seen in natural employment though. Is
9 that --

10 Mr. Chandler: Well, I think that this is --

11 Commissioner Wilkerson: -- significant enough?

12 Mr. Chandler: -- related to some of the other
13 issues.

14 Commissioner Wilkerson: Oh, I see what you're
15 saying. No, I'm -- I'm fine with that. No, I'm
16 fine with that. Okay, that's fine.

17 Q. And is this where they had to put the feeding tube in?

18 A. Yes.

19 Q. Any other scars on your abdomen?

20 A. Just a small one by my shoulder.

21 Q. Did they have to put medicines in through this?

22 A. Yes.

23 Commissioner Wilkerson: Okay.

24 Q. Okay. Anything on this right shoulder?

25 A. No.

1 Q. Okay. Any scars on your back?

2 A. No.

3 Q. Okay. Any scars on your arms?

4 Commissioner Wilkerson: On the left.

5 Q. So, on your left arm? Do you know what caused this
6 scar?

7 A. No.

8 Q. Okay. Any scars on your right arm?

9 A. No.

10 Q. Okay.

11 Mr. Chandler: I'll let you please button your --
12 your shirt as best you can.

13 Q. Okay. Do you have any scars on your legs?

14 A. No.

15 Q. Okay. Now, Mr. Fragoso, you've sustained an injury to
16 your right foot that resulted in a partial amputation
17 of your foot; is that right?

18 A. Yes.

19 Q. And all you have left is your residual right big toe on
20 that foot; is that right?

21 A. Yes.

22 Q. Okay.

23 Mr. Chandler: Thank you.

24 Commissioner Wilkerson: Sure. Thank you. No,
25 I'm fine. Thank you.

1 Mr. Chandler: I'll allow you to take your --
2 Commissioner Wilkerson: Take your -- take your
3 time, we're in no hurry.

4 Mr. Chandler: -- take you time.

5 Q. Thank you for doing that, Mr. Fragoso. I know that
6 that's difficult for you. Mr. Fragoso, I want to ask
7 you about any and all problems that you have as a
8 result of this claim. And I know you don't have a
9 memory of how it happened but I need your assistance
10 now in telling me what kind of problems that you're
11 left with to this very day. And I want to start, Mr.
12 Fragoso, with any symptoms that you have that you
13 relate to the head trauma or the brain injury that
14 we've alleged that you have. Do you have headaches?

15 A. Yes.

16 Q. How often -- well, frequent are your headaches?

17 A. Exactly, I don't know but I've got three (3), four (4)
18 times. Sometimes I have a headache once a week. The
19 pains that I have, they're very strong. Exactly, I'm
20 not too sure how often but I do have headaches.

21 Q. Do you have headaches at least once a week?

22 A. Yes.

23 Q. Do you have a headache every day?

24 A. Yes. I can't sleep.

25 Q. Okay. Do you have days of the week where your

1 headaches are stronger than other days of the week?

2 A. Yes.

3 Q. okay. And on days that they seem to be the strongest
4 what kind of limitations or problems do the headaches
5 cause you?

6 A. I don't want to do nothing. I don't want to be around
7 anybody. I feel like when someone is talking I get
8 desperate and frustrated for the pain.

9 Commissioner Wilkerson: When it gets dark; is
10 that what he said?

11 Interpreter: When he's around people.

12 Commissioner Wilkerson: Oh, when he's around
13 people. Okay. I'm sorry. I apologize.

14 Q. Are you taking medicines that are prescribed by Dr.
15 Sandoz for your headache?

16 A. Yes.

17 Q. Do those medicines help your headaches?

18 A. Just a little bit.

19 Q. Are you taking those medicines every day?

20 A. Yes.

21 Q. Do you have any problems with your balance? Do you
22 have dizziness?

23 A. Yes.

24 Q. Is that problem with your balance related to your -- in
25 your opinion, related to your head injury or is in part

1 related to the fact that you're missing part of your
2 foot?

3 A. Both.

4 Q. How often do you experience dizziness?

5 A. Dizziness? Constantly.

6 Q. Have you been given any kind of prescriptions or have
7 you gone through therapy for the dizziness problems
8 that you have?

9 A. Yes.

10 Q. Did that therapy for the balance and dizziness provide
11 you any relief?

12 A. I didn't have -- I didn't have therapy for my balance;
13 it was just for my shoulder.

14 Q. Did you have any what they call vestibular exercises,
15 if you know, for the dizziness?

16 A. No, I was just given medicine.

17 Q. Now, do you have any problems with your short or your
18 long-term memory?

19 A. Yes.

20 Q. Do you have more problems with short term or long-term
21 memory?

22 A. I don't understand.

23 Q. If I were to tell you something today would you have a
24 problem remembering what I told you tomorrow?

25 A. Yes.

1 Q. Do you have any problems with directions, following
2 directions either to a location -- if I were to tell
3 you to go to the local Walmart would you have problems
4 with following directions that I would provide you in
5 writing?

6 A. Yes. Yes, but I would have more difficult than to find
7 out what am I looking for.

8 Q. Okay. So, do you notice that you have problems -- if
9 you have to go to a grocery store and pick up groceries
10 for your household do you have problems with
11 remembering what you came to the store to get?

12 A. Yes.

13 Q. Mr. Fragoso, did you have something to add?

14 A. Yes. About the headaches that I have, I have more
15 severe headaches when I'm trying to concentrate.

16 Q. Okay.

17 Commissioner Wilkerson: Are you having a headache
18 right now?

19 A. Yes. It's started a little bit more -- more than
20 regularly.

21 Q. Okay. So, being in this courtroom with me asking you
22 questions is causing you an increased amount of a
23 headache?

24 A. Yes.

25 Q. Mr. Fragoso, do you have problems with your hearing?

1 A. Yes.

2 Q. And do you have problems hearing out of one (1) ear,
3 both ears?

4 A. Both.

5 Q. You're obviously hearing me; you're answering my
6 questions. Tell me how the problem with your hearing
7 has affected you. Do you have problems hearing high
8 noises, low noises? Do you have -- have problems with
9 the clarity of what I'm saying?

10 A. I hear like a buzzing in my ears, like -- like it's a
11 clog -- like I have a clog in my ear.

12 Q. Are those sensations present with you all the time?

13 A. Not all the time.

14 Q. How often do those symptoms of buzziness -- buzzing and
15 clogged sensations affect you?

16 A. Between three (3) or four (4) times a week.

17 Q. Mr. Fragoso, I want to ask you -- I'm -- I'm going to
18 come back to your -- to your head and -- and brain
19 issues. I want to move to your shoulder. I understand
20 that you got some treatment for your shoulder; is that
21 right?

22 A. Yes.

23 Q. And is that your left shoulder?

24 A. Yes.

25 Q. Okay. And did Dr. Merrill treat you for your shoulder?

1 A. Yes.

2 Q. okay. What problems do you have with your shoulder?

3 A. When I move my shoulder hurts. If I try to lift my arm
4 it will hurt. When I go to sleep it bothers me. I
5 don't have the same strength that I used to have. When
6 I try to grab something I couldn't hold it long enough.
7 When I try to turn my neck to either side it bothers
8 me.

9 Q. When you say when you turn your neck from either side
10 it bothers you; are you referring to your shoulder now
11 or are you telling me about your neck bothering you?

12 A. In both of them. Both.

13 Q. okay. You had some fractures in your back that was
14 diagnosed down at the Medical University of South
15 Carolina. Do you still have ongoing problems with your
16 neck, your middle back, and your lower back?

17 A. Yes.

18 Q. okay. Tell the Commissioner what kind of problems you
19 have with your neck, your middle back, and your lower
20 back.

21 A. If I sit down for a long period of time it starts
22 bothering me, like the lower back, my back. I cannot
23 stay too long of a time sitting down. My neck, I
24 cannot move it freely because it bothers me. I feel
25 like I have like a -- a something in my throat.

1 Q. And let me switch gears real quick since you mentioned
2 that. Do you believe that that's a problem that
3 relates back to the tracheotomy that you had done?

4 A. I -- I don't know. I don't understand.

5 Q. I believe you testified in your deposition that you
6 have problems with -- with choking on your saliva; do
7 you still have problems with that?

8 A. Yes.

9 Q. Describe for the Commissioner when you experience those
10 symptoms.

11 A. When I'm drinking any kind of liquid or my food I feel
12 like I'm choking. Even with my own saliva I feel like
13 I'm choking. I feel like it's dry -- dryness on my
14 throat.

15 Q. Does that affect you when you go to -- try to go to
16 sleep at night?

17 A. Yes. I have problems to breathe.

18 Q. Have you -- have you told the doctor about those
19 problems?

20 A. Yes.

21 Q. Did they offer you any treatment for that?

22 Mr. Burkett: Objection to hearsay.

23 Commissioner Wilkerson: You can't --

24 Mr. Chandler: I think he can --

25 Mr. Burkett: I mean, he's going to answer what

1 they told him but I think any treatment would be
2 in the medical records if they have recommended
3 anything. The medical records speak for
4 themselves.

5 Commissioner Wilkerson: -- yes. I mean, they
6 speak for themselves.

7 Q. Mr. Fragoso, you were talking about your neck and your
8 back symptoms. Do you have problems with your neck and
9 your back every day?

10 A. Yes.

11 Q. Are you prescribed medicines for those problems as well
12 as for the headaches?

13 A. For my headache, yes. But for my neck I think they
14 only gave me a couple of injections.

15 Q. Do you have problems with your hips?

16 A. Yes.

17 Q. What problems do you have?

18 A. When I bend down or when I'm trying to stand up I feel
19 like someone is cutting me out.

20 Q. Do you have problems with your legs?

21 A. No.

22 Q. Do you have problems with your right foot?

23 A. Yes.

24 Q. What problems do you have?

25 A. I cannot walk for a long period of time because I've

1 got inflammation. I have a lot of balance problems.
2 And I can't walk like I used to, like, just do some
3 walking. Occasionally I feel like a -- some kind of --
4 sort of a pain on where they cut my fingers -- I mean
5 toes and it's -- it's a permanent pain. I feel like --
6 I have a -- like a very sensitive part or section.

7 Q. Mr. Fragoso, do you have a -- a special pair of shoes
8 that were made for you?

9 A. Yes. Yes.

10 Q. Okay. And do you have those on today?

11 A. Yes.

12 Q. Do you wear those everywhere you go?

13 A. Yes.

14 Q. Do you also have a -- a special insert for your right
15 shoe?

16 A. Yes.

17 Q. Are your shoes still holding up or are they wearing out
18 at this point?

19 A. Well, it's just worn out. Yes, they're worn pretty
20 bad.

21 Q. Do you even wear shoes inside your house?

22 A. I try not to use them too much because I'll get tired.

23 Q. If you didn't have the shoes on or the special
24 prosthetic device inside of your shoe would you have
25 even more problems with walking and balance?

- 1 A. Oh, yes. Before I had the prosthetic insert I have a
2 lot of problems with trying to keep my balance. Yes,
3 the insert, the prosthetic -- the insert.
- 4 Q. Mr. Fragoso, who do you live with?
- 5 A. With two (2) friends.
- 6 Q. Okay. Do you provide financial support for that
7 household at all?
- 8 A. Yes.
- 9 Q. So, you use some of your weekly check to pay for things
10 like groceries, and the electric bill, and the rent?
- 11 A. Yes.
- 12 Q. Mr. Fragoso, have you had a relationship with a member
13 of the opposite sex since your accident in 2007?
- 14 A. No.
- 15 Q. And -- and why haven't you been able to engage in a
16 relationship with a -- a female since this accident?
- 17 A. I don't feel too social. I don't feel like I can't be
18 too social or socialize with -- with any -- anybody.
- 19 Q. Do you -- so, do you have problems socializing with
20 both men and women?
- 21 A. Yes.
- 22 Q. And, specifically, what problems do you have
23 interacting with other people?
- 24 A. I don't -- no, I don't feel comfortable talking to
25 them. It feels like they're going to renounce him, you

1 know, for his physical appearance on his foot.

2 Interpreter: Reject him, that's what I meant.

3 Q. Okay. So, you feel like you're going to be rejected?

4 A. Yes.

5 Q. Did you have relationships, physical and social, with
6 men and women before this accident?

7 A. Not very much, sir. I was social. I will talk to more
8 people and I would like to find more friends.

9 Q. And let me -- let me get that straight. Before this
10 accident is your testimony that you were a more social
11 and outgoing person?

12 A. Yes.

13 Q. Do you have depression now?

14 A. Oh, so the doctor told me.

15 Q. And I don't want you to tell us what the doctor told
16 you but I want you to tell us from your -- your
17 personal recollection of yourself knowing how you were
18 before this accident and knowing how you are now; do
19 you have -- do you have problems with your -- your
20 mental, your -- your personality. Has your personality
21 changed because of this accident?

22 A. Oh, yes, it has changed. I feel today like I -- I can
23 get irritated for any -- anything. I feel like I can't
24 maintain any kind -- some sort of a conversation with
25 anybody.

1 Q. So, do -- do you have mood changes?

2 A. Yes.

3 Q. And are those mood changes in a bad way; are you angry
4 easily?

5 A. Oh, yes.

6 Q. Are you frustrated easily?

7 A. Yes. I get so frustrated that I just go to my room and
8 shut the door.

9 Q. Are you sad?

10 A. Yes. There's times when I feel a few minutes happy and
11 other times I feel like I don't belong there or here.

12 Q. Mr. Fragoso, do you believe that you're physically or
13 mentally capable of returning to any kind of work that
14 you've ever done before in your working life?

15 A. No.

16 Q. And how do you spend your waking hours at home everyday?

17 A. I try to get up. I fix my breakfast, make my bed. I --
18 I try to distract myself by listening to the music.
19 When I can I just kind of try to dust up my room. And
20 in the afternoons I'll just fix myself something to
21 eat.

22 Q. Does he feel like that he's a prisoner in his own home?
23 Mr. Burkett: Objection to leading. It's a pretty
24 -- pretty heavy questioning, a very suggestive
25 question.

1 Commissioner Wilkerson: Yes.

2 Mr. Chandler: Well --

3 Mr. Burkett: It's the very definition of leading.

4 Commissioner Wilkerson: Just redirect it in a
5 different manner.

6 Mr. Chandler: -- okay.

7 Q. Do you feel like you have the mental or physical
8 ability to go outside of your home?

9 A. Sometimes I feel like doing something but my shoulder
10 pain won't let me. I feel like when I'm in pain in my
11 shoulder I just don't want to do anything and I -- I
12 have the other people do the cleaning and he just don't
13 feel like doing anything because his -- his pain in his
14 shoulder it -- it increases. And leaving the house is
15 kind of hard because he can't walk for a long distance
16 and he feels like a sharp pains in his foot.

17 Q. I forgot to ask you this earlier but the medical
18 records indicated that you have problems, and you
19 testified I think, in your deposition, that you have
20 problems with your vision. Do you still have problems
21 with your vision?

22 A. Yes.

23 Q. Tell the Commissioner what kind of problem you have
24 with your vision.

25 A. I have blurry vision. Occasionally I can see like a

1 sparkling lights especially when I have the dizziness.
2 I have a problem when I take a shower; I don't feel
3 comfortable doing it sometimes because I feel like I'm
4 going to go backwards losing my balance.

5 Q. okay. And is that because of the dizziness that you
6 feel?

7 A. Yes.

8 Q. Okay. And when you have headaches that are bad
9 headaches how do you treat those headaches? Do you
10 have to go lay down? Do you have to go put ice packs
11 on your head? What do you do to treat it besides the
12 medicines that the doctor gives you?

13 A. I do take the medicine and it tends to slow down my
14 pains but it doesn't go away all the way.

15 Q. Okay. Answer any questions that Attorney Burkett has
16 for you.

17 Commissioner Wilkerson: Let me ask you one (1) more
18 question. Can he give me his month, day, and year of
19 birth?

20 A. October the 4th, 1980.

21 Commissioner Wilkerson: And that's his date of
22 birth? Okay.

23 A. Yes.

24 Commissioner Wilkerson: October 4th, 1980?
25 October the 4th, 1980; is that correct?

1 A. Yes.

2 Commissioner Wilkerson: Tell him we have the same
3 birthday. Mr. Burkett.

4 CROSS-EXAMINATION

5 By Mr. Burkett:

6 Q. Just briefly, Mr. Fragoso. You -- you live with two
7 (2) roommates and sometimes your uncle; is that right?

8 A. Yes.

9 Q. And -- and we already discussed you share the expenses
10 with your roommates, correct?

11 A. Yes.

12 Q. All right. And you use your weekly benefit check to
13 take care of the things you need to take care of,
14 correct?

15 A. Yes.

16 Q. And sometimes if you need to go places your roommates
17 will drive you; is that right?

18 A. Yes.

19 Q. And other times you'll drive yourself, correct?

20 A. Sometimes.

21 Q. Okay. And only because I know Mr. Chandler's going to
22 jump up, you testified you were twenty-nine (29) but
23 you're actually thirty (30); is that right? You'll be
24 thirty-one (31) this year, in October?

25 A. Yes.

1 Q. Okay.

2 Mr. Burkett: I don't have anything further, Your
3 Honor.

4 Commissioner Wilkerson: Thank you. Anything
5 else?

6 Mr. Chandler: That's the Claimant's case.

7 Commissioner Wilkerson: Thank you. Thank you.
8 This concludes the hearing. If I could meet with
9 the Attorneys for a few minutes. Thank you.

10 (THERE BEING NO FURTHER QUESTIONS, THE HEARING CONCLUDED AT
11 11:38 A.M.)

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STATE OF SOUTH CAROLINA }

COUNTY OF HORRY }

CERTIFICATE

Be it known that I took the foregoing South Carolina Workers' Compensation Commission Hearing of Hector Gomez Fragoso, vs. Kade Construction, LLC;

That I was then and there a Notary Public in and for the State of South Carolina-At-Large;

That by virtue thereof I was duly authorized to administer an oath;

That the witness was first duly sworn to testify the truth, the whole truth, and nothing but the truth, concerning the matter in controversy aforesaid;

The foregoing transcript of 49 typewritten pages represents a true, accurate and complete transcription of the testimony so given at the time and place aforesaid to the best of my skill and ability;

That I am not related to nor an employee of any of the parties hereto, nor a relative or employee of any attorney or counsel employed by the parties hereto, nor interested in the outcome of this action;

Witness my hand and seal this 19th Day of July, 2011.



Gloria Davis
Notary Public for South Carolina
My Commission Expires 1/22/12

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BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 0717624

HECTOR G. FRAGOSA,	)	
	)	FULL COMMISSION HEARING
CLAIMANT,	)	PANEL B
vs.	)	
	)	COMMISSIONER McCASKILL-CHAIR
KADE CONSTRUCTION, LLC,	)	COMMISSIONER BARDEN
	)	COMMISSIONER WILLIAMS
EMPLOYER,	)	
	)	
and	)	
	)	
KEY RISK INSURANCE	)	
COMPANY,	)	
	)	
CARRIER,	)	
DEFENDANTS.	)	
	)	

THE WORKERS' COMPENSATION HEARING, TAKEN BEFORE
CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR THE
STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF
2:50 P.M., MONDAY, MARCH 19, 2012, SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION, 1333 MAIN STREET,
COLUMBIA, SOUTH CAROLINA 29202.

CORA ELLIS BRUTON
COURT REPORTER
131 BROWNING COURT
LEXINGTON, SOUTH CAROLINA 29073
803-397-0189

APPEARANCES**FOR THE CLAIMANT**

STEPHEN B. SAMUELS, ESQUIRE
 SAMUELS LAW FIRM
 POST OFFICE BOX 50349
 COLUMBIA, SOUTH CAROLINA 29250
 803-779-4000

FOR THE DEFENDANT

MICHAEL W. BURKETT, ESQUIRE
 WILLSON, JONES, CARTER & BAXLEY, P.A.
 4500 FORT JACKSON BOULEVARD
 COLUMBIA, SOUTH CAROLINA 29209
 803-227-2886

REPORTED BY

CORA ELLIS BRUTON
 COURT REPORTER
 131 BROWNING COURT
 LEXINGTON, SOUTH CAROLINA 29073
 803-397-0189

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EXHIBITS

(No Exhibits Proffered)

1 THE COURT REPORTER: Today is March 19, 2012.

2 This is South Carolina Workers' Compensation Case
3 Number 0717624. This is the case of Hector G.
4 Fragosa, Claimant, versus Kade Construction, LLC,
5 Employer and Key Risk Insurance Company is the
6 Carrier. The Appellant is the Claimant represented by
7 Attorney Stephen B. Samuels. The Respondent is
8 represented by Attorney Michael W. Burkett.

9 Each side is allowed ten minutes for oral
10 argument and Appellant three minutes in reply. You
11 are requested to argue the grounds of exception and
12 stay within the record.

13 THE COURT: All right. Mr. Samuels.

14 BY MR. SAMUELS: Thank you, Your Honor. May it
15 please the Court. I think Mr. Chandler was intending
16 to be here but we got moved up a little bit and he was
17 not able to make it all the way from Myrtle Beach.

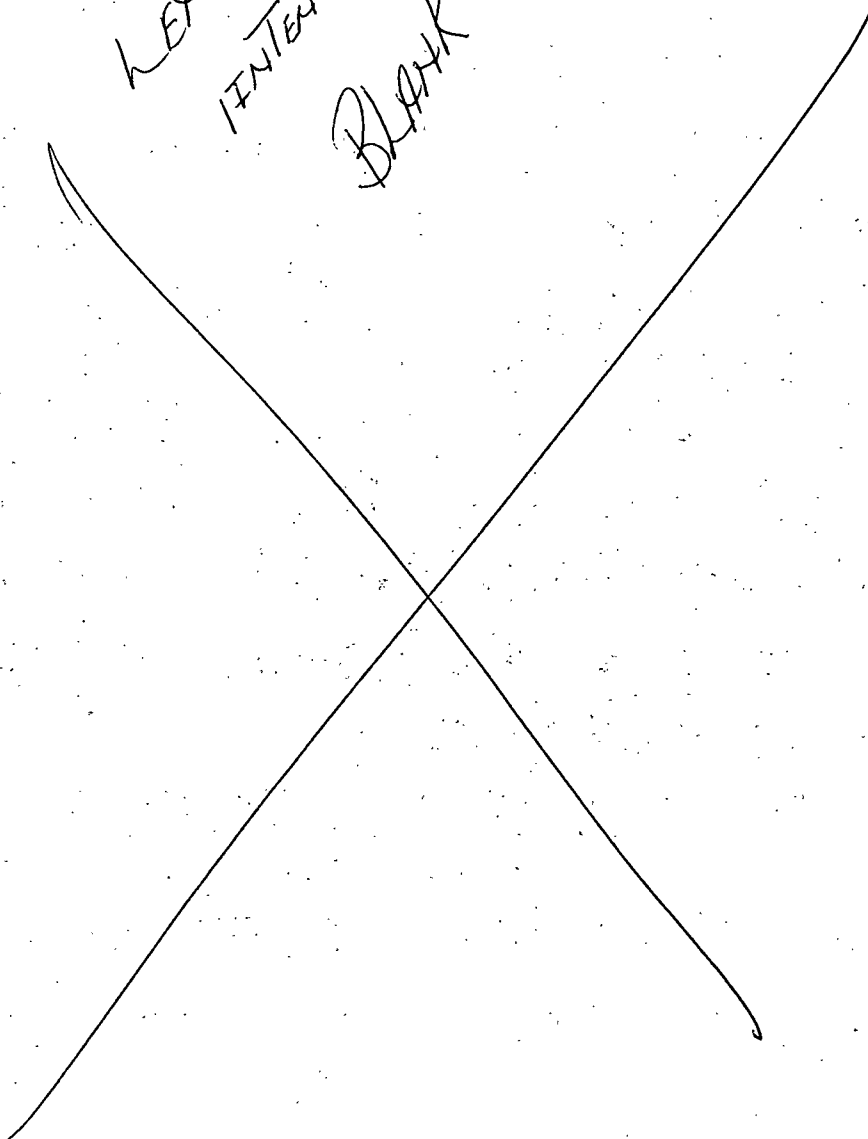
18 Regarding this case, Your Honors, November 1st,
19 2007 Hector Fragosa was working on a construction
20 project in Marion, South Carolina. He was on the roof
21 of a garage, a construction crane broke loose, hit him
22 in the head, fractured his skull and knocked him off
23 the roof onto the ground. He was transported to MUSC
24 by helicopter because he was not breathing; they
25 performed an emergency tracheotomy. He remained in a

1 coma for two weeks and remained at MUSC for a full
2 month. Ultimately Mr. Fragosa suffered too many
3 injuries to list, but we listed in the Brief. But the
4 most important injuries for this appeal; the matter
5 here today, he fractured his skull, midline sagittal
6 to the front and parietal. He had subdural and
7 epidural hematomas. He had bilateral contusions to
8 the frontal lobe of his brain. Why do these
9 particular injuries matter; because they are
10 conclusive evidence of physical brain injury? Here
11 it's undisputed that Mr. Fragosa is permanently and
12 totally disabled; undisputed that he requires lifetime
13 medical treatment. It's even undisputed he suffered
14 physical brain damage in this accident. Despite that
15 and these are the issues on Appeal, the Single
16 Commissioner held that Mr. Fragosa has not suffered a
17 physical brain injury and is not entitled to lifetime
18 compensation benefits. He found in the Facts, "Based
19 on the greater weight of the evidence I found there
20 has not been a physical brain injury as it does not
21 meet the criteria established under the South Carolina
22 Workers' Compensation Act."

23 Respectfully, Your Honors, these findings are
24 completely against the evidence. There's no way --

25 COMMISSIONER BARDEN: Well, what about awarding

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1 the brain at a minimum pursuant to -- well, he got an
2 impairment rating in his favor, so I guess that's --
3 okay. All right. Go ahead, sir. I'm sorry. I'm
4 thinking out loud here.

5 MR. SAMUELS: You know, going through the record
6 and looking at the Findings and listening to the
7 arguments, there's really only one Finding that could
8 even remotely supports the Conclusion of no physical
9 brain damage and that's from the neuropsychologist
10 Mark Wagner's report. And the Finding there is -- and
11 this is Finding of Fact on page 10. Mark Wagner noted
12 that the Claimant sustained a skull fracture and acute
13 underlying minor structural change to the brain. Dr.
14 Wagner concluded the possible study such as the ENG,
15 CT and MRI were read as remarkable in quoting the
16 report, "Demonstrating structural resolution to the
17 work related injury." And I'll say two things on
18 that. First of all --

19 COMMISSIONER BARDEN: Did you say remarkable or
20 unremarkable?

21 MR. SAMUELS: Unremarkable.

22 COMMISSIONER BARDEN: Okay.

23 MR. SAMUELS: I'd say first off a
24 neuropsychologist while certainly qualified to give an
25 opinion on physical brain damage would have to do so

1 based within his level of competence in subliminal
2 testing not based on reading scans. And that quote
3 was actually a quote within a quote when they're
4 simply reading a scan. But essentially the argument
5 made by the Defendants is, well, yeah, he had a
6 physical brain injury but it got better and they argue
7 that means he's got a loss of use of his brain, but
8 not physical brain damage. Your Honors, that is
9 simply not true. He had a brain bleed; the brain
10 bleed reabsorbed; because it reabsorbed the hematoma
11 is no longer visible on the CT and MRI scan. There's
12 overwhelming evidence of a typical brain injury with
13 permanent deficit proving it's a physical brain
14 injury. The authorized treating neurologist, Dr.
15 Sandoz, opined to a reasonable degree of medical
16 certainty that Mr. Fragosa suffered physical brain
17 damage that has rendered totally and permanently
18 disabled. He assigned 46 percent whole person
19 impairment to the brain injury based on clinical
20 dementia and he repeated throughout his records,
21 throughout his deposition that this is physical brain
22 damage. In fact, Dr. Wagner agrees, because Dr.
23 Wagner says, "Trauma to the body and skull, acute
24 underlying minor structural change to the brain."
25 Structural change to the brain is physical brain

1 injury and while he goes on to say the previous quote
2 about demonstrating structural resolution he then goes
3 on to say, "He has persisting -- persisting cognitive
4 complaints, he has existing symptoms of a concussive
5 syndrome, he has abnormal sight, he has lost his
6 (inaudible) complex attention concentration. He may
7 have some degree of (inaudible) deficiency." What
8 that tells us, Your Honors, is that that's the
9 sequelae of the physical brain injury because the
10 reason for those problems is the brain damage. This
11 man has a severe residual damage. He's got proven
12 cognitive deficit, he's got health problems,
13 dizziness, seizures and difficulty in complex tasks
14 and it's from the brain injury; it's not from
15 medication, it's not a psychological overlay, not any
16 other cause but brain injury. And you've got a
17 qualified treating neurologist of physical brain
18 injury. You've got a neurologist who basically says
19 the same thing; just that the single Commissioner took
20 a long sentence out of context and that was the basis
21 for the erroneous rule. In fact, Your Honors, there
22 are plenty of brain injury cases; most of them are
23 close calls between many neuropsychologists and their
24 battle with the expert; many of them are close calls.

25 COMMISSIONER WILLIAMS: Y'all deposed Dr. Sandoz

1 and he said there was no physical brain injury or
2 damage on change in function. There is little
3 difference in the CT, ENG results (inaudible). Is
4 that correct or am I reading the record wrong?

5 MR. SAMUELS: I think you're reading the record
6 wrong; if I can specifically go to the testimony. Mr.
7 Burkett asked him in the deposition, "As far as
8 physical findings on his brain if you're to look at
9 the scans is it fair to say there is no physical
10 damage to the brain that we can see?" He doesn't ask
11 him is there physical damage to the brain or is there
12 no physical damage to the brain. He says is there
13 physical damage to the brain that we can see? Dr.
14 Sandoz replied, "There's no evidence of any damage on
15 the brain that we can go and see, that's correct."

16 COMMISSIONER WILLIAMS: I think the doctor opined
17 there's something that we can't see.

18 MR. SAMUELS: Because, Your Honor, what he's
19 talking about is the existing CT and MRI Scans, they
20 don't pick up the diffused actual injury. What they
21 can show -- what they will show is that the brain
22 bleed is reabsorbed. This is -- this is like a
23 tsunami.

24 COMMISSIONER WILLIAMS: Okay, so you could see it
25 before on the scan and not see it -- I think it's

1 almost where we couldn't see it before and it's still
2 there?

3 MR. SAMUELS: Because --

4 COMMISSIONER WILLIAMS: And again, would you
5 agree with me that the body part that's injured in the
6 brain can heal; the swelling can go down?

7 MR. SAMUELS: Well, if they -- if there's only
8 swelling and no damage then it can go down. The
9 swelling will go down, while swelling itself isn't
10 brain damage, it's circumstantial evidence of brain
11 damage.

12 COMMISSIONER WILLIAMS: So -- and maybe I -- and
13 maybe it's obvious. If the brain is injured can it
14 not heal? Or does the brain not heal, is that the one
15 organ that does it not heal?

16 MR. SAMUELS: I think, Your Honor, --

17 COMMISSIONER WILLIAMS: I guess -- probably that
18 you may not know. Probably not a fair question.

19 MR. SAMUELS: I don't think that specific
20 question was answered -- was asked, but I think the
21 doctor's opinion was --

22 COMMISSIONER WILLIAMS: How was the doctor not
23 speculating when he says -- Michael asked him, you
24 know, is there any physical brain damage that -- that
25 we can see? If you can't see it how else -- I mean if

1 you can't state that there's brain damage if you can't
2 see it I'm just wondering how he got to the conclusion
3 or how you can tell me that's the result of his injury
4 is brain damage.

5 MR. SAMUELS: Well, I have to go back to the
6 tsunami example, Your Honor. We have the tidal wave
7 that sweeps in and causes all sorts of damage; then it
8 -- the water recedes. You can't see the water
9 anymore, but the damage remains.

10 COMMISSIONER WILLIAMS: I agree with that. Was
11 there any neuro-psyche tests or any cognitive
12 functioning testing?

13 MR. SAMUELS: Yes, sir, by Dr. Mark Wagner.

14 COMMISSIONER WILLIAMS: Okay. And Dr. Wagner's
15 tests showed?

16 MR. SAMUELS: Dr. Wagner's tests showed
17 specifically that --

18 COMMISSIONER BARDEN: And that's on page 655?

19 MR. SAMUELS: It's on page 614. --

20 MR. BURKETT: It's on page 655.

21 COMMISSIONER BARDEN: 655 says that cognitive
22 findings were mostly normal with (inaudible) contained
23 no contact of (inaudible) concentration. Then it says
24 (inaudible) also contributed to his disability. Is
25 that what your record is saying?

1 MR. SAMUELS: It is page 655, Your Honor. I had
2 the wrong page and I apologize.

3 THE COURT: Thank you. Mr. Burkett.

4 MR. BURKETT: Thank you, Commissioners.

5 COMMISSIONER WILLIAMS: Mr. Burkett, let me ask
6 this. Off the hearing notes, if someone has a
7 contested finding, the finding then -- let me say
8 concussion and a lot of other physical damage, then
9 42-9-10(c), will it always result in finding as a
10 result of physical damage or can we go to the
11 Schedule? I think it was 67-1101.

12 MR. BURKETT: I think that's what the schedule
13 says. I think the law presupposes something and I can
14 give you an example. If you are a Claimant and you
15 lose both your legs to amputation, you're confined to
16 a wheelchair from right then for the rest of your
17 life; you're going to recover 500 weeks. If that same
18 person who may lose both of his legs because he's
19 paraplegic is confined to a wheelchair all the right
20 -- the result is the same; the law presupposes
21 additional medical complications because of the
22 paraplegia that goes along with it. So the law in
23 that case allows this 500 -- this exclusion of 500
24 weeks; we allow the lifetime indemnity benefits. In
25 this case -- and so we have is -- is does that kind of

1 law covers the physical brain damage, that's the
2 question is what is the physical brain damage and what
3 is covered under Regulation 67-1101. In this case I
4 think it's important to note that for all of the
5 things that we're alleging and how horrible this case
6 is a couple of things we noted; one, not at one time
7 ever did they make a motion to have anybody appointed
8 Guardian Ad Litem for the Claimant. In fact, he was
9 at the hearing and testified on his own behalf and how
10 he was doing, so yet he's entitled to -- he's got such
11 a significant brain injury that he's entitled to
12 lifetime benefits. Between August 2009 and November
13 -- I'm sorry, yeah, between August 2009 and November
14 2010 the Claimant didn't see the authorized doctor,
15 Dr. Sandoz one time, didn't have a single prescription
16 filled, didn't go to a single appointment. It wasn't
17 until after Dr. Sandoz' deposition where all of this
18 started to come up and the Claimant started going to
19 regular appointments again; which is fine, that was
20 the authorized doctor and he takes some medications
21 for headaches and things like that. So -- so somebody
22 who has such a severe physical brain damage case suit
23 and has lifetime indemnity, doesn't see a doctor for
24 the one condition that entitles him to that for over a
25 year; no Guardian Ad Litem is appointed. Like I said,

1 the law presupposes these things and they'll tell you
2 that -- and I think they even said in the Brief the --
3 the record is replete with Dr. Sandoz saying physical
4 brain damage. There are over 600 pages of medical
5 records in these three stacks and you won't find it;
6 you won't find the words physical brain damage used
7 until right before the hearing and seven months after
8 Dr. Sandoz' deposition on page -- I just had it --
9 page 882 of the APA submissions is a letter from the
10 Claimant's attorney with a yes or no circled, does the
11 Claimant have physical brain damage, and refers to CT
12 Scans and things like that, but it doesn't reference
13 what CT Scans. Now, there were no CT Scans after 2009
14 so whatever was in existence at the time of Dr.
15 Sandoz' deposition when I flat out asked him, "Is
16 there physical brain damage? Is there anything we can
17 see?" He said, "No.", except he used the work
18 traumatic brain injury. In the letters that he wrote
19 from page 711 and 716 APA submissions he used the term
20 "traumatic brain injury". So traumatic brain injury
21 is the same as physical brain injury; I admit I might
22 have a problem. But I think physical brain injury, in
23 fact, the General Assembly and Legislature has put a
24 burden on us with something we can physically see,
25 something that requires something more here. Now,

1 it's -- it's -- in their Brief there's a question
2 about Dr. Wagner and how much he can say and what he
3 can't say and everything like that, but if you look at
4 their -- their report from Dr. Brabham and Dr. Brabham
5 reaches a conclusion the Claimant has physical brain
6 damage, but what Dr. Brabham does he looks at page 655
7 of the APA submissions and says, "Mr. Gomez had a
8 serious -- a very serious work related injury
9 resulting in trauma to his body and skull. He had a
10 skull fracture with acute underlying minor structural
11 change to the brain", period. They left off the rest
12 of that which was, "Follow up structural and
13 functional studies have been read as unremarkable
14 (inaudible). Dr. Wagner didn't interrupt these; he's
15 saying what the radiologist who read the reports --
16 who produced the reports had said these are all -- all
17 resolved. So it's funny to sit here and say they
18 don't need this finding of physical, yet they're
19 leaving out Dr. Brabham's -- it's in the Commission's
20 file, there was a case synopsis handed up in the Trial
21 Brief. And in the Trial Brief by the Claimant's
22 attorney it said -- it mentions Dr. Sandoz' report on
23 number 3, the very last page and it leaves out that
24 very important, all these things have been resolved.
25 So to stand here and say this isn't important, this

1 isn't what we need and conveniently leave it out of
2 your vocational report and leave it out of your Trial
3 Brief is a little bit disingenuous. Really if you
4 boil this case down to its skeletal parts it's, what
5 is a physical brain injury for purposes of the
6 Workers' Compensation Act? Our position is that it's
7 something physical that you can see. I have a
8 Claimant had a nail go through his eye, it went into
9 his frontal lobe, when they did the surgery some of
10 his frontal lobe came out and you can see it. You can
11 take scans today and see where it's missing and that
12 is a physical change to the brain. Dr. Sandoz, like I
13 said, repeatedly said traumatic brain injury in his
14 physician and his notes, what have you. It's -- also
15 I want to point out that in their Brief on page 10 it
16 says, "It's not at all unusual for a physical brain
17 injury not to be visible on conventional CT and MRI
18 Scans." Once again, they're noting that you've got to
19 be able to see something. You need PET Scans and
20 (inaudible) MRI Scans, so they're acknowledging and --
21 this was necessary just to see what's here, the other
22 problem I have with that paragraph on page 10 is that
23 it's full of medical opinion that's not -- that's not
24 supported anywhere, nobody said that except for Mr.
25 Sandoz in this case, so in that paragraph themselves,

1 they are admitting that there are -- there's a need to
2 see something. And that's just not the case here and
3 so I'm -- I'm probably oversimplifying it, but I think
4 there's something you need to see. Dr. Sandoz said
5 you can look at all the Scans you want; you're not
6 going to see anything. He does have cognitive
7 deficits, what have you -- so that's why we have
8 Regulation 67-1101. So the short answer to your
9 question is, yes, you can be awarded for the brain and
10 not have a physical brain injury in South Carolina.

11 COMMISSIONER McCASKILL: As I understand what
12 you're saying if it is a physical brain injury you've
13 got to be able to see it?

14 MR. BURKETT: That is our position there would be
15 some physical change that something would pick up on a
16 Scan, whether it be -- I don't know what kind of Scan,
17 but any kind of Scan and this -- you won't see it in
18 any of these 700 pages of medical records; it's just
19 not there. The first time Dr. Sandoz -- the word
20 physical comes out of his mouth -- it didn't come out
21 of his mouth, he circles yes on page -- he circled yes
22 on the questionnaire page 882, APA submissions right
23 before the hearing. So at the very least he's got Dr.
24 Sandoz contradicting himself without any medical
25 explanation whatsoever because of what he testified

1 to.

2 Thank you.

3 THE COURT: Okay. Mr. Samuels.

4 BY MR. SAMUELS: Thank you, Your Honors. Again,
5 for the rest of us 67-1101, this is a simple
6 dichotomy. 67-1101 is how the Commission is supposed
7 to award a brain injury in a physical brain injury
8 case where the Claimant is not also permanently and
9 totally disabled by that. It's pretty darn easy; it's
10 just the same as 42-9-10, totally disabled, totally
11 disabled; 42-9-30 and 67-1101 is the disability for
12 somebody who's still working under the scheduled
13 member. The medical model, that Your Honors, is a red
14 herring, that's why we filed the Reply Brief. I think
15 that sort of explains that distinction. You go back
16 and look at the medical records. The argument I
17 heard, a brain injury can only be a physical brain
18 injury if you can see it; that reminds me of the
19 argument advanced in Reid Richards, but that would be
20 incomplete -- I believe the case where the Defense
21 position in that case was, we interpret paraplegia as
22 total loss of function below that level. The Court
23 said, no, that's not it, because the doctors can give
24 you an opinion on what the definition is and that's
25 what the doctor had done here. Both Dr. Sandoz and

1 Dr. Wagner have explained why this is physical brain
2 damage. Dr. Sandoz gave an explicit opinion. Now we
3 do have a little bit of a dichotomy between the terms
4 the doctors used, which is traumatic brain injury and
5 what lawyers use, which is physical brain injury, but
6 at his deposition as a follow-up to that mysterious
7 question about if you see the brain damage, the
8 question is "Was there a jar to the brain casing and
9 concussion in an area. The answer, "The concussion
10 should resolve." The case that we're looking at in
11 (inaudible) took a longer period of time." Answer;
12 The authorized treating neurologist said there had
13 been some damage and injury to the function of the
14 brain. And again -- once again, we know, we've got
15 dizziness, we've got proven cognitive deficits, proven
16 on neuropsychological examining. We've got a rating
17 -- 46 percent rating for brain damage, for clinical
18 dementia, including dizziness, vertigo, balance
19 problems and all these things that show that the brain
20 damage is permanent. And again, you can't see the
21 water, you can't see the blood, because that tsunami
22 has receded. But what we know about the testing on
23 this --

24 Is it all right if I finish my sentence, Your
25 Honors?

1 Is that the physical brain damage hasn't left
2 this poor man. He has all of these problems
3 documented by both of the doctors.

4 THE COURT: Thank you very much.

5 (The hearing concluded at 3:11 p.m.)
6
7
8

STATE OF SOUTH CAROLINA)
)
 COUNTY OF LEXINGTON)

CERTIFICATE

BE IT KNOWN THAT I TOOK THE FOREGOING
 WORKERS' COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN
 AND FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF 19
 TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND
 COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT
 THE TIME AND PLACE AFORESAID TO THE BEST OF MY SKILL
 AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF
 ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE
 OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES
 HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 31ST DAY OF AUGUST,
 2012.

CORA ELLIS BRUTON
 NOTARY PUBLIC FOR SOUTH CAROLINA
 MY COMMISSION EXPIRES JANUARY 18, 2015

MUSC Medical Center
CONSULTATION REPORT
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date: 11/01/2007
Service: Orthopedic
Attending: Shane K. Woolf, MD

HISTORY OF PRESENT ILLNESS: The patient is a 56-year-old patient, at a construction site was hit in the head with a crane. Apparently he vomited prior to the ED arrival, with unsuccessful intubation at an outside hospital. Past medical history none. No known drug allergies. No known previous surgeries, no current medical conditions. Apparently could smell alcohol on the patient's breath. Questionable tobacco use.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Unable to obtain.

This patient incurred a large fracture through his skull, apparently it is open, with subdural and epidural fluid collections. Orthopedics was consulted for a right clavicle fracture as well as fractures of the proximal phalanges of the right foot, 2-12, with traumatic arthrotomies of the 4th and 5th toes as well as a nondisplaced oblique fracture of the right great toe.

PHYSICAL EXAMINATION: The patient is a Hispanic male, intubated, sedated. Apparently he was moving all extremities upon admission. His right upper extremity is noted to have some bruising and swelling about the right hand, but no crepitus is noted about the hand, wrist, elbow, arm, or shoulder. There is gross crepitus at the right clavicle. The left upper extremity is unremarkable. Again it was moving, apparently, on admission. There is no crepitus or step-off noted. His left lower extremity also has no obvious injuries, swelling, step-offs, crepitus noted about the hip, thigh, knee, leg, or ankle or foot. The right foot is significant for traumatic arthrotomies of the 4th and 5th digits, and gross swelling about the foot. The ankle appears to be intact without any swelling or bony step-offs or crepitus, as well as the leg, knee, and thigh, and there is range of motion in his hip without crepitus. His pelvis is stable to AP and lateral compression. Abdomen is soft, nontender, nondistended.

ASSESSMENT: Hispanic male with the aforementioned injuries with traumatic arthrotomies at the 4th and 5th toes of the right foot as well as right clavicle fracture. Will apply a splint to the clavicle fracture. The arthrotomies will be washed out and assessed. Antibiotics q. 8h will be recommended, and patient apparently is not a surgical candidate at the moment per neurosurgery. Will possibly take him to the OR for more definitive washout and closure and possible pinning of the fractures at a future date.

The plan has been discussed with the attending and he is in agreement.

Dictated by: Bennett Grimm, MD

Bennett Grimm, MD

Shane K. Woolf, MD
Attending

902536 / 35634 /

JOB: 367701

DD: 11/01/07 08:40 PM

DT: 11/02/07 12:19 PM

Additional CC: _____

DOCID: 18231902536

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:22:19 AM

MUSC Medical Center
CONSULTATION REPORT
Patient Name: TRAUMA, VICTIM JW
MRN: 002581962
Patcom: 490943644
Date: 11/01/2007
Service: Neurosurgery Service
Attending: Istvan Takacs, MD

CHIEF COMPLAINT AT TIME OF ADMISSION: Status post fall.

HISTORY OF PRESENT ILLNESS: A 27-year-old Hispanic male who was working at a construction site as per report, the counterweight of the crane fell on his head. He has a left scalp laceration, intubated. As per report, he was combative at the scene and had some vomiting. His wound was cleaned and sutured by the trauma service. Among other injuries, he has right big toe fracture, right fifth toe fracture, right clavicle fracture.

ALLERGIES: None.

MEDICATIONS: None.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Unknown.

REVIEW OF SYSTEMS: Unable to obtain.

PHYSICAL EXAMINATION: Pulse 101, respiratory rate 18, blood pressure 117/82, sats 100% on vent. Neck: He is in C-collar. Head and face: He has some left frontoparietal laceration. Heart: Regular rate and rhythm. Lungs: Bilaterally clear. Abdomen: Soft, nontender. Neuro examination on minimal sedation is E2, V1, M5, GCS of 8/10. Cranial nerves: He has bilateral pupils 2 mm and nonreactive. His face appears to be symmetric. He localizes bilateral upper and lower extremities briskly. His toes are downgoing bilaterally. CT of the head reveals a left scalp laceration with scalp hematoma with left frontoparietal skull fracture which extends to the base of the skull with minimal underlying contusion. CT scan of the C-spine reveals a C7-T1 transverse process fracture. No fractures or malalignment otherwise. T and L films reveal no fractures.

LABORATORIES: Sodium is 143, potassium 3.9, BUN 13, creatinine 1.2, white count 15.1, H&H of 10.3 and 30.7, platelets of 207, PT of 17.7, INR of 1.4.

ASSESSMENT AND PLAN: Patient is a 27-year-old status post closed head injury with open skull fracture. We recommended ICU admission, frequent neuro checks. start vancomycin and Claforan. Keep INR less than 1.3, platelets greater than 100,000, sodium between 135 and 140, normal temperature. We will recommend starting on antiepileptics for seizure prophylaxis. We will discuss the patient's details with Dr. Takacs. There is no need for repeat imaging at this point unless the exam declines. We will continue to follow.

Dictated by: Vibhor Krishna, MD

Vibhor Krishna, MD

Istvan Takacs, MD
Attending

901511 / 41177 /
JOB: 367697
DD: 11/01/07 07:25 PM
DT: 11/02/07 11:57 AM

Additional CC: _____

DOCID: 18231901511

Edited By VIBHOR KRISHNA on 11-19-2007 at 08:46:28 PM
Electronically signed by ISTVAN TAKACS, MD on 12-05-2007 at 08:44:50 PM



Medical University of South Carolina

Charleston, SC

843-792-2123

Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075390

MRN: 002581962
Date Exam Completed: 11/01/2007 18:15
Last Update: 11/02/2007

EXAMINATION: CT BRAIN 11/01/07 18:15:00

ACCESSION NUMBER: 5075390

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple contiguous five mm axial CT images were obtained through the brain without IV contrast.

FINDINGS: There is a minimally displaced fracture with significant diastases extending longitudinally from left occipital bone up to the parietal, temporal and frontal bone and extending obliquely through the left orbital roof. There is associated midline small parietal extra-axial hemorrhage. There is small amount of pneumocephalus along the fracture line, worrisome for a small epidural hematoma. There are also bilateral basilar frontal contusions. Ventricles are small but symmetric in size. There is no evidence of herniation. There is diastases of right coronal suture and dorsal part of the sagittal suture. There is opacification of the nasal passages and fluid layering in the sphenoid and left maxillary sinus, likely traumatic. If nondisplaced skull base or facial fractures are suspected thin cut facial CT may be considered. Mastoid air cells are well aerated. There is significant scalp hematoma and emphysema. Endotracheal and oro gastric tubes are in place.

IMPRESSION:

1. Comminuted fracture as above with small extra-axial parietal hematoma at midline at the vertex, worrisome for a small epidural hematoma.

Findings were discussed with Dr. Hiott and Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT ABDOMEN W/CONTRAST
Accession #: 5075388

MRN: 002581962
Date Exam Completed: 11/01/2007 18:18
Last Update: 11/02/2007

EXAMINATION: CT ABDOMEN 11/01/07 18:18:00

ACCESSION NUMBER: 5075388

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple 2 mm axial CT images were obtained of the abdomen from the domes of the diaphragm to the iliac crest after the intravenous bolus administration of 140 cc Omnipaque 300 (iohexol) without immediate adverse reaction. Sagittal and coronal reformatted images were generated. Please refer to separate CT of the chest and pelvis for pertinent findings in those regions.

FINDINGS: The liver, spleen, gallbladder, pancreas, left adrenal gland and kidneys show no evidence for acute injury. There is a right adrenal hemorrhage. The gastrointestinal tract is also unremarkable without wall thickening or obstruction. Abdominal and hepatic vasculature is normal. There is no evidence for free intraperitoneal gas, fluid or lymphadenopathy. Review of bony structures demonstrates bilateral L1-2 transverse process fractures, and right L3 transverse process fracture.

IMPRESSION:

1. Right adrenal hemorrhage.
2. Bilateral L1-2 and a right L3 transverse process fractures and multiple posterior right rib fractures.

Findings were discussed with Dr. Wilson by Dr. Fernandez at completion of the exam.

Please refer to separate CT of the chest and pelvis for additional pertinent findings in those regions.

VOICE DICTATED BY: Dr. MIGUEL FERNANDEZ
I have reviewed the images and agree with the findings in this report.

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT ABDOMEN W/CONTRAST
Accession #: 5075388

MRN: 002581962
Date Exam Completed: 11/01/2007 18:18
Last Update: 11/02/2007

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON
Interpreter 1: TIMOTHY ALDER
Interpreter 2: MIGUEL FERNANDEZ
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/2/2007

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Page: 2



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT CHEST W/ CONTRAST
Accession #: 5075391

MRN: 002581962
Date Exam Completed: 11/01/2007 18:20
Last Update: 11/02/2007

EXAMINATION: CT CHEST 11/01/07 18:20:00

ACCESSION NUMBER: 5075391

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: chest radiograph same day

TECHNIQUE: Multiple 2 mm axial CT images were obtained of the thorax from the level the clavicles to the domes of the diaphragm after the bolus administration of 140 cc Omnipaque 300 (iohexol) without immediate adverse reaction. Sagittal and coronal reformatted images were generated. Please refer to separate CT of the abdomen and pelvis for additional pertinent findings below the level of the diaphragm.

FINDINGS: The aorta and great vessels are unremarkable in course and caliber without evidence for acute injury. There is no evidence for mediastinal hematoma or pericardial effusion. Evaluation of lung parenchyma demonstrates bilateral patchy consolidation compatible with lung contusions and/or aspiration. There is no pneumothorax or pleural effusion. The endotracheal tube is low in position just proximal to the carina. Review of bony structures demonstrates a right clavicle fracture as well as C7 and T1 spinous process fractures. In addition, right T8 through 10 and T11 rib fractures are noted.

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1

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **CT CHEST W/ CONTRAST**
Accession #: **5075391**

MRN: **002581962**
Date Exam Completed: **11/01/2007 18:20**
Last Update: **11/02/2007**

IMPRESSION:

1. Bilateral lung contusions and/or aspiration.
2. Right clavicle fracture and C7 and T1 spinous process fractures.
3. Low position of the endotracheal tube, recommend withdrawing approximately 1.0 cm.

Findings were discussed with Dr. Wilson by Dr. Fernandez at the completion of the exam.

Please refer to separate CT of the abdomen and pelvis for additional pertinent findings.

VOICE DICTATED BY: **Dr. MIGUEL FERNANDEZ**

History: **58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION**

Technologist: **JOYCE WILKINSON**
Interpreter 1: **TIMOTHY ALDER**
Interpreter 2: **MIGUEL FERNANDEZ**
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist:
Date Authenticated:

Transcribed by: **Tech IntTalk**

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075386

MRN: 002581962
Date Exam Completed: 11/01/2007 17:18
Last Update: 11/02/2007

EXAMINATION: CHEST 11/01/07 17:18:00

ACCESSION NUMBER: 5075386

INDICATION: EHIT IN HEAD, ETT

COMPARISON: None.

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomedistinal silhouette. There is right apical and left peritracheal airspace opacity, representing contusion versus atelectasis. There is no evidence of pneumothorax. Endotracheal tube overlies tracheal air column and terminates at the level of carina. Enteric catheter transverses the thorax and terminates overlying proximal stomach. There is midshaft right clavicular fracture with significant diastases and superior displacement of distal fracture fragment.

IMPRESSION:

1. Bilateral apical contusions versus atelectasis
2. Right midshaft clavicular fracture

Findings were discussed with Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

History: EHIT IN HEAD, ETT

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Page: 1

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075386

MRN: 002581962
Date Exam Completed: 11/01/2007 17:18
Last Update: 11/02/2007

Technologist: CASSANDRA FERRELL
Interpreter 1: TIMOTHY ALDER
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/2/2007

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075390

MRN: 002581962
Date Exam Completed: 11/01/2007 18:15
Last Update: 11/02/2007

EXAMINATION: CT BRAIN 11/01/07 18:15:00

ACCESSION NUMBER: 5075390

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple contiguous five mm axial CT images were obtained through the brain without IV contrast.

FINDINGS: There is a minimally displaced fracture with significant diastases extending longitudinally from left occipital bone up to the parietal, temporal and frontal bone and extending obliquely through the left orbital roof. There is associated midline small parietal extra-axial hemorrhage. There is small amount of pneumocephalus along the fracture line, worrisome for a small epidural hematoma. There are also bilateral basilar frontal contusions. Ventricles are small but symmetric in size. There is no evidence of herniation. There is diastases of right coronal suture and dorsal part of the sagittal suture. There is opacification of the nasal passages and fluid layering in the sphenoid and left maxillary sinus, likely traumatic. If nondisplaced skull base or facial fractures are suspected thin cut facial CT may be considered. Mastoid air cells are well aerated. There is significant scalp hematoma and emphysema. Endotracheal and oro gastric tubes are in place.

IMPRESSION:

1. Comminuted fracture as above with small extra-axial parietal hematoma at midline at the vertex, worrisome for a small epidural hematoma.

Findings were discussed with Dr. Hiott and Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075390

MRN: 002581962
Date Exam Completed: 11/01/2007 18:15
Last Update: 11/02/2007

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON
Interpreter 1: MARIA SPAMPINATO
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: MARIA SPAMPINATO
Date Authenticated: 11/2/2007

Transcribed by: Tech IntTalk

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MRN: 002581962

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075505

Date Exam Completed: 11/01/2007 22:53
Last Update: 11/02/2007

EXAMINATION: CHEST 11/01/07 22:53:00

ACCESSION NUMBER: 5075505

INDICATION: 28 yo hit by a crane with LOC and foot fractures and rib fractures

COMPARISON: 11/01/07.

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomedistinal silhouette. There has been interval withdrawal of endotracheal tube, with its distal tip now 2 cm from the carina. Enteric catheter is unchanged. Again noted are bilateral apical air space opacities, contusions versus atelectasis or aspiration. There is no evidence of pneumothorax. Right clavicular fracture is also noted.

IMPRESSION:

1. Status-post repositioning of endotracheal tube
2. Bilateral apical opacities, contusions versus atelectasis or aspiration

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

History: 28 yo hit by a crane with LOC and foot fractures and rib fractures

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Page: 1

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **DIAG CHEST PORTABLE 1 VIEW**
Accession #: **5075505**

MRN: **002581962**
Date Exam Completed: **11/01/2007 22:53**
Last Update: **11/02/2007**

Technologist: **LAKEISHA WILLIAMS**
Interpreter 1: **PHILIP COSTELLO**
Interpreter 2: **DOBRINKA DIMITROVA**
Interpreter 3: **MARQUES BRADSHAW**
Date Dictated:

Proxy Signer:

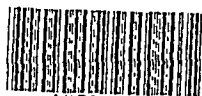
Authenticating Radiologist: **PHILIP COSTELLO**
Date Authenticated: **11/2/2007**

Transcribed by: **Tech IntTalk**

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Page: **2**



HISPHYS

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Adult Initial Neurosurgery Evaluation

Page 1 of 2

Form Origination Date: new
Version: Version Date: in progress

Date: 11/1/07

☐ Neurosurgery H&P ☒ Neurosurgery Consult



P490943644 DOB: 01/01/1951 U U

TRAUMA

VICTIM JW

Adm: 11/01/07 M2581962

Patient Name: 2581962
MRN

STAMP PLATE AREA

Requesting MD/Service: _____ Location of consult: ☒ ER ☐ ICU ☐ Floor ☐ Other:

Chief Complaint:

HPI (4): 27 y/o M @ work has a counter weight of crane fall on his head, → scalp lacer. intubated @ MUSC, 10 min after washout. was combative, ADLs vomiting @ scene. smells of EtOH.

Ⓡ big toe fx, Ⓡ tibia fx, Ⓡ clavicle fx

(Location, duration, timing, severity, quality, context, things that relieve or exacerbate, associated symptoms)

Medical Allergies: unknown

Medications: φ

ROS (NAT = Not able to test)

Neuro	☐ Neg	☐ NAT	Endocrine	☐ Neg	☐ NAT
General	☐ Neg	☐ NAT	GI	☐ Neg	☐ NAT
Hematologic	☐ Neg	☐ NAT	GU	☐ Neg	☐ NAT
ENT	☐ Neg	☐ NAT	Musculoskeletal	☐ Neg	☐ NAT
Cardio/Vasc	☐ Neg	☐ NAT	Skin	☐ Neg	☐ NAT
Respiratory	☐ Neg	☐ NAT	Psych	☐ Neg	☐ NAT
Eyes	☐ Neg	☐ NAT	Other	☐ Neg	☐ NAT

PMH

PSH

Family Hx

Social Hx

unknown

PE: Temp _____ Tmax _____ Pulse 101 B/P 117/82 Resp 18 ☐ Ventilated: no ☒ on vent

General Appearance: _____ Activity: ☐ Bedrest ☐ In chair ☐ Ambulating

Nutrition: ☐ NPO ☐ Tube Feeds ☐ PN ☐ Fluids ☐ Solids

General Exam (NE = Not examined)

Neck	☐ WNL	☐ NE	Right arm	☐ WNL	☐ NE
Head / face	☐ WNL	☐ NE	Left arm	☐ WNL	☐ NE
Heart	☐ WNL	☐ NE	Right leg	☐ WNL	☐ NE
Lungs	☐ WNL	☐ NE	Left leg	☐ WNL	☐ NE
Abdomen	☐ WNL	☐ NE	Other		
GU	☐ WNL	☐ NE			
Rectal	☐ WNL	☐ NE			

in C-collar
lacerations (4) r-par-
ax
612 air entry
soft, ND

Resident/MLP Signature

Pager ID 15388

Date 11/1/07 Time 18:43 AM/PM

Attending Signature
neurosurgery/initials

Pager ID

Date Time AM/PM

OTE 900396 7/06



HISPHYS

Adult Initial Neurosurgery Evaluation
Page 2 of 2Form Origination Date: 7/06
Version: 1

Version Date: 7/06

Date: 11/1/07

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P490943644 DOB: 01/01/1951 U U

TRAUMA

VICTIM JW

Adm: 11/01/07 M2581962

Patient Name
MRN

STAMP PLATE AREA

Neuro Exam		☒ Minimal or no medical sedation		☐ Heavily sedated		☐ Sedated and pharmacologically paralyzed			
Neuro: Best motor exam:		☐ Spontaneously		☐ To command (6)		☒ Localizes (5)		☐ Withdrawals (4)	
Best verbal exam:		☐ Normal		☐ Oriented (5)		☐ Confused (4)		☐ Inappropriate (3)	
GCS: Best eye opening:		☐ Spontaneous (4)		☐ To speech (3)		☒ To pain (2)		☐ None (1)	
Alertness:		☐ Alert		☐ Drowsy but arousable		☐ Lethargic, difficult to arouse		☐ Confused / delirious	
Orientation:		☐ NAT (Not able to test)		☐ Oriented to time, place, person		☐ Oriented only to:		☐ Time ☐ Place ☐ Person ☐ None Other:	
Memory:		☐ NAT		☐ Appears WNL		☐ 3/3 objects at 5 min		Other:	
Knowledge:		☐ NAT		☐ Appears WNL		☐ 3/3 objects at 5 min		Other:	
CN 2	V fields / acuity	☐ NAT	☐ Normal fields	☐ Normal acuity gross	☐	CN 7	Facial movements	☐ NAT	☒ Normal facial symmetry
Discs	☐ Not seen well	☐ NAT	☐ No papilledema	☐	☐	CN 8	Hearing	☐ NAT	☐ Normal hearing bilaterally
CN 3, 4, 6	Pupils	☐ NAT	PERL ☒ Right pupil 2 mm	☐ RRL ☐ Other:	☐	CN 9, 10	Soft palate	☐ NAT	☐ Rises symmetrically
	EOM	☐ NAT	☐ EOM full	☐	☐	CN 11	Sternocleidomastoid & Trapezius	☐ NAT	☐ NL Sternocleidomastoid & Trapezius
CN 5	Facial sensations	☐ NAT	☐ Facial sensation normal	☐	☐	CN 12	Tongue	☐ NAT	☐ Midline, normal
		☐	☐ Rt corneal ☐ Present ☐ Absent	☐	☐			☐	☐
		☐	☐ Lt corneal ☐ Present ☐ Absent	☐	☐			☐	☐
Strength	☐ NAT	☐ All Normal	Right ARM ☐ Normal ☐	Left ARM ☐ Normal ☐	☐			☐	☐
		☐	Right LEG ☐ Normal ☐	Left LEG ☐ Normal ☐	☐			☐	☐
		☐	Hemiparesis: ☐ Right: ☐	☐	☐			☐	☐
Motor Group Specific	☐ NAT	☐	Del Bic Tri WE Grip HI Other: IP	Quad Ham DF EHL PF Other:	☐			☐	☐
		☐	Right Left <i>localizes</i>	<i>localizes</i>	☐			☐	☐
Sensation	☐ NAT	☐ All Normal	Right ARM ☐ Normal ☐	Left ARM ☐ Normal ☐	☐			☐	☐
		☐	Right LEG ☐ Normal ☐	Left LEG ☐ Normal ☐	☐			☐	☐
		☐	Sensory level: ☐	Other: ☐	☐			☐	☐
Gait	☐ NAT	☐ Normal ☐			☐			☐	☐
Babinski	☐ NAT	☐ Right ☐ Absent ☐ Present	☐ Left ☐ Absent ☐ Present		☐			☐	☐
Coor	☐ NAT	☐ Normal Rt FN ☐ ABN	☐ Normal Lt FN ☐ ABN		☐			☐	☐
Tone	☐ NAT	☐ WNL ☐	☐		☐			☐	☐
Pulses	☐ NAT	☐ Carotid WNL ☐	☐		☐			☐	☐

Abbreviations: EVD=External ventricular drain; NAT=Not able to test; Del=Delirious; Bic=biceps; WE=Wrist extensors; HI=Hand intrinsic; IP=Iliopsoas; Quad=Quadriceps; Ham=Hamstring; EHL=Extensor hallucis longus; PF=Plantar flexors; DF=Dorsi flexors

AP: 27 y/o M. BHI & open skull for -
 1. Agree to I & H admission, frequent neuro checks
 2. Agree to Vanc / Penicillin / Clindamycin
 3. Keep I & H C & Z. PT > 100 mmHg. ABG = 135-40, Normal temp, AT E.D (keep for 100% O2)
 4. Will do w/ Dr. Tacker.
 5. No need to repeat imaging unless exam declines

Resident/MLP Signature

☐ I saw and evaluated the patient. Discussed with residents and/or MLP and agree with their findings and plan as documented in the note.
☐ More than 50% of this visit (min total) was spent on education and counseling.
Attending Signature
neurosurgical/initial

Pager ID 15388

Date 11/1/07

Time 18:43

AM/PM

Pager ID

Date

Time

AM/PM

OTE 900395 7/06



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P490943644 DOB: 01/01/1951 U U
TRAUMA
VICTIM JW
Adm: 00000000 M2581962

Trauma Center Initial Patient Evaluation

Page 1 of 6

HISTORY

Chief Complaint (Mechanism of Injury): ☐ Auto-ped ☐ MVC ☐ Motorcycle Crash ☐ Gunshot ☐ Shotgun ☒ Fall - object fell on pt

☐ Stabbing ☐ Assault ☐ Other (describe):

History of Present Illness: ☐ Check if complete HPI cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

Source(s) of History: ☐ Patient ☒ EMS ☐ Family ☐ Police ☐ Other:

Patient Age: Patient Gender: ☐ M ☐ F

Patient Origin: ☐ Scene ☐ Walk-in ☐ Transfer: Referring hospital:

Transport Mode to MUSC: ☐ Ground Ambulance ☒ Helicopter ☐ Private Vehicle ☐ Other:

Time from event to MUSC arrival:

History of event (to include any history of LOC):

5 ft ft at a construction site a crane elevated + it fell on
hit him.

Prehospital Course:

- Vomiting x1 prior to EMU arrival
- Tried to be intubated by Marion County unsuccessful, when
Carolina Life care arrived

Subjective Complaints (location and severity of symptoms):
unable to speak
they were able to intubate
pt got 1 Liter
prior to arrival

Modifying Factors (EtOH consumption, environmental hazards, etc):

unknown

Safety Devices in use (check all that apply): ☐ Not applicable ☒ Unknown ☐ Seat belt
☐ Shoulder Restraint ☐ Helmet ☐ Other (Describe):

Additional HPI:

fenoxyl 1 Ativan 2 - both prior to arrival. Pt vomited prior
to EMU on scene

Past Medical History: ☐ Check if complete PMH cannot be obtained due to need for urgent evaluation
and/or urgent management of patient's condition

Medications:

Allergies:

Previous Surgeries:

Chronic Medical Conditions:

Primary Care Physician:

Social History: ☒ Check if complete Social History cannot be obtained due to need for urgent evaluation
and/or urgent management of patient's condition

EtOH use: ? - able to smell EtOH on patient

Tobacco Use: ?

Drug Use: ?

Employment: ?

Family History: ☒ Check if complete family history cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

Injury List	Injury	AIS Code
1.	Right toe fracture	
2.	Right toe fracture	
3.	Fracture of skull	
4.	High frontal/	
5.	Subdural/epidural	
6.	Fluid collection	
7.	Basilar	
8.	contusion	
9.	nasopharynx	
10.	acute hemorrhagic	
11.	scalp laceration	
12.	SLP repair	
13.	P7 + T1 spine, present	
14.	P2, 6 FX 7, 8, 9, 10	
15.	Ble transverse process	
	FX L1 + L2; Right C5	



Trauma Center Initial Patient Evaluation Page 2 of 6

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HISTORY (continued)

Review of Systems: ☒ Check if complete ROS cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition
(* If no notation, system was not evaluated)

System*	WNL	Abnormal (describe)
(Constitutional) Overall health	☐	
Eyes	☐	
Ears, nose, throat, mouth	☐	
Cardiac	☐	
Vascular	☐	
Respiratory	☐	
Gastrointestinal	☐	
Genitourinary	☐	
Musculoskeletal	☐	
Skin/breasts	☐	
Neurologic	☐	
Psychiatric	☐	
Endocrine	☐	
Hematologic/lymphatic	☐	
Immunologic	☐	

PRIMARY SURVEY (INITIAL FINDINGS)

- Airway:** ☒ Patent and stable *- pt arrived intubated*
☐ Unstable (explanation):
 Actions taken:
- Breathing:** ☒ Breath sounds clear bilaterally, no respiratory compromise or distress
☐ Abnormalities (describe):
 Actions taken:
- Circulation:** ☒ No signs/symptoms of shock; no external hemorrhage
☐ Abnormalities (describe):
 Actions taken:
- Disability:** ☒ No abnormalities *unable to respond*
☐ Abnormalities (describe):
 Actions taken:

- RESUSCITATION:** (Check all that apply including actions taken during entire Emergency Department evaluation)
- ☒ Peripheral Intravenous Lines Placed (see nursing notes for locations) *RFA + LAC 16 gauge both 16 gauge in @ hand*
☐ Chest Tube placed: (location): (See procedure note(s) for specific details and nurses notes for total output)
☐ Chest Tube #2 placed: (location): (See procedure note(s) for specific details and nurses notes for total output)
☐ Central Venous Line placed: (location): (See procedure note(s) for specific details)
☐ Central Venous Line #2 placed: (location): (See procedure note(s) for specific details)
☐ Foley Catheter placed
☐ NG / ☐ OG Tube placed (check as appropriate)
☐ ECG monitor placed
☐ Patient placed on supplemental O₂
☐ Patient placed on ventilator
 Mode _____ F_iO₂ _____
 PEEP/CPAP _____ V_T _____ Rate _____
☐ End Tidal CO₂ Monitor placed
☐ Pulse Oximeter placed
☐ Other: _____

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Trauma Center Initial Patient Evaluation
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PHYSICAL EXAMINATION

Initial Vital Signs:

BP: 141/79 → 80/34

Pulse: 116

Resp. Rate: 24 on PRVC

Temperature: 96.4

Initial GCS:

Eye Opening:

Verbal Response:

Motor Response:

Total GCS Score:

pts

pts

pts

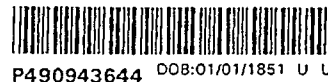
pts

unable to
quantify 2nd to
intubation + sedation

9790 - intubated

Part Examined	WNL	Abnormal (describe)
General	☐	
Head		
Scalp	☐	1 inch front to back open laceration with aponeurosis exposed
Facial Skin	☐	
Facial Bones	☐	
Mandible	☐	
Eyes		
Pupils	☐	unreactive, but pt received Pentamyl, Narcan, & Ativan @ 1605, but pinpoint & equal
EOM	☐	
Fundi	☐	
Ears		
TM's	☒	
Ext Aud. Canals	☐	
Pinna	☐	
Nose		
Nasal Septum	☐	
Mouth		
Teeth	☐	
Tongue	☐	swollen
Pharynx	☐	
Hard/soft Palate	☐	
Neck		
Bony Spine	☐	- pt is in a miami-J collar
Soft Tissues	☐	
Chest		
Breath Sounds	☒	CTA (D)
Chest Wall	☐	
Heart	☐	
Abdomen	☐	soft
Pelvis	☐	stable
Genitalia	☐	toilet placed
Rectum/Perineum		
Prostate	☐	
Sphincter Tone	☒	
Stool Gross Blood	☐	
Back	☒	

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Trauma Center Initial Patient Evaluation
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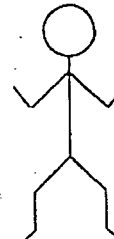
Vascular Examination			
Vessel	Lt	Rt	Comments
Carotid	✓	✓	
Brachial			
Radial			
Ulnar			
Femoral	✓	✓	
Popliteal	✓	✓	
Dorsalis Pedis	✓	✓	
Posterior Tibial	✓	✓	

Extremity Examination		
Extremity	WNL	Abnormalities (describe)
Left Clavicle	☐	
Right Clavicle	☐	
Left Upper Arm / Shoulder	☐	
Right Upper Arm / Shoulder	☐	abrasion ~ 3x4cm - "road rash" - abrasion
Left Forearm	☐	
Right Forearm	☐	abrasion
Left Hand	☐	
Right Hand	☐	
Left Thigh / Hip	☐	
Right Thigh / Hip	☐	
Left Calf / Knee	☐	
Right Calf / Knee	☐	
Left Foot / Ankle	☐	
Right Foot / Ankle	☐	bleeding from 4th toe + swelling crepitus with movement (by physician) of all toes

NEUROLOGIC EXAMINATION:

Muscle Group	Motor Strength					
	0	1	2	3	4	5
Biceps						
Triceps						
Grip Strength						
Quadriceps						
Ileopsoas						
Foot Plantar Flexion						
Foot Dorsiflexion						

☐ Check if unable to assess motor strength due to patient's inability to cooperate with exam



Reflexes

Sensory Examination: ☐ Intact Overall ☒ Unable to examine due to patient's inability to cooperate with exam
☐ Deficits (describe):

Cranial Nerves (II-XII): ☐ Intact Overall ☒ Unable to examine due to patient's inability to cooperate with exam
☐ Deficits (describe):

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Trauma Center Initial Patient Evaluation
Page 5 of 6

ADDITIONAL PHYSICAL FINDINGS:

LABORATORY STUDIES:

PT: 17.7 PTT: NR 1.4 Platelet: 207 HCG: φ

Other Laboratory Studies:

Signatures given in ER

ADDITIONAL STUDIES: (Results based on preliminary verbal reports available at time of initial viewing)

right clavicle fx
multiple pharyngeal fx - open
skull fracture, epidural hematoma
fracture of ribs
fracture of C7-T1 spine
fracture of L1-L2
fracture of L4-L5
fracture of L5-S1
fracture of S1-S2
fracture of S2-S3
fracture of S3-S4
fracture of S4-S5
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fracture of S98-S99
fracture of S99-S100

Other Ancillary Studies Performed (describe study and results):

FAST: negative

Diagnoses/Injuries:

Skull fx, open - large complex scalp laceration
fracture of ribs
fracture of C7-T1 spine
fracture of L1-L2
fracture of L4-L5
fracture of L5-S1
fracture of S1-S2
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fracture of S95-S96
fracture of S96-S97
fracture of S97-S98
fracture of S98-S99
fracture of S99-S100

Management options were discussed with physicians from the following services:

☒ Orthopaedic Surgery ☒ Neurosurgery ☐ Facial Surgery ☐ Trauma Surgery ☐ CT Surgery
☐ Others (list):

Physician Signature: Mary A. Scott
Service: Trauma

☒ Resident ☐ Attending
Pager ID: 15469 Date: 11 / 1 / 07

OTE 800038 Rev. 7/04



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Trauma Center Initial Patient Evaluation
Page 6 of 6

P490943644 D08:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

MUSC Trauma Center Initial Patient Evaluation

Attending Physician's Statement

Attending Statement: The patient has been seen and examined by me personally. I have reviewed the house staff documentation above and a discussion of the history and physical findings has been held.

I can confirm the following key history factors: 2yo ♂ hit in back w/ part of car/crow
+ LOC at scene, significant blood loss, lacerations at scene
intubated by EMS

I have examined the patient and key findings include: Complex scalp laceration 10 inches; skull fr
epidural/subdural hematoma RC clavicular fr; multiple R pharyngeal
fr

I have personally reviewed all available radiographic images: ☒ Yes ☐ No

Assessment (see page 5 for complete diagnosis list):

2yo ♂ s/p skull fr, open complex scalp wound washed
out and closed in Trauma Bay - epidural/subdural hematoma
B) frontal contusions

Plan: Admit to ICU: resp failure - cont vent support - Digoxin
IVF hydration, serial Hombrows to evaluate acute hemorrhagic
anemia. maintain MAP > 80 to improve CPP; prevent neurosurgery
and other recommendations

Patient Condition: ☒ Critical/Unstable ☐ Serious ☐ Fair ☐ Good

This document is serving as:

☒ Admission History and Physical ☐ Emergency Dept. Evaluation ☐ Consultation (service consulting):

☒ Critical Care Services (Total time spent with patient, family, and reviewing data: 1 1/2 hours)

Signature: [Signature] Attending Physician Pager ID: 14175
Date: 1/1/18

OTE 800038 Rev. 7/04



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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06

P490943644 DOB: 01/01/1951 U U
TRAUMA
VICTIM JW
Adm: 00000000 M2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM
(i.e., upper or lower case, with or without periods):

mcg, ug or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO ₄	-MgSO ₄

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)

Do not write a whole number with a trailing zero.

USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5mg Not .5 mg

Date	Time	
		Ortho Consult
11/10/04	2100	Briefly: HM had a crane fall on him c/w
		⇒ open head injury. Ortho consulted for (R)
		Full consult clavicle fx + (R) foot fx.
		dictated
		PE: <u>III</u>
		Inhibited / Sedated. Moved all extremities upon admission
		per trauma team
		RVE (+) Crepitus @ clavicle
		φ deformities or crepitus @ shoulder, arm, elbow, forearm
		or hand
		(+) Swelling over dorsum of (R) hand
		2+ RP
		LVE: φ crepitus / bony deformities, 2+ RP
		Relax: Stable to lat + AP compression
		LVE: φ crepitus or bony deformity
		Full ROM hips
		2+ DP
		RLE: CR < 2 sec
		Traumatic arthralgia of 4th / 5th digit
		X-rays: (R) clavicle fx
		(R) dist phalanx great toe fx
		(R) 2-5 prox phalanx fx, 4/5 open
		A/P HM i plane of the pelvic injuries plus epidural / subdural
		bleeds L-S TP fx, Rib fx
		- (R) foot Washed out @ bedside. To OR for fx
		It & O when stable
		- Ancl IV q 8h
		- Splint RVE

prgreocrd1

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15258



PRGRCRD

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06

MUSC
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OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M

Patient Name
GOMEZ
HECTOR
MRNAdm:11/01/07 M:2581962
STATE DATE

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mcg, ug or ug	U or u	IU
qd / QD	qod / QOD	MS / MSO ₄
		MgSO ₄

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USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5mg Not: .5 mg

Date	Time	Notes
11/1/07	9:15	STLU R, DN
		56yo Hispanic male was hit in the head by a construction crane while working at construction worksite. The patient was found down & LOC. While being transported pt had emesis & was intubated in field & was mechanically ventilated on breath per EMS. Pt was sent to East Scan & found to have intracranial bleed, cervical rib fracture, rib fractures, scalp laceration, several vertebral body fractures & (B) Frontal Contusion. Pt arrived to STLU in Guedel condition.
		01 Vitals
		Neuro: GCS 7T, Withdraws from pain & per nursing moved all extremities in ED.
		HENT - Lt Scalp laceration in hair region (sutured), PER LA.
		CIL 3 S, 5, 8 M, H/L
		Lungs: Pt has expiratory wheezing
		Abd (BST) Soft NTIN
		Extremities: Rt foot (LLE) lasted & good cap refill, at DP, & Minor Abnormalities on all vol study
		Labs: 146/117/10 (97) H ₂ O 604 H ₂ O 464/100/207 FIO ₂ 60% 7.36/40/22/194/112 3.8/24/1.1 6.4/5.2/1.9 14.2/1.20 0.5mole/Lt = 437
		A/P 56yo Hispanic male & Epilepsy Subdural hematoma, (B) Frontal Contusion, Rt leg & 5th rib fracture, scalp wound, C7-T1 SP Fracture, T12 Fracture, Rt hand (fracture), Skull fracture, & Multiple rib fractures non displaced & stable.
		(1) Neuro: Pt would localize to pain, will not the Neuro checks will reassess Neuro status AM
		(2) Cardio: Pt stable & mildly tachy, will place Holo for BP monitoring & reassess PRN HR 140
		(3) Resp: Pt Intubated & Sedated will obtain morning ABG & UA/Totals tomorrow
		(4) GI - Rt Hand (fracture) in ED, will keep NPO Q/N
		(5) Renal: BUN/Cr stable good UOP
		(6) FSU - Pt on
		(7) Endo - SSF
		(8) H&MS - RBC & Platelets count today will recheck H&T tomorrow if not > 20, maintain
		(9) Extremities - SCD for DVT & PDE for GEL
		(10) 16 on Celestone & Vanc for Skull Fracture

prgrecrd1

OTE 700222 Rev. 9/06

(5310)



PRGRCRD

MUSC
 MEDICAL UNIVERSITY
 OF SOUTH CAROLINA

 P:490943644 DOB:01/01/1951 L M
 GOMEZ
 HECTOR
 Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/08

Patient Name
MRN

STAMP PLATE AREA

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qd / QD	qod / QOD	MS / MSO ₄	MgSO ₄

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USE: 0.5mg Not: .5 mg

Date	Time	Notes
11/2/07	0725	STECU / CC No events 38 ⁵ 37 ⁴ 101 176/71 403067 / 1485 Propofol 100 / MS 20 KCl / Fentanyl 100 / Clonidine / Vanc Sedated → propofol 100 → E4 Vt M6 Moves all extremities, localizes PERL Does not s/c in English or Spanish 144 113 9 102 100 41.3 9 16.4 30 29 25 1.1 312 25.9 1.7 RRK 0.006, Lungs: CT = temporary pharynx (D) - not / lung CT head - (D) AP: stp CHE, (D) great toe fx, subcutaneous contusion, scalp laceration, CTI SP, lumbar T10 fx ① Neuro: CT head pending. Cont to follow. Cont. C collar ② CV: H+H stable. Cont to monitor. S/P JLU PRBCs ③ Resp: cont intubation / vent until head CT, then reassess. ④ Ren: good uob, BUN+Cr. Cont IVF + replace electrolytes ⑤ ID: Vanc / Clonidine ⑥ MS: to ortho OR for workup in future. Cont. RLE splint J. H. 10325

prgrecrd1

OTE 700222 Rev. 9/08

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/02/2007
Surgeon: Shane K. Woolf, MD
Assistant(s): Shaun L. Traub, MD
Yuehuei An, MD

PREOPERATIVE DIAGNOSIS: Crush injury to right foot with open fractures.

POSTOPERATIVE DIAGNOSIS: Crush injury to right foot with open fractures.

PROCEDURES:

1. Irrigation and debridement of open fracture of phalanges (skin to bone).
2. Closed reduction and percutaneous pinning of hallux second, third, and fifth toe proximal phalanx fractures (T5, T6, T7, T9).
3. Nailbed repair fourth and fifth toes (T8 and T9).

ESTIMATED BLOOD LOSS: Minimal.

INDICATIONS FOR PROCEDURE: This patient was crushed by a piece of construction equipment yesterday that fell on his head and foot. He sustained a closed-head injury with a cranial fracture, but was felt to be stable today for debridement of an open fracture about the right foot and management of the crush injury with multiple proximal phalanx fractures.

CONSENT: The risks and benefits were discussed with the patient's family including but not limited to bleeding, infection, nerve and vessel injury, wound healing complications, dysesthesia or paresthesia of the toes; malunion/nonunion of fractures, the need for reoperation, and possible amputation of one or all of the toes, as well as the risks of anesthesia. They understood and agreed to proceed.

DESCRIPTION OF PROCEDURE: Following consent and identification of the correct operative site, the patient was taken to the operating room and placed supine on the operating table. Prophylactic antibiotics were already administered prior to the operating room. He was maintained on the ventilator under general anesthesia. The limb was cleansed with chlorhexidine and prepared and draped in the sterile field with Betadine. The fourth and fifth toe as well as hallux nailbeds were debrided. There was a complex nailbed laceration to the fourth and fifth toes, which was debrided, irrigated, and repaired with 3-0 chromic interrupted stitches. There was also a small open wound over the lateral aspect of the foot overlying fractures to the fifth toe, proximal, and middle phalanges. This was irrigated also with saline after debridement. Fresh drapes were applied, then the minimally-displaced hallux distal phalanx fracture was stabilized with percutaneous pin which improved the overall clinical alignment. The second toe remained grossly unstable, and this was stabilized with a Kirchner wire. The image intensifier confirmed that the pin was contacting bone in multiple views. On the second toe where the wire went into the proximal segment to the proximal phalanx, there was only a portion of the cortex captured by the pin, but under direct visualization with the C-arm the fracture was satisfactorily stabilized, with plans to place him in a splint afterwards. Similar treatment was provided to the third ray. The fourth toe, which had a complex fracture and dislocation involving the proximal phalanx,

middle phalanx, and possibly a portion of the distal tuft of the terminal phalanx. Multiple attempts were made to reduce the fracture closed and percutaneously pin it. These were unsuccessful, so a 2 cm dorsolateral incision was made over the proximal interphalangeal joint, and a Freer elevator used to capture and stabilize the distal segment of the proximal phalanx. Crossed Kirchner wires were then passed through this fragment to provide some degree of stability to end of the small toe. Overall clinical alignment and stability were improved, but not ideal. However, due to the comminuted nature of the fractures it was felt that more stable fixation could not be achieved.

We were unable to pass a Kirchner wire in a retrograde fashion in the fifth toe due to extensive comminution. With the crosspin fixation there was satisfactory stability. A 1.6 mm wire was used in the great toe and second ray, and 1.25 mm in the third and fifth. All of the wounds were then irrigated again with saline. The nail plates from the fourth and fifth toes, which were removed and debrided, were reapplied loosely without suturing to protect the healing nailbed. Foot compartments were soft with no swelling noted before or after the procedure. Sterile dressings then were applied and he was placed in a well-padded posterior splint with stirrups.

He was then transferred to an ICU bed for transport to the intensive care unit in guarded condition. He tolerated the surgery without any apparent complications. All sponge and needle counts were reported as correct. I was present throughout the procedure.

Dictated by: Shane K. Woolf, MD

Shane K. Woolf, MD
Surgeon

918526 / 41737 /
JOB: 367907
DD: 11/02/07 04:24 PM
DT: 11/04/07 04:16 PM

Additional CC: _____

DOCID: 18231918526

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:21:56 AM

Patient: GOMEZ-FRAGOSO, HECTOR

Procedure: CT HEAD/BRAIN W/O CONTRAST

Accession #: 5075490

MRN: 002581962

Date Exam Completed: 11/02/2007 08:10

Last Update: 11/03/2007

EXAMINATION: CT of the Brain 11/02/07 08:10:00

ACCESSION NUMBER: 5075490

INDICATION: s/p impact with heavy object, closed head injury.

COMPARISON: Head CT 11/1/07

TECHNIQUE: CT of the head without contrast

FINDINGS: There is no new hemorrhage nor clear signs of acute infarct. The CSF spaces are symmetric and unchanged. There is no herniation. Again seen is extensive left sided frontotemporal soft tissue swelling with gas, with underlying fracture is extends to the left frontal bone obliquely into the sagittal suture. The fracture posteriorly also extends into a lambdoid suture. The fracture line is again seen to extend obliquely through the roof of the orbit and traverses the posterior aspect of the optic canal. There has been interval increase in opacification of all the sinuses with gas fluid levels. The previously described extra axial fluid collection near the vertex is not as well seen on today's study; however does not appear any larger.

IMPRESSION:

1. No clear interval change, with no new hemorrhage, infarct, or herniation.

DICTATED BY: Dr. CHRISTOPHER MOSES

I have reviewed the images and agree with the findings in this report.

History: s/p impact with heavy object

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Printed: 01/07/2008 10:43 AM

Page:

1

Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075490

MRN: 002581962
Date Exam Completed: 11/02/2007 08:10
Last Update: 11/03/2007

Technologist: SHMICA HENDERSON
Interpreter 1: ZORAN RUMBOLDT
Interpreter 2: CHRISTOPHER MOSES
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: ZORAN RUMBOLDT
Date Authenticated: 11/3/2007

Transcribed by: Tech IntTalk

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Printed by: LINCOLN, COURTNEY

Page: 2

Printed Time: 10/26/2007 13:07:33 PM

Page 2 of 2

MUSC
171 Ashley Ave. Cl. ton, SC 29425
Name:



P490943644 DOB: 01/01/1951 U U
TRAUMA
VICTIM JW
Adm: 00000000 M2581962

Gomez Hector

THORAX/RESP: ☒ Normal ☐ Unequal Breaths
CV: ☒ Normal ☐ Tachycardic ☐ Diminished Pulses ☐ Hypotensive
ABDOMEN/GI: ☒ Normal ☐ Tender Guaiac (+/-)
GU: ☒ Normal
MS (includes neck and back): ☐ Normal ☐ Neck Tenderness ☐ Back Tenderness
RUE: crush - appears injury to LUE: steel (2) foot
RLE: Absent to distal (2) upper arm
HEMA/LYMPH: ☒ Normal
NEURO: ☐ Normal ☐ Lethargic ☐ Obtunded ☐ Disoriented ☐ Focal Deficit GCS: 3 (Intubated)

MEDICAL DECISION MAKING: ☐ Discussed With Family ☐ Old Chain Requested FINDINGS:
DDX: Skull Fx Hemothorax Flail Chest / Multiple Rib Fxs General Aches Pneumothorax Solid Organ Injury Diaphragmatic Rupture Scapular Fx
Chest Contusion Esophageal Rupture Cervical Strain Traumatic Aortic Dissection Subdural Hematoma Spine Injury Hemorrhagic Shock

LAB PERFORMED: ☐ Labs Essentially Normal Unless Noted Below PT / PTT: / ☐ T&S ☐ T&C

☐ CBC: WBC Hg Hct Plts ☐ CHEMISTRIES: Na K Cl HCO3 BUN Cr Glu
☐ URINALYSIS: pH SG Protein Glu WBCs RBCs Bacteria
☐ ETOH: ☐ URINE DRUG SCREEN

EKG INTERPRETATION: ☐ NSR ☐ No ST Abnormality ☐ Compared To EKG On / / ☐ No Significant Change

RHYTHM STRIP: ☐ Normal ☐ Hypoxic

IMAGING: ☐ C SPINES ☐ Normal C7-T1 transverse fx ☐ CXR: ☐ Normal ☐ PTX ☐ Rib Fx ☐ Widened Mediastinum ☐ ABD SERIES: ☐ Normal ☐ PELVIS X-RAY: ☐ Normal ☐ CT of Head: ☐ Normal ☐ CT of ABD / Pelvis: ☐ Normal

ADDITIONAL PROCEDURES (done by Physician): ☐ NGT Insertion ☐ Foley Insertion ☐ ABG ☐ Blood Transfusion ☐ Venous Cutdown ☐ Splint ☐ Application / ☐ Inspection ☐ ABG ☐ Vaso-Active Drips

RE-EVALUATION: Time: ☐ Improved ☐ Worsened ☐ No Change

PE: Pain in right chest & trauma ortho and USA services
by scalp laceration by ASA. Transferred (trauma attending).
PE: No other hemodynamically stable during stay. PE
admitted to ICU.

☐ CRITICAL CARE: I have spent minutes in the direct care of this critically ill patient, excluding procedure time. ☐ Comfort measures only

CONSULTATION: Dr: @ Returned @ ; Dr: @ Returned @
To See @ ☐ ED ☐ Hospital ☐ Office Rec.

ADMITTING TEAM:

ATTENDING PHYSICIAN NOTE:

HISTORY:

EXAM:

MEDICAL DECISION MAKING:

FINAL IMPRESSION: ① Epidural hematoma ② Skull fracture ③ Pulmonary contusion ④ Rib fracture ⑤ Int. fractures ⑥ Clavicle fracture

DISPOSITION: ☐ Discharge ☐ Improved / ☐ Stable ☒ Admit ☐ Transfer ☐ AMA ☐ LWT ☐ LDT ☐ DOA ☐ ED Death

Prescriptions: Follow-up: ☐ PMD

☒ I performed / ☐ I was present for the H & P on the patient. I have discussed treatment / management options with the ☐ PA / ☐ NP / ☐ Resident / ☐ Student.

☐ I agree with the documented findings and the plan of care. Comments:

ATTENDING SIGNATURE: *Yelini J. Jarama* ⑦ Spine fracture

NAVIGATOR PC

ED RECORD

MVC MULTI-TRAUMA - ASSULT - MALE

Printed by COL9

Page 386

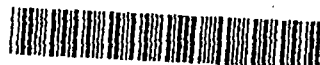
01-07-2008 10:28:16

97

-146-



PRGRECORD

MUSC
 MEDICAL UNIVERSITY
 OF SOUTH CAROLINA


P:490943644 DOB:01/01/1951 L M

TRAUMA
VICTIM JW

Adm: 11/3/07 11:07 AM

(8:45am)

 Propofol 500
 Fentanyl 50mcg/hr
 Reprid
 ISS
 Eye
 Clav
 Kepra

ATTENDING PHYSICIAN NOTE

Patcom: 490943644

MRN: 2581962

NAME: Hector Gomez

Service: ICU

 Date: 11/3/07
 The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

- ☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to
- ☐ Upon personally questioning the patient, I can confirm that the following are the key history factors:

 Physical Examination: Pulse: 118 BP: 56 Resp Rate: 19 T: 37.9 Input: 3731 Output: 4175
 Neuro: Sedated, though arousable
 Eyes: middeviated to the maxillary sinus
 ENT: ST
 CV: 95% sat
 Resp: few scattered wheezes
 GI/Nutr: Soft, NT/ND
 CUI/Renal: 7/264/88 138/109/4/110
 MuscSkel: 3-5/23/1.9
 Skin: 15/15/15-2/15-2
 Psych: 15/15/15-2/15-2
 Other: BG: 107-117

- ☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
- ☐ I have reviewed the results radiographs as documented in the resident's note.
- ☐ I have personally reviewed pertinent X-ray examinations.
- ☐ I have personally reviewed the results of additional medical testing and monitor output.
- ☐ I have personally discussed the case with Dr. B. [unclear]

Diagnoses/Problems

1. Respiratory insufficiency	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
2. CHV & EDH	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
3. S-process [unclear]	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
4. [unclear]	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
5. [unclear]	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
6. [unclear]	☐ New	☐ Improved	☒ Unchanged	☐ Worsening

Management Options/Recommendations

1. Respiratory - [unclear] 30 minutes of T- [unclear] trials
2. [unclear]
3. [unclear]
4. [unclear]
5. [unclear]
6. [unclear]

 Risk of complications/mortality: ☐ Minimal ☐ Low ☐ Moderate ☒ High
 Patient is critically ill/injured. I spent 30 minutes providing critical care to this patient.
 Overall Condition: ☒ Critical ☐ Serious ☐ Fair ☐ Good

Signature: [unclear] Date: 11/3/07

 I-D - Continue Vase [unclear] empirically.
 Endocrine: Good BG Control on ISS
 Continue Serial neuro exams.

UMA #19100-13 revised 11/06

OTE 700222 Rev. 9/06

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"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06

Patient Name
MRN

STAMP PLATE AREA

 P:490943644 DOB:01/01/1851 L M
 TRAUMA
 VICTIM JW
 Adm:11/01/07 M:2581962

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Write a decimal point with a leading zero:

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Date	Time	STICU
11/5/07	06:00	Pt had episode of respiratory failure overnight that required respiration. He had been intubated for approx. 18 h yesterday. E copious secretions that he had been cleaning appropriately. He was requiring a lot of suction.
		37° 36° 89 18 166/80 98% PRVC 50/18/5/60%
		3694/11 4120
		On NAO, intubated, sedated & FC.
Insulin		HEART ET in place.
1/2 N92 20 @ 10		Neck: Mianin in place.
Perforator 40mg		CV: DRA & M/A/P
Repsid		Blues: Coughs RS @
Combivent		And: gels, at, ad @
Clonidine		CV: Foley in place.
Keppra		Extremities: Flaccid, silent C/PT
Vanc		UE: SCD in place.
		Labs: 7.42 / 40 / 78 / 95.2%
		App: 26.4/10 HM 1/p. Wound accident.
		1. Resp. cont wearing FiO ₂ . We would like to see a 2.3
		Resp. Pao ₂ on current settings before we reduce FiO ₂ to a non-toxic level. We will plan to draw a blood gas w/i a few hours.
		2. Neuro. cont Vanc / clonidine for skull fx. w/1 cont to follow neuro exam. He was appropriate when awake yesterday.
		3. Ortho - NAO RLE. PT when appropriate.
		4. ID. cont obs as above. Vanc transf 4.4. Well I don't

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PROGRESS RECORD

MUSC
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 OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06



P:490943644 DOB:01/01/1951 L M

TRAUMA

VICTIM JW

Adm:11/01/07 M:2581962

Patient Name
MRN

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USE: 0.5mg Not .5 mg

Date	Time	Notes
11/5/07	0740	CRITIC - staff
		Intubated, Sedated.
		Splint RLE intact.
		Toes erythematous but CR 2 & 3.
		Pin sites clear
		& drainage.
		APP Post CRPP @ 1, 2, 3, 5 phalange Px's, CR 5
		Cervical Px, Resp. failure post extubation
		- elevate, splint
		- pin care
		- NMB
		- 2° survey when fully awake

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"PRGRECRD"

MUSC
 MEDICAL UNIVERSITY
 OF SOUTH CAROLINA

 P:490943644 DOB:01/01/1951 L M
 GOMEZ
 HECTOR
 Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

ATTENDING PHYSICIAN NOTE

MRN: 2581962NAME: Gomez, HectorService: ICU
 Date: 11-5-07
 The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

 History: S/P crane to head
☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRUC 18 558
☐ Upon personally questioning the patient, I can confirm that the following are the key history factors: 8 558

 Physical Examination: Pulse: 89 BP: 177 Resp Rate: 37 Tm: 37.2 Input: 3641 Output: 4120
Neuro: seized, intubated

Eyes:

ENT:

CV: RRR 1 @ 2Resp: course BGU/Nurr: soft, NO/NT/TBS

CU/Renal:

Musc/Skel:

Skin:

Psych:

Other:

☒ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☒ I have personally reviewed pertinent X-ray examinations.

☐ I have personally reviewed the results of additional medical testing and monitor output.

☐ I have personally discussed the case with

Diagnoses/Problems

1. <u>Respiratory failure - nonintubated but night</u>	☐ New	☒ Improved	☒ Unchanged	☐ Worsening
2. <u>CHF with R/L failure & head injury</u>	☐ New	☐ Improved	☐ Unchanged	☐ Worsening
3. <u>Clearing + massive pneumonia/embolism</u>	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
4. <u>Clearing + massive pneumonia/embolism</u>	☐ New	☐ Improved	☒ Unchanged	☐ Worsening
5. <u>Clearing + massive pneumonia/embolism</u>	☐ New	☐ Improved	☐ Unchanged	☐ Worsening
6. <u>Clearing + massive pneumonia/embolism</u>	☐ New	☐ Improved	☐ Unchanged	☐ Worsening

Management Options/Recommendations

- Add Ceftriaxone
- FTU Resp Cultures
-
-
-
-

 Risk of complications/mortality: ☐ Minimal ☐ Low ☐ Moderate ☒ High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

 Overall Condition: ☒ Critical ☐ Serious ☐ Fair ☐ Good

 Signature: [Signature] Date: _____

UMA #19100-13 revised 11/06

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OF SOUTH CAROLINA



PRGRECRD
INTERDISCIPLINARY PROGRESS NOTES
PHARMACOKINETIC EVALUATION
(Page 1 of 2)

STAMP PLATE AREA



P490943644 DOB: 01/01/1951 L M
GOMEZ
HECTOR
Adm: 11/01/07 M2581962

Patient Name Hector Gomez
MRN 2581962

Evaluation requested by: STICU ServiceMedication evaluated: Vancomycin

Comments (include current regimen and pertinent laboratory and clinical data):
26yo male w/skull fracture; meningitis ~~diagnosis~~ prophylaxis treatment. Also treating w/
cefotaxime 2gm Q6°. WBC: 15 (11/1) ~~6 (11/5)~~ SCr: 1.2 (11/1) ~~0.7 (11/5)~~ Tmax: 38.5 (11/1) ~~37.1 (11/5)~~

Wt (actual): 89.6 kg Ht: 64 cm IBW: 59.2 kg Dosing wt 89.6 kg
Serum concentration (☒ trough ☐ peak ☐ random) drawn at 0535 (time) on 11/5/07 (date) reported as
4.4 mcg/mL (desired 15-20 mcg/mL)

Serum concentration (☐ trough ☐ peak ☐ random) drawn at _____ (time) on _____ (date) reported as
_____ (desired _____)

Steady-state concentration? ☒ Yes ☐ No

Summary of dosing (if not steady-state):

Volume of distribution: 62.7 L/kg ☒ Calculated ☐ EstimatedElimination rate (k_e): 0.155 hr⁻¹; half-life: 4.47 hr

Assessment: Expected trough was much lower due to ~~increased~~ underestimation of CrCl and pt. was originally
thought to be 56 yo. The new dose should produce a trough ≈ 17 mcg/mL.
- Verify duration of prophylaxis with neuro

Recommendations:

☐ Continue current regimen. No further serum concentrations needed unless patient's condition changes.

☐ Continue current regimen. Recheck serum concentration (☐ trough ☐ peak ☐ random) on
_____ (date/time).

☒ Change regimen to Vancomycin 1500mg Q6°
☒ Recheck serum concentration (☒ trough ☐ peak ☐ random) on 11/6/07 @ 0200 (date/time).

Other: Monitor Scr daily

Pharmacist _____ Pager ID _____ Date _____ Time _____

Co-signature (if applicable) J. I. Guy Pager ID 17168 Date 11/5/07 Time 0800

Time spent: _____ minutes
PHARMACOKINEVAL

OTE 800744 Rev. 9/03



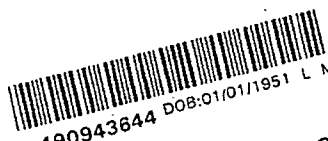
"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06



P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM
(i.e., upper or lower case, with or without periods):

mcg, ug or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO ₄	MgSO ₄

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.

USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5mg Not: .5 mg

Nurse Case Manager Note:
11/5/07 PT slip accident & change falling on
11/4/07 head. In fall - status as MD
notes. Will follow clinical course.
- *Dimmon R*

11/5/07 MSUG R
0600 977 68-114 150/62 4492/13275

HE Eye up *dark*
④ Cough ④ Sg ④ Karmel
Lve (R) Lve
VD (L) E KEE case

C - collection
P/R: sp m/c - skull p. radiologically
- *cons. clinical course*

11-6-07 Orthop:

3. Indubated, sedated
O: R. foot in splint, elevated
2-5 toe slow CR. warm skin color
dark, Doppler & AP - PT
s/p. percutaneous pinning @ 1-5 toe fr.
possible various congestions
lowering splint
- *observation*

OTE 700222 Rev. 9/06

prgreord1

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5078680

MRN: 002581962
Date Exam Completed: 11/06/2007 09:03
Last Update: 11/07/2007

Addendum Begins

Please note that the correct impression for this report is as follows:

1. No significant changes since the prior examination. Stable extra-axial collection at the vertex, skull fracture. 2. No new acute intracranial hemorrhage or infarcts.

Addendum Ends

EXAMINATION: BRAIN CT 11/06/07 09:03:00

ACCESSION NUMBER: 5078680

INDICATION: Trauma, altered mental status

COMPARISON: Head CT 11/02/2007 and 11/01/2007

TECHNIQUE: CT of the brain without intravenous contrast.

FINDINGS: There is no new extra-axial fluid collections nor clear signs of acute infarct. The CSF spaces are symmetric and unchanged. There is no herniation. Again seen is extensive left sided frontotemporal soft tissue swelling with gas, with underlying fracture is extends to the left frontal bone obliquely into the sagittal suture. The previously described extra axial fluid collection near the vertex is not significantly changed since the prior studies. There is a small amount of subarachnoid blood in the inter-peduncular cistern.

IMPRESSION:

1. No evidence of intracranial injury or fractures.

VOICE DICTATED BY: %full name%

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5078680

MRN: 002581962

Date Exam Completed: 11/06/2007 09:03
Last Update: 11/07/2007

History: sp mvc

Technologist: SHANNON MILLS
Interpreter 1: MARIA SPAMPINATO
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: MARIA SPAMPINATO
Date Authenticated: 11/7/2007

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Page: 2



Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **DIAG CHEST PORTABLE 1 VIEW**
Accession #: **5077914**

MRN: **002581962**
Date Exam Completed: **11/06/2007 03:53**
Last Update: **11/06/2007**

EXAMINATION: CHEST 11/06/07 03:53:00

ACCESSION NUMBER: 5077914

INDICATION: 27 year old with open skull fracture and respiratory insufficiency

COMPARISON: 11/5/07

FINDINGS: AP portable view. Support line and tubes remain in satisfactory position. Mediastinal and hilar contours and cardiac silhouette are stable. Left basal atelectasis and small left pleural effusion, stable.

IMPRESSION: Left lower lobe atelectasis and small pleural effusion

VOICE DICTATED BY: Dr. JAMES RAVENEL

History: 27 year old with open skull fracture

Technologist: GAY MARTIN
Interpreter 1: JAMES RAVENEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/6/2007

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Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **DIAG CERVICAL SPINE 2 VIEWS AP/LAT**
Accession #: **5080007**

MRN: **002581962**
Date Exam Completed: **11/06/2007 22:24**
Last Update: **11/07/2007**

EXAMINATION: CERVICAL SPINE 11/06/07 22:24:00

ACCESSION NUMBER: 5080007

INDICATION: c spine clearance, altered mental status

COMPARISON: None.

FINDINGS: Lateral flexion/extension views of the cervical spine were obtained. The craniocervical junction is unremarkable. The vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. Disc spaces are well maintained. There is a normal cervical curvature. There is no abnormal cervical motion with flexion/extension. The paraspinal soft tissues are normal. Left parietal/temporal/frontal bone fracture. Endotracheal tube with distal tip not visualized.

IMPRESSION:

No cervical instability.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: for c spine clearance

Technologist: DAVID DECHANT
Interpreter 1: WILLIAM CONWAY

Proxy Signer:

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CERVICAL SPINE 2 VIEWS AP/LAT
Accession #: 5080007

MRN: 002581962
Date Exam Completed: 11/06/2007 22:24
Last Update: 11/07/2007

Interpreter 2: MADELINE LEWIS

Authenticating Radiologist: WILLIAM CONWAY

Interpreter 3:

Date Authenticated: 11/7/2007

Date Dictated:

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Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: CT CHEST PULMONARY EMBOLUS STUDY
Accession #: 5078646

MRN: 002581962
Date Exam Completed: 11/06/2007 09:01
Last Update: 11/06/2007

EXAMINATION: CT CHEST WITH IV CONTRAST 11/06/07 09:01:00

ACCESSION NUMBER: 5078646

INDICATION: Status post blunt force trauma to the head with open skull fracture, poor A-A gradient, runs of tachycardia

COMPARISON: Chest 11/1/7

TECHNIQUE: Multiple contiguous helical slices were obtained from the lung apices to the lung bases following IV administration of 100 cc of Omnipaque 350 without immediate adverse reaction. PE protocol was utilized.

FINDINGS: There is no evidence of pulmonary embolus or aortic dissection. Heart is normal in size with no pericardial fluid or thickening. There is no mediastinal or hilar lymphadenopathy. Endotracheal tube and enteric tube are in satisfactory position.

Moderate dependent atelectasis is present bilaterally. There is no evidence of pleural fluid or pneumothorax. There are scattered patchy ground glass opacities, most compatible with foci of atelectasis or resolving contusion.

There are no worrisome lytic or blastic lesions in the visualized osseous structures. Right midshaft clavicular fracture is present.

Limited evaluation of the upper abdomen is unremarkable.

IMPRESSION:

1. No evidence of pulmonary embolus.
2. Moderate dependent atelectasis bilaterally.

VOICE DICTATED BY: Dr. Rick Bonsall
I have reviewed the images and agree with the findings in this report.

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT CHEST PULMONARY EMBOLUS STUDY
Accession #: 5078646

MRN: 002581962
Date Exam Completed: 11/06/2007 09:01
Last Update: 11/06/2007

History: 27 yo hm sp blunt force trauma to the head with open skull fracture

Technologist: SHANNON MILLS
Interpreter 1: JAMES RAVENEL
Interpreter 2: RICHARD BONSALE
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/6/2007

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Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5080006

MRN: 002581962
Date Exam Completed: 11/07/2007 03:50
Last Update: 11/08/2007

EXAMINATION: CT BRAIN 11/07/07 03:50:00

ACCESSION NUMBER: 5080006

INDICATION: Closed head injury with altered mental status

COMPARISON: CT brain 11/6/07

TECHNIQUE: Multiple contiguous 5 mm axial CT images were obtained through the brain without IV contrast. Coronal and sagittal reconstructions were also performed.

FINDINGS: There is no evidence for new extra-axial collection, and the previously seen collection adjacent to the vertex is unchanged. Extensive left-sided frontotemporal soft tissue swelling is again noted along the fracture of the left frontal bone extending to the sagittal suture, unchanged. There are no signs of acute infarction. The CSF spaces are symmetrical, without evidence for herniation. The small amount of blood seen near the interpedicular cisterns is poorly seen on today's study. There is no evidence for new hemorrhages. Gas fluid levels are again seen in bilateral paranasal sinuses.

IMPRESSION:

1. Stable examination without evidence for acute interval findings.

VOICE DICTATED BY: Dr. Matt Murray

I have reviewed the images and agree with the findings in this report.

History: s/p CHI

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5080006

MRN: 002581962
Date Exam Completed: 11/07/2007 03:50
Last Update: 11/08/2007

Technologist: HAYLEY KOUROFFKY
Interpreter 1: M, MATHEUS
Interpreter 2: MATTHEW MURRAY
Interpreter 3: JOSH MCCAIN
Date Dictated:

Proxy Signer:

Authenticating Radiologist: M, MATHEUS
Date Authenticated: 11/8/2007

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PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/08



P: 490943644 DOB: 01/01/1951 L M
GOMEZ

Patient Name: HECTOR
MRN: Adm: 11/01/07 M: 2581962

CLAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM
(i.e., upper or lower case, with or without periods):

mcg, ug or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO ₄	MgSO ₄

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)

Do not write a whole number with a trailing zero:

USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5mg Not: .5 mg

Date	Time	STICK
11/7/07	06 ⁴⁵	Pt had another head CT overnight following development of disconjugate eye movements. FiO ₂ was decreased to 50%. Otherwise new admission. Transferred 2 U PRBCs for H/H of 6.9. 7.94/37/146/24.9 373 373 68 18 150/88 88% 149/119/119/24.9 5843/2025 → 500 NG 3.1/27 10.7 8.7 2.23
11/7/07	08:15	On NAD, intubated, sedated & FL
11/7/07	08:29	HEENT: ET/NAD in place. Considerable discordant gaze. PERRL 3+2
11/7/07	15:00	Neck: remains in place
11/7/07	15:00	Chest: Coarse BS throughout - some transmitted upper airway sounds
11/7/07	15:00	CV: distal H ₂ , difficult to auscultate over vent. S ₁ heard.
11/7/07	15:00	Q and/or H ₂ auscultation.
11/7/07	15:00	Abd: gait at rest @ ps.
11/7/07	15:00	Ext: gait in place.
11/7/07	15:00	PE: less restriction than + congested / congestive pulmonary fluid
11/7/07	15:00	Good BP + PT cap refill not evident.
11/7/07	15:00	AP: 27 y/o m s/p above accident, BFT to head: open skull fr.
11/7/07	15:00	1. Resp - cont to wear fido today. Will flt on resp BAP, no results currently. Pt continues to slowly improve.
11/7/07	15:00	2. Neuro - Head CT this am. Neuro to come by to assess this am. Will hold sedation for exam.
11/7/07	15:00	3. Heme - 1/2 PRBCs going now. Will follow. If it is recalled that pt has head injury with threat for H+H of 10/30.
11/7/07	15:00	4. ID: On Vanc, tbra, none for VAP suspected. Will flt on cultures. Will communicate time of necessary given volume status.

prgreord1

OTE 700222 Rev. 9/08

MRN: 002581962

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5081109

Date Exam Completed: 11/08/2007 04:17
Last Update: 11/08/2007

Chest

Accession Number: 5081109

Indication: 27 yo hm sp crane accident with open skull fracture

Comparison: 11 07 07

Findings: Single frontal radiograph of the chest demonstrates unchanged position endotracheal tube tip well above carina, left central venous catheter tip over superior vena cava nasogastric tube over stomach unchanged since prior exam. The size and contour of the cardiomeastinal silhouette and hilum are unchanged. Lungs again demonstrate air space opacity worse in the left lower lung and right upper lung apparent collapse in left lower lobe improves from prior film but no pneumothorax visible.

Impression:

No significant interval change.

History: 27 yo hm sp crane accident with open skull fracture

Technologist: LORI RAGER
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/8/2007

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Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **DIAG CHEST PORTABLE 1 VIEW**
Accession #: **5082457**

MRN: **002581962**
Date Exam Completed: **11/09/2007 04:32**
Last Update: **11/09/2007**

EXAMINATION: PORTABLE CHEST 11/09/07 04:32:00

ACCESSION NUMBER: 5082457

INDICATION: OPEN SKULL FRACTURE, RESPIRATORY FAILURE

COMPARISON: CXR 11/8/07

FINDINGS: Single frontal radiograph of the chest demonstrates unchanged position of support tubes and lines. Stable size and contour of the cardiomeastinal silhouette. Hila and lungs demonstrate right upper lobe linear atelectasis and left lower lobe segmental atelectasis. Visualized portions of the bony thorax are unremarkable.

IMPRESSION:

1. Unchanged atelectasis of the right upper lobe and left lower lobe.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW

I have reviewed the images and agree with the findings in this report.

History: 27 yo hm sp bft to head with open skull fx

Technologist: LORI RAGER
Interpreter 1: JAMES RAVENEL

Proxy Signer:

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Page: 1

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Patcom: 103530309
Admitted: 12/12/2007
Discharged: 12/15/2007
Service: Orthopedic Surgery
Attending: KEITH D MERRILL, MD

Referring:

CHIEF COMPLAINT: Foot pain.

HISTORY OF PRESENT ILLNESS: This is a young gentleman who presents after previously having a TMA secondary to a crush injury who presents with a wound dehiscence. Patient came into clinic today with kind-of foul-smelling open wound. Patient denies any fevers, chills, nausea, vomiting, or diarrhea, however.

PAST MEDICAL HISTORY: Patient had a a subdural hematoma as well as some bilateral frontal contusions with his traumatic injury.

PAST SURGICAL HISTORY: Right 2 through 5 transmetatarsal amputation.

SOCIAL HISTORY: The patient denies smoking.

CURRENT MEDICATIONS: Oxycodone.

MEDICAL ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION: He is alert and oriented in no acute distress. Skin is unremarkable. Lungs are clear. Heart is regular. Abdomen is soft, nondistended, nontender. Foot wound is completely dehisced. It is kind-of foul-smelling. There is fibrinous exudate at this point.

HOSPITAL COURSE: Patient was admitted to MUSC Hospital on 12/12/2007 to the orthopedic surgery service for a diagnosis of wound dehiscence from a previously transmetatarsal amputation. Patient was started on IV antibiotics. On 12/14, patient was consented and taken down to the operating room for an irrigation and debridement of the wound under anesthesia. For full details of this operation, please refer to operative report as dictated. Patient tolerated the procedure quite well. Postoperatively he was taken to the PACU and then to the floor in stable condition. His diet was advanced as tolerated. His pain was controlled on p.o. pain medications. Since the nature of the procedure was relatively minor, the patient did quite well. We felt that he was medically safe for discharge on day of procedure. At time of discharge patient was afebrile. His vital signs were stable. His pain was controlled. His wound was packed and dressed. He was instructed to leave this on until he followed up with Orthopedics in 1 week. Patient's weightbearing status was nonweightbearing to that lower extremity.

DISCHARGE DIAGNOSIS(ES): Wound dehiscence from previous transmetatarsal amputation.

DISCHARGE MEDICATIONS:

1. Oxycodone 5-10 p.o. q.4 hours p.r.n. for pain.
2. Colace 100 mg p.o. b.i.d.
3. Bactrim double strength 160/800 mg p.o. b.i.d.

PATIENT DISPOSITION: Patient is discharged to home in stable condition.

condition. Patient is to follow up with McClennan-Banks Clinic next Wednesday. Patient's weightbearing status is nonweightbearing, right lower extremity. Patient is instructed to do no driving while on pain medications. He may have a regular diet. He is to call for any fevers greater than 101.5, any excessive pain, redness, swelling, bleeding, increased drainage from incision site, any opening or pulling apart of incisions, any other problems, questions, and/or pain medication renewal. Patient may shower if he is able to keep the wound and dressings dry. He is instructed on no soaking wound for 3-4 weeks. Patient is not to change his dressing until followup appointment.

Dictated by: Mark Perna, MD

Mark Perna, MD

KEITH D MERRILL, MD
Attending

747043 / 30028 / 36495
JOB: 375460
DD: 12/14/07 01:51 PM
DT: 12/18/07 09:28 AM

Additional CC: _____

DOCID: 18233747043

Edited By ANN SHULER on 12-20-2007 at 03:50:28 PM
Edited By MARK PERNA on 01-14-2008 at 07:52:13 AM
Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:59 PM

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5085564

MRN: 002581962
Date Exam Completed: 11/13/2007 04:36
Last Update: 11/13/2007

EXAMINATION: PORTABLE CHEST 11/13/07 04:36:00

ACCESSION NUMBER: 5085564

INDICATION: OPEN SKULL FRACTURE, RESPIRATORY FAILURE

COMPARISON: CXR 11/12/07

FINDINGS: Single frontal radiograph of the chest demonstrates no interval change in position of endotracheal tube or left central venous catheter. Interval advancement of enteric tube with tip now likely trans-pyloric. The size and contour of the cardiomeastinal silhouette and hilum are stable. Lungs and pleura show left lower lobe atelectasis or effusion. Osseous structures are unchanged.

IMPRESSION:

1. No significant interval change in left lower lobe atelectasis and/or effusion.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW

I have reviewed the images and agree with the findings in this report.

History: 27 yo hm sp open skull fracture

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Page: 1

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: **DIAG CHEST PORTABLE 1 VIEW**
Accession #: **5085564**

MRN: **002581962**
Date Exam Completed: **11/13/2007 04:36**
Last Update: **11/13/2007**

Technologist: **GENE BRUNSON**
Interpreter 1: **JAMES RAVENEL**
Interpreter 2: **MARQUES BRADSHAW**
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: **JAMES RAVENEL**
Date Authenticated: **11/13/2007**

Transcribed by: **Tech IntTalk**

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Printed: **01/07/2008 10:39 AM**
Printed by: **LINCOLN, COURTNEY**

Page: **2**



PRGRECRD

MUSC
 MEDICAL UNIVERSITY
 OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/08

Patient Name
MRN

STAMP PLATE AREA

 P:490943644 DOB:01/01/1951 L M
 GOMEZ
 HECTOR
 Adm:11/01/07 M:2581962

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM
(i.e., upper or lower case, with or without periods):

mcg, ug or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO ₄	MgSO ₄

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)

Do not write a whole number with a trailing zero.

USE: 5 mg NOT: 5.0 mg

Write a decimal point with a leading zero:

USE: 0.5mg Not: .5 mg

Date	Time	Notes																		
11/13/07	06 ²	<u>SICA</u> Pt seemed not follow commands for brother yesterday. He is more awake and would verbally follow a few commands in Spanish. Otherwise, acute events. 38⁴ 37 107 22 125/79 95% # 449/4555 Gen: WAD, intubated, apnoeic, will localize, grimace to pain, tries to follow commands HEENT: ET/OG in place. MMM, PERRL - NEA Miami 1 in place Lungs: N/BS CTAD CV: Tachy, regular & M/L/R. ABG: Galt, w/nd, hypochloride. Extrem: RLE dressing C/PLT U/L: SCD in place Moves all four limbs. Labs <table border="1"> <tr> <td>7.46</td> <td>36</td> <td>71</td> <td>25.3</td> <td>11.9</td> <td>297</td> <td>4</td> <td>28</td> <td>0.7</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>33</td> <td></td> <td></td> <td></td> <td></td> </tr> </table> 198 112/18/80 AP: 26 y/o mm S/P open skull fracture. 1. Resp - Pt has been on minimal settings of CPAP since the past 24 hrs. He has few secretions. He is more awake than yesterday and tries to follow commands. ABG shows hypoxia but not have been OK all day. We will plan to extubate later today. 2. Extrem - RLE shows necrotic tips of toes 2-4 - once fully debrided with or without manage surgically.	7.46	36	71	25.3	11.9	297	4	28	0.7					33				
7.46	36	71	25.3	11.9	297	4	28	0.7												
				33																

prgreocrd1

OTE 700222 Rev. 9/08

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SECRET

Adm:11/01/07 M:2581962

STAMP PLATE AREA

Version Date: 9/06

Do not write a whole number with a trailing zero.

Write a decimal point with a leading zero:

USE: 0.5mg Not .5 mg

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO ₄	MgSO ₄

Date	Time	Notes
11/13/09	0645	3. Neuro - Pt remains partially unresponsive / confused. He follows commands better today, yesterday - Russell, neurologist. He has improved since d/c of sedation/pain meds. 4. Gt once we extubate will ~~be able to~~ begin liquid diet if we feel he can protect his airway. Will have swallowing trials. If he cannot will drop NG and begin TF/IVF. 5. Renal - 2 issues. 6. ID - Pay pb. memo for enterobacter pneumonia. WBC NI, @ labile.

OTE 700222 Rev. 9/06

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5087173

MRN: 002581962
Date Exam Completed: 11/14/2007 03:45
Last Update: 11/14/2007

EXAMINATION: PORTABLE CHEST 11/14/07 03:45:00

ACCESSION NUMBER: 5087173

INDICATION: SKULL FRACTURE, HYPOXIA, FAILED EXTUBATION

COMPARISON: 11/13/07

FINDINGS: Single frontal radiograph of the chest with right costophrenic sulcus collimated from field of view demonstrates endotracheal tube with tip overlying the trachea at the level of the clavicular heads. Left central venous catheter with tip overlying the superior vena cava. Enteric tube with tip distal to diaphragm, overlying the stomach. Stable size and contour of the cardiomeastinal silhouette. Lungs demonstrate left basilar subsegmental atelectasis with small effusion. Visualized portions of the bony thorax are unchanged.

IMPRESSION:

1. Left basilar subsegmental atelectasis with small effusion.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW

I have reviewed the images and agree with the findings in this report.

History: /p blow to head with skull fracture

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MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/15/2007
Surgeon: Stuart M. Leon, MD
Assistant(s): James P. Stokes, MD

PREOPERATIVE DIAGNOSIS: Closed-head injury with epidural hematoma.

POSTOPERATIVE DIAGNOSIS: Closed-head injury with epidural hematoma.

TITLE OF PROCEDURE: Placement of percutaneous endoscopic gastrostomy tube.

ANESTHESIA: Local MAC.

OPERATIVE INDICATIONS: Mr. Gomez is a 56-year-old Hispanic gentleman who was struck by a crane while at a construction site earlier this month. The patient sustained several injuries, the most significant of which was a closed-head injury with an epidural hematoma. This injury has left Mr. Gomez neurologically devastated. We have discussed with the family the need to place a percutaneous endoscopic gastrostomy tube for continued enteral feeds and nutritional support. The risks and benefits of this procedure were discussed with the patient's family in great detail, and operative consent was obtained for us to proceed at this time.

OPERATION TECHNIQUE: Mr. Gomez was laid supine in bed in the surgical trauma intensive care unit. The patient was given Dilaudid and was then placed on a propofol drip in order to achieve conscious sedation.

After these medications have been given, a bite block was placed between the patient's teeth, and an Olympus endoscope was then passed per oral down the esophagus and into the stomach without difficulty. The stomach was insufflated with air. A site was chosen along the left subcostal margin for placement of our gastrostomy tube. This site was noted to be approximately 2 fingerbreadths distal to the left subcostal margin and had an excellent finger counterpulsation when viewed from within the stomach endoscopically. This site was also noted to easily transilluminate. The patient's abdomen was then prepped and draped in the usual sterile fashion. One percent lidocaine was injected at the gastrostomy tube entry site. After appropriate local anesthetic had been administered, a 1-cm stab incision was made at this location, and a Jelco needle was then passed through the center of the stab incision directly into the stomach on the first attempt. The Jelco needle was grasped with the endoscopic snare. A guidewire was then threaded through the needle and in turn grasped with the endoscopic snare. The endoscope snare and guidewire were then withdrawn retrograde out of the stomach and esophagus and brought out through the oral cavity. A 24-French Ponsky gastrostomy tube was then attached to the free end of the guidewire, and the guidewire and gastrostomy tube were then pulled antegrade back through the esophagus and into the stomach. The endoscope followed. The gastrostomy tube button was noted to seat nicely along the anterior wall of the stomach. It was approximately 2 cm from the skin surface.

The bolster was placed so that the gastrostomy tube button remained snug to the anterior wall of the stomach but was able to freely rotate with digital manipulation. The remaining gastrostomy appliance was replaced. The stomach was then deinsufflated of air, and the endoscope was removed. Mr. Gomez tolerated this procedure well without incident. Throughout the entire procedure his heart rate, blood pressure, and pulse oximetry were continuously monitored, and at

no point during the procedure did he become hypoxic, bradycardic, or hypotensive.

ATTESTATION STATEMENT: I, Stuart Leon, MD, was personally present, assisted, and supervised all aspects of this procedure from beginning to end.

Dictated by: Stuart M. Leon, MD

Stuart M. Leon, MD
Surgeon

249384 / 38351 /
JOB: 370330
DD: 11/15/07 04:10 PM
DT: 11/17/07 11:10 AM

Additional CC: _____

DOCID: 18232249384

Electronically signed by STUART LEON, MD on 11-19-2007 at 07:52:45 PM

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/15/2007
Surgeon: Christian Minshall, MD
Assistant(s): James P. Stokes, MD

PREOPERATIVE DIAGNOSIS: Closed head injury with epidural hematoma.

POSTOPERATIVE DIAGNOSIS: Closed head injury with epidural hematoma.

PROCEDURES: Tracheostomy.

ANESTHESIA: Moderate sedation.

INDICATIONS FOR PROCEDURE: Mr. Gomez is a 26-year-old Hispanic gentleman who was struck by a crane while at a construction site earlier this month. He sustained a severe head injury at that time and, despite multiple attempts, has been unable to tolerate extubation and protect his airway. It was felt he was a good candidate for a tracheostomy. The risks, benefits, and alternatives were explained and informed consent was obtained.

DESCRIPTION OF PROCEDURE: The patient was prepped and draped in normal sterile fashion after having his C-collar removed and placed between sandbags. A vertical incision, approximately 2 cm, was made approximately 1 fingerbreadth above the sternal notch. This was carried down through the subcutaneous tissue and to the platysma. The strap muscles were then split and dissected down sharply with cautery until the trachea was visualized. Anterior tracheal fascia was then dissected off the trachea using the Blue Rhino percutaneous kit. Percutaneous tracheostomy was then performed between the second and third tracheal rings. This was done with serial dilation and an 8-cuffed Shiley trach was placed and was visualized in the airway. End-tidal CO2 was returned and end-tidal volumes were maintained. The skin incision was closed with an interrupted 2-0 Vicryl, and the trach was secured in place with interrupted 2-0 nylon stitches.

Dr. Minshall was present and scrubbed throughout the entire case.

Dictated by: James P. Stokes, MD

Christian Minshall, MD
Surgeon

435784 / 35634 /
JOB: 372205
DD: 11/27/07 04:27 PM
DT: 11/29/07 08:12 AM

Additional CC: _____

DOCID: 18232435784

Edited By JAMES STOKES on 11-30-2007 at 06:13:58 PM
Electronically signed by TODD MINSHALL, MD on 12-05-2007 at 03:50:23 PM

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5087924

MRN: 002581962
Date Exam Completed: 11/15/2007 03:05
Last Update: 11/15/2007

Chest

Accession Number: 5087924

Indication: 27 yo hm sp crane accident

Comparison: 11 14 07

Findings: Single frontal radiograph of the chest demonstrates unchanged position endotracheal tube tip well above carina, left central venous catheter tip over superior vena cava, nasogastric tube over stomach and temperature probe unchanged since prior exam. The size and contour of the cardiomeastinal silhouette and hilum are unchanged. Lungs again demonstrate air space disease in the left base and no pneumothorax, or pleural effusion. Fractured right clavicle is unchanged

Impression:
No significant interval change.

History: 27 yo hm sp crane accident

Technologist: ELMON WATSON
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/15/2007

Transcribed by: Tech IntTalk

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

(0700) Received report and assumed care of pt R (0745) Assessment completed. Propofol ctf held for neuro assessment. Pt opens eyes to voice, PERCUL, but will not follow commands & extremities, withdraw only. Miami T collar secure. Lungs & rhonchi throughout, clear & settling. Vent settings (BIVENT) on flushnet. Abd soft/nontender & @BS. Receiving TF through OGT, placement checked @air tube. Foley & amber urine R (1000) Turned, repositioned, opens eyes to voice, does not follow commands & extremities, but does have spontaneous movt x4 extrem. 2f ped pulse, movt @foot R (1230) Dr. Brian notified @ U/O x 2 hrs. Starts to flush Foley, wait 30 min, if @ output, then replace Foley R (1245) Foley flushed & NS, yellow urine & small blood clots aspirated, then good U/O (>200cc) R (1305) TF held and OGT placed to suction by Dr. Stokes for GT placement this afternoon R (1325) PEG placement procedure started - Dr. Stokes and Dr. Leon & endocrine nurses. Time out done. Pt given 2mg IV Albuterol prior to procedure. Remain on propofol. (1345) PEG placed U/O & difficulty. PEG tube placed to gravity drain. Pt remained sedated throughout procedure R (1545) Continues to have adequate U/O. GT & small amt drainage (TF). Per Dr. Brian, TF will be held until tomorrow R (1700) Bed bath & linen change done R (1800) BS=69, 15ml D50 given IV per protocol. Will recheck BS in 15 min. R (1810) BS=114, insulin re-initiated R (1930) Received report and completed chartcheck & off going RU. Assessed patient, ved drips and assumed care R (2200) Complete bath & linens. SH

UP# 411230 rev B/03

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5091251

MRN: 002581962
Date Exam Completed: 11/17/2007 06:12
Last Update: 11/18/2007

EXAMINATION: CHEST 11/17/07 06:12:00

ACCESSION NUMBER: 5091251

INDICATION: head injury, skull and facial fx, failed extubation multiple times, s/p trach 11/16

COMPARISON: 11/16/07

FINDINGS: Single frontal radiograph of the chest demonstrates interval removal of endotracheal tube and placement of a tracheostomy tube which overlies the tracheal air column. Nasogastric tube is been removed. Left subclavian central venous catheter is unchanged. The size and contour of the cardiomeastinal silhouette and hilum are unchanged in appearance as well. Lungs again demonstrate left pleural effusion with left basilar atelectasis. Right midshaft clavicular fracture.

IMPRESSION:

1. Exchange of endotracheal tube for tracheostomy tube.
2. Left pleural effusion with left basilar atelectasis.

VOICE DICTATED BY: Dr. KIRK KIZZIAH
I have reviewed the images and agree with the findings in this report.

History: head injury, skull and facial fx, failed extubation multiple times, s/p trach 11/16

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MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Admitted: 11/01/2007
Discharged: 12/01/2007
Service: Trauma Surgery
Attending: CHRISTIAN T MINSHALL, MD

Referring:

ADMITTING DIAGNOSES:

1. Status post skull fracture.
2. Open complex scalp wound with epidural and subdural hematoma.
3. Bilateral frontal contusions.

HISTORY OF PRESENT ILLNESS: This is a 27-year-old Hispanic male who was hit in the head with part of a construction crane with positive loss of consciousness at the scene, significant blood loss, positive emesis at scene. He was intubated by EMS. This occurred in Marion County after an elevated crane fell and hit him. The patient was attempted to be intubated by Marion County which was unsuccessful. Then, Carolina Lifecare was able to intubate.

REVIEW OF SYSTEMS: Per HPI.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

SOCIAL HISTORY: Questionable use of ETOH.

DISCHARGE PHYSICAL EXAMINATION: Vital signs: Temperature 99.3, heart rate 114; respiratory rate 19, blood pressure 118/81, saturating 99% on room air. Neurologic: Patient alert and oriented. Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs. Lung sounds clear to auscultation bilaterally. Abdomen: Positive bowel sounds, nontender, nondistended. Trauma: PEG tube in place. Extremities: Right foot in dressing, clean, dry, and intact. Moves knee and ankle joints.

DIAGNOSTIC TESTS: CT of the abdomen on 11/01/2007 showed a right adrenal hemorrhage, bilateral L1 and L2 and right L3 transverse process fractures and multiple posterior rib fractures.

CT pelvis on 11/01 showed a high density structure in the rectum of uncertain significance.

CT of the head on 11/01/2007 showed a comminuted fracture with small extraoccipitoparietal hematoma at the midline at the vertex, worrisome for a small epidural hematoma.

CT of the chest with contrast on 11/01/2007 showed bilateral lung contusions and/or aspiration. Right clavicle fracture and C7 and T1 spinous process fractures.

Patient has had multiple CTs of the head and chest x-rays.

CONSULTS SERVICE:

1. Neurosurgery.
2. Orthopedics.

HOSPITAL COURSE: The patient had a protracted hospital stay. Patient was admitted initially through the trauma bay via trauma protocol and then taken to the STICU for medical management.

Neurology: Patient was managed by neurosurgery for his subdural and epidural hematomas. Patient was also managed for multiple spinous process fractures. Patient has subsequently recovered function. He was ambulating without any difficulties, moving all extremities. Patient alert and oriented x3.

Cardiovascular: Patient remained hemodynamically stable. No acute issues.

Pulmonary: Patient initially intubated en route from Marion County by the air medical services. Patient was subsequently transferred to STICU on the ventilator service. Patient had failure to wean off the ventilator and subsequently had a tracheostomy performed while in the hospital. Subsequently, patient had tracheostomy removed.

Gastrointestinal: A PEG tube was placed for nutritional concerns. Patient tolerated tube feeds throughout his stay. Subsequently, after patient was transferred to floor, tube feeds were held and patient was started on p.o. intake. Patient was tolerating p.o. without any problems. PEG tube remained intact at time of discharge to be pulled out at his appointment with trauma surgery.

Musculoskeletal: Patient with multiple fractures that were initially evaluated and treated by orthopedics. The day prior to discharge, the patient was taken to the operating room by orthopedics to have his 2nd through 5th metatarsals amputated. Patient had a full weightbearing status at time of discharge. Subsequently, physical therapy recommendations no further out of hospital physical therapy needed.

DISCHARGE DIAGNOSIS(ES):

1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. C7 and T1 spinous process fractures.
7. Right rib fractures which included 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.
10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes.

DISCHARGE MEDICATIONS: Patient will go home on oxycodone. He will take 1-2 tabs p.o. q.4-6 h. p.r.n. pain.

DISCHARGE PLANS: Patient will follow up with orthopedic clinic at McClennan-Banks on Wednesday in 2 weeks. Patient will also follow up with trauma clinic on Friday in 2 weeks.

DISCHARGE INSTRUCTIONS: Patient is to call for temperature greater than 101.5, pain not controlled with medicine, redness around or drainage from wound. Additionally, patient is to keep wound dry until seen by orthopedics. Activity as tolerated. Diet as tolerated.

Dictated by: Daniel Schwerin, MD

Daniel Schwerin, MD

CHRISTIAN T MINSHALL, MD
Attending

513512 / 30028 /
JOB: 373087
DD: 12/01/07 01:36 PM
DT: 12/04/07 10:26 PM

Additional CC: _____

DOCID: 18233513512

Edited By DANIEL SCHWERIN MD on 12-19-2007 at 08:27:06 AM



MUSC
THERAPEUTIC SERVICES

Discovering. Understanding. Healing.

Medical University Hospital Authority
Rehab Services
Charting Report

NAME: GOMEZ, HECTOR

PAT 490943644

MRN 002581962

Date/Time: 11/23/2007 1:17:00PM

Patient Room/Bed at Time of Encounter: 006W:D657/A

Orders Completed: EVAL30
THERA

Evaluation: 30 minutes; Untimed use only one per e
Therapeutic Activity: transfers, closed chain and
Number Performed: 1
Number Performed: 1

Physical Therapy Initial Evaluation

Date/Time of Evaluation: 11/23/07 0930

Physician Service: MINSHALL, CHRISTIAN

Funding: FX

Initial Assessment:

Diagnosis: crane accident

History of Present Illness/Mechanism of Injury: HECTOR GOMEZ is a 56 year old M who presents with with crane accident at work. Admitted 11/1 after crane fell and landed on pt. Pt sustained skull fracture, B frontal contusion, R great toe distal phalanx fracture, R 2-5 toes proximal phalanx fracture (R 4 and 5 open), C7-T1 spinous process fractures, R 7-10 rib fractures, B L1-L3 transverse process fractures, R L3 transverse process fractures, R clavicle fx. S/p I and D and pinning of R toes 11/2. Trach placed 11/16. Sustained post traumatic vasospasm of R foot-pt now with gangrenous toes and awaiting possible TMA.

Past Medical History (medical complications): none

Home Environment: unknown-pt reports living in Marion County

Prior Level of Function/Occupation: unknown

Subjective: pt Spanish speaking only with minimal English. No translator available

Pain (average pain intensity over the last 24 hours (0=no pain 10=E.R.)):pt shakes head no to pain when questioned in Spanish

Patient Goals: none stated

Objective:

Treatment Location: Patient seen bedside.

Mental Status: alert, following all commands with cues/gestures/Spanish commands as able, unable to accurately assess orientation

Barriers to Learning/Goals: Language Cognitive?

Special Conditions: trach, IV, foley, SCD's, PEG, Miami J collar, B UE restraints

Range of Motion:

* Upper Extremities: WFL

* Lower Extremities: WFL

Strength:

* Upper Extremities: WFL except: R shldr NT due to clavicle fracture

* Lower Extremities: WFL except: R ankle NT formally due to gangrene but pt moving WFL

Endurance: Fair - Tolerates 5 to 15 minutes of an uninterrupted exercise bout.

Sensation: Not Tested Location: formally due to language but pt shakes head that he can feel light touch in all 4 extremities-needs further assessment of R foot/toes

Balance: Sitting (Motor Assessment Scale for Sitting Balance 0-6) is 2 initially but progressed quickly to 3 as dizziness

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Rehab Charting Report Continued

NAME: GOMEZ, HECTOR

PAT 490943644

MRN 002581962

subsided

Muscle Tone: no abnormal tone noted

Level of Function at Start of Care (FUNCTIONAL LIMITATIONS):

- Bed mobility:
 - Rolling: Right: Minimum Assistance
 - Scooting: Minimum Assist
 - Supine to Sit: Minimum Assist
 - Sit to Supine: Minimum Assist
- Transfers
 - Sit to Stand: Patient is moderate assist (x 3 reps) pt able to maintain NWB R LE after demo given-stood with min assist static stand
 - Bed to Chair: Not tested as pt declined OOB/ambulation
- Ambulation: NT
- Stairs: NT
- Wheelchair Propulsion: Not Tested

Treatment: Total Treatment Time: 30 minutes. Total Treatment Time Timed Codes: 15 Evaluation, Transfer Training Bed Mobility Training.

Patient/Family Education: Patient was instructed in P.T. Role Weight Bearing Precautions.

Response to Education: Needs Reinforcement.

Equipment Owned: unknown

Equipment Needed: ongoing assessment

Assessment:

Pt presents s/p crane accident with multiple fractures, CHI and now awaiting possible TMA for R foot gangrene. Moving well despite language barrier. Good understanding of NWB status but needs reinforcement in Spanish to promote compliance. If TMA performed, will need resume PT order when pt medically stable and appropriate. Will cont to assess for needs

Patient's Response to Treatment: dizziness with sitting EOB

Impairments (problem list): decreased mobility

decreased ambulation

R foot gangrene NWB

Prognosis based on patients medical history, response to education, home exercise performance, and response to treatment: good

Plan of Treatment/Functional Goals:

Short Term Goals as discussed with patient and/or family to be met by 11/30/2007

- * Patient to perform rolling with Modified Independence for position in bed.
- * Patient to perform supine to sit with Modified Independence for getting in and out of bed.
- * Patient to perform sit to stand with Modified Independence to come to stand for ambulation..
- * Patient to ambulate >30 feet with Modified Independence with least restrictive assistive device for household ambulation.

Will update stair goal as home setting determined with translator

Outcome Goals (Long Term as discussed with patient and/or family) to be met in 3 months.

- * Patient will demonstrate independence with all transfers.
 - * Patient will ambulate >2500 feet Independently with least restrictive assistive device.
- In order to achieve the maximum level of independence with all personal, household, and community activities.

Plan:

Continue PT daily.

Treatment Specifics: transfer training gait training education balance training therapeutic exercise wheelchair mobility training to achieve maximum independence and safety.

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Page 2 of 3



* P R G R E C R D *

Rehab Charting Report Continued

NAME: GOMEZ, HECTOR

PAT 490943644

MRN 002581962

*FUNCTIONAL ACTIVITY SCALE

Total Assist: patient expends < 25% of effort

Maximum Assist: patient expends >25% and <50% of effort.

Moderate Assist: patient expends >50% but <75% of effort.

Minimal Assist: patient expends >75% of effort.

Supervision: patient requires only verbal cues or coaxing.

Modified Independence: patient requires assistive device, extra time, or there is a safety risk.

Independent: patient is completely independent.

*MOTOR ASSESSMENT SCALE FOR BALANCED SITTING:

1. sits only with support

2. sits unsupported for 10 seconds

3. sits unsupported with weight well forward and evenly distributed

4. sits unsupported, turns head and trunk to look behind

5. sits unsupported, reaches forward to touch floor and returns to starting position

6. sits unsupported, reaches sideways to touch floor and returns to upright

*TINETTI GAIT AND BALANCE:

High Fall Risk: score of less than or equal to 19 out of 28 points

Moderate Fall Risk: score of 20-24 out of 28 points

Low Fall Risk: score greater than or equal to 25/28 points

Electronically Signed by: Paige Thomas, MSRPT

If you received this report in error, please notify the MUSC Compliance Office immediately at (843) 792-4037 or 1-800-296-0269. Thank you.

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CONSULTATION REPORT

Patient: GOMEZ-FRAGOSO, HECTOR

MRN: 002581962

Date: 11/1/2007

Status: FINAL

MUSC Medical Center

CONSULTATION REPORT

Patient Name: GOMEZ, HECTOR

MRN: 002581962

Patcom: 490943644

Date: 11/01/2007

Service: Orthopedic

Attending: Shane K. Woolf, MD

HISTORY OF PRESENT ILLNESS: The patient is a 56-year-old patient, at a construction site was hit in the head with a crane. Apparently he vomited prior to the ED arrival, with unsuccessful intubation at an outside hospital. Past medical history none. No known drug allergies. No known previous surgeries, no current medical conditions. Apparently could smell alcohol on the patient's breath. Questionable tobacco use.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Unable to obtain.

This patient incurred a large fracture through his skull, apparently it is open, with subdural and epidural fluid collections.

Orthopedics was consulted for a right clavicle fracture as well as fractures of the proximal phalanges of the right foot, 2-12, with traumatic arthrotomies of the 4th and 5th toes as well as a nondisplaced oblique fracture of the right great toe.

PHYSICAL EXAMINATION: The patient is a Hispanic male, intubated, sedated. Apparently he was moving all extremities upon admission. His right upper extremity is noted to have some bruising and swelling about the right hand, but no crepitus is noted about the hand, wrist, elbow, arm, or shoulder. There is gross crepitus at the right clavicle. The left upper extremity is unremarkable. Again it was moving, apparently, on admission. There is no crepitus or step-off noted. His left lower extremity also has no obvious injuries, swelling, step-offs, crepitus noted about the hip, thigh, knee, leg, or ankle or foot. The right foot is significant for traumatic arthrotomies of the 4th and 5th digits, and gross swelling about the foot. The ankle appears to be intact without any swelling or bony step-offs or crepitus, as well as the leg, knee, and thigh, and there is range of motion in his hip without crepitus. His pelvis is stable to AP and lateral compression. Abdomen is soft, nontender, nondistended.

Patient: GOMEZ-FRAGOSO, HEOR

MRN: 002581962

Date: 11/1/2007

Status: FINAL

ASSESSMENT: Hispanic male with the aforementioned injuries with traumatic arthrotomies at the 4th and 5th toes of the right foot as well as right clavicle fracture. Will apply a splint to the clavicle fracture. The arthrotomies will be washed out and assessed. Antibiotics q. 8h will be recommended, and patient apparently is not a surgical candidate at the moment per neurosurgery. Will possibly take him to the OR for more definitive washout and closure and possible pinning of the fractures at a future date. The plan has been discussed with the attending and he is in agreement.

Dictated by: Bennett Grimm, MD

Bennett Grimm, MD

Shane K. Woolf, MD

Attending

902536 / 35634 /

JOB: 367701

DD: 11/01/07 08:40 PM

DT: 11/02/07 12:19 PM

Additional CC:

DOCID: 18231902536

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:22:19 AM

Radiology Results

Page: 1

Date Printed: 04/21/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962

SEX: M AGE: 27

11/06/07 : 10:24pm
DIAG CERV SPINE AP/LAT
Accession number: 5080007

EXAMINATION: CERVICAL SPINE 11/06/07 22:24:00

ACCESSION NUMBER: 5080007

INDICATION: c spine clearance, altered mental status

COMPARISON: None.

FINDINGS: Lateral flexion/extension views of the cervical spine were obtained. The craniocervical junction is unremarkable. The vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. Disc spaces are well maintained. There is a normal cervical curvature. There is no abnormal cervical motion with flexion/extension. The paraspinal soft tissues are normal. Left parietal/temporal/frontal bone fracture. Endotracheal tube with distal tip not visualized.

IMPRESSION:

No cervical instability.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

AUTHENTICATING RADIOLOGIST: WILLIAM CONWAY

4STN4STN04 krishna 15388 please page 15388 to schedule
for c spine clearance

Progress Notes

Page: 1

Date Printed: 12/10/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

12/01/08 : 00:00am

MUSC ORTHOPAEDICS INITIAL NOTE - MT PLEASANT

D99

CHIEF COMPLAINT: Left shoulder pain, neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old Hispanic gentleman whom I treated about a year ago following a work-related injury where a construction crane landed, striking him on the head, causing a small, subdural hematoma as well as cervical spinous process and transverse process fractures, also in the thoracolumbar area and a crush injury to the right foot which required amputation of dysvascular toes ultimately. He has done well from the standpoint of his foot and is actually planning to have an insert made for his shoe this week and is basically having no pain or issues with the wound. The shoulder continues to be painful for him as does his neck and lower back. He has not had formal treatment to date. He has radiation of pain down the forearm to his hand as well as some numbness compared to the contralateral side and all of his digits. He has had weakness about the shoulder and pain at nighttime. He has not had injections, therapy or any specific medications to treat his pain symptoms.

Past Medical History, Past Surgical History, Allergies, Medications, Social History, Family History and Review of Systems are all documented on the New Patient Encounter form and reviewed by me today.

ALLERGIES: Penicillin, which apparently causes some respiratory issues.

PHYSICAL EXAMINATION: He is a young, healthy appearing, Hispanic male in no acute distress. He is cooperative during the exam. He does not speak English and is accompanied by an interpreter. His cervical spine is tender at around C6, 7 and has slight increase in motion with lateral bend and flexion, extension, secondary to discomfort. His shoulder is tender anterolaterally and at the AC joint on the right. He has mild coracoid tenderness and no atrophy. Neer, Hawkins, crossover are negative. Drop-arm, lift-off, belly press, apprehension, sulcus, crepitation and O'Brien's negative. He does have pain at the AC joint as well as deep with O'Brien's but it is equal with supination, pronation. Lumbar spine is tender at around L4-5. He has reasonable motion of his lumbar spine and his DTRs in the upper and lower extremities are equal bilaterally. He is subjectively slightly hypesthetic on the right compared to the left, but his strength and grip, abduction, flexion, extension of the wrist and hand are all equal with elbow, flexion, extension and strength is equal bilaterally. Negative straight leg raise in the lower extremities. Palpable radial and dorsalis pedis pulses bilaterally. Active total elevation of the shoulder is about 150. ER is 35 and IR is to the midlumbar spine with negative lift-off. Passive supine forward flexion is about 165. ER 90 is 55. IR 90 is 35 on the right.

IMAGING: Plain radiographs show a Type II acromion, minimal degenerative spurring of the AC joint but no significant abnormality and no glenohumeral arthrosis. Cervical spine films show persistent, unhealed spinous process fracture at C7.

IMPRESSION:

1. Left AC joint arthritis.
2. Left shoulder posttraumatic stiffness.
3. Rotator cuff strain.
4. C7 spinous process nonunion with paracervical pain.
5. Low back pain.

PLAN: He agreed to a diagnostic and therapeutic left shoulder AC joint and subacromial injection performed through an _____ approach

PROCEDURE: With the patient's consent, using sterile technique, the left shoulder was injected with 80 mg of Depo-Medrol plus 8 cc lidocaine/Marcaine mix without complication. This was well tolerated, and the patient will notify us if problems develop.

He is referred to physical therapy to work on motion and strengthening of his left shoulder as well as paraspinal strengthening of the neck and lumbar stabilization program. Follow up with me in 2-1/2 months to measure his progress. He has been unable to work since this incident, mostly because of shoulder and neck pain. If he continues to have symptoms, particularly the radicular type complaints, we may consider MRI of the cervical spine to specifically evaluate

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ORTHOPED

12/10/08 21:19 8437523149

Progress Notes

Page: 2

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 12/10/08

ID: 2581962 SEX: M AGE: 28

C6, 7 and C7,8 for right sided nerve root injury or compression. His lumbar symptoms appear to be more mechanical in nature rather than radicular so no further imaging at this point. He is comfortable with our plan.

Shane Woolf, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843 792-0404
Facsimile: 843 792-3843

SW/AM:1251
838384

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 12/03/2008 12:40PM

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PAGE 03/03

ORTHOPED

12/08/2008 21:19 8437923149

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR

MRN: 002581982

Procedure: 5141659

Date Exam Completed: 2008/01/17

Accession# 5141659

Last Update: 2008/01/17

EXAMINATION: CT of the Brain 01/16/08 09:59:00

ACCESSION NUMBER: 5141659

INDICATION: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS, FRONTAL CONTUSION, SKULL FRACTURES, ASSESS STABILITY

COMPARISON: Head CT 11/7/07

TECHNIQUE: Multiple contiguous axial CT images of the head were performed without IV contrast.

FINDINGS: There is no evidence of new hemorrhage or extra-axial fluid collection. There are no signs of acute infarct. There has been interval resolution of previously visualized left parietal and right temporoparietal soft tissue swelling. Again seen are skull fractures with extension into the sutures as described on prior CT. The fracture do appear to have some healing, but the fracture lines are still present. There's been interval on clearing of the paranasal sinuses with no significant mucosal thickening or fluid levels identified. The orbits are unremarkable.

IMPRESSION:

1. No evidence of acute intracranial process.
2. Healing skull fractures.

DICTATED BY: Dr. CHRISTOPHER MOSES

I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Printed by: POLLY, DEBORAH

Date Printed: 10/14/2008

Page1

Progress Notes**Page: 1**

Date Printed: 04/24/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:27

01/16/08: GOMEZ-FRAGOSO, HECTOR: 2581962
NEUROSURGERY CLINIC
MEDICAL UNIVERSITY OF SOUTH CAROLINA
N64

HPI: 27-year-old Hispanic male who on 11/01/07 was struck by a construction crane and sustained multi-trauma and was treated on the trauma service. The patient had a skull fracture with a small thin-rimmed subdural hematoma in the right frontoparietal region. He also sustained multiple spinous and transverse process fractures in the thoracolumbar area. He also sustained a crush injury to his right foot necessitating amputation of several toes. He is now here for a clinical follow-up. He was discharged from the hospital on 12/01/07.

PHYSICAL EXAMINATION: Vital signs: temperature 97.8, blood pressure 111/76, respirations 20, pulse 74. Weight 73.9 kilograms.

Constitutional: Stocky body build. In no apparent distress.

Neurological: GCS 15. Patient is interviewed through an interpreter. Oriented x3. Cranial nerves II-XII are intact. Strength is 5/5 x4. Reflexes are brisk and symmetrical. Patient has a right-sided limp due to his foot injury. He complains of numbness in the fingertips bilaterally. Unclear if this has gotten any better over time.

RADIOGRAPHIC STUDIES: I reviewed the patient's head CT as well as his T and L-spine films from today. There are no surgical relevant lesions in the spine. His hematoma is still visible as a thin rim without mass effect in the right frontoparietal region.

ASSESSMENT AND PLAN: 27-year-old Hispanic male status post closed head injury. No neurological sequela. His fingertip numbness could possibly be from a whiplash injury for which I do not have a surgical solution. Patient is not in need of neurosurgical at this time.

Istvan Takacs, MD
Assistant Professor
Department of Neurosciences
Medical University of South Carolina
IT/AM:205
JOB:169463

SIGNED BY ISTVAN TAKACS, MD (N64) 01/31/2008 02:07PM

Progress Notes**Page: 1**

Date Printed: 01/14/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX: M AGE: 28

01/05/09 : 00:00am
 MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT
 D99

CHIEF COMPLAINT:

1. Left shoulder pain.
2. Neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns with his interpreter today, still having pain about the neck and shoulder. His low back has been symptomatic without radicular symptoms. His upper extremity pain seems to radiate down into the hand globally. He has not had atrophy or weakness about the hand. He feels physical therapy seems to help the neck, particularly with improvement in pain around his treatments, but his pain does return. He has had a modest improvement in his motion. His low back pain seems to be worse since starting therapy, but he is not associating radicular symptoms.

PHYSICAL EXAMINATION: He has mild tenderness at C6, 7 and his motion remains slightly decreased in lateral bend flexion and rotation because of his discomfort. His shoulder remains tender at the coracoid and AC joint mildly. His strength and motion remain about 150 of total elevation, ER of 35 and IR to the mid-lumbar spine with negative lift-off. His strength remains 5- in abduction and ER. His low back is still somewhat tender around L4, 5 with good motion and negative provocative test.

IMPRESSION:

1. Left AC joint arthritis.
2. Left shoulder posttraumatic stiffness.
3. Rotator cuff strain.
4. C7 spinous process nonunion with paracervical pain.
5. Low back pain.

PLAN: Given the nature of his injury and his upper extremity symptoms, I recommend MRI of the cervical spine which has not yet been performed as well as MRI of the shoulder. I would expect him to not have a rotator cuff tear but that is a possibility which may be a confounding factor. I would also like to assess his cervical disks, particularly at C6 - C8 nerve roots which may explain his upper extremity symptoms altogether. Concerning his low back problem, I still think physical therapy and nonsurgical treatment will be his course. If he continues to have pain, we will consider referral to Dr. Christopher Merrell for further management. He is comfortable with our plan. Follow up with me after the study is completed.

Shane Woolf, MD
 Assistant Professor
 Department of Orthopaedic Surgery
 Medical University of South Carolina
 96 Jonathan Lucas Street, Suite CSB 708
 Charleston, South Carolina 29425
 Telephone: 843 792-0404
 Facsimile: 843 792-3843

SW/AM:997
 919567

cc:

Workman's Compensation

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 01/07/2009 04:01PM

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PAGE 02/02

ORTHOPED

01/12/2009 23:51 8437523149

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p.m. 02-13-2009

4/5

Progress Notes**Page: 1**

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

01/27/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE-BONE AND JOINT CENTER

D99

CHIEF COMPLAINT:

1. Left shoulder pain.
2. Neck pain.
3. Right foot pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns, again with his interpreter, to follow-up on his cervical spine and shoulder MRI. He continues to have the same pain, which he localizes to the base of the neck on the left side and in the upper portion of the trapezius. He has radiating symptoms sometimes down the hand and arm. In addition, he has also had pain on the dorsum of the right foot just proximal to his transmetatarsal amputation site which otherwise has done well. He has been in a new modified shoe for the past couple of weeks but it seems that the pain has developed prior to that.

PHYSICAL EXAMINATION: On exam of the foot, he is tender directly over the base of the fourth metatarsal. There is no skin damage, no ulceration, no evidence of compromise to his wound, which is nicely healed, and the overall contour of his amputation stump looks excellent. He is somewhat tender along the distal scar. His shoe is in good shape, the insert appears well molded and formed, made of a closed cell foam. The uppers are soft and I do not appreciate any potential area for impingement. The shoulder he can move reasonably well but notes pain at the base of the neck. This is the case also with impingement testing as well as strength testing. He has pain with rotation in the lateral bend as well. He is otherwise neurovascularly intact to exam today.

IMAGING: Cervical spine MRI shows multilevel central disc bulge and a small paracentral disc protrusion or possibly osteophyte at C4-5. He has a slight disc bulge at C-7/T-1 and at C4-5. Shoulder MRI is reported as normal but to my read shows a small upper infraspinatus partial undersurface tear with articular side bony evulsion of a portion of the tendon. This is small and does not appear to involve much of the cuff. The labrum appears healthy and subacromial space is healthy.

IMPRESSION:

1. Painful right transmetatarsal amputation stump, with metatarsalgia.
2. Small partial thickness infraspinatus tear of the left shoulder.
3. Possible C4-5 nerve root impingement.

PLAN: Concerning the shoulder, I do not think that is a major source of his pain. I am more concerned about his neck, given his symptoms at the base of the neck and trapezius as well as his radiating symptoms in the upper extremity. I would like him to see Dr. Merrell for his opinion on the MRI as well as consideration for a trigger point or nerve root injection guided by his MRI finding. Concerning his foot, he may have some neurogenic pain along the digital nerves and I think his dorsal foot pain may be related to the shoe. He can float the area with a corn pad and may need some adjustments made to the position of the spacer. He is prescribed Neurontin to treat neurogenic pain in both the foot as well as the neck and will follow-up with me in a couple months after his assessment by Dr. Merrell. He is comfortable with that plan.

Shane Woolf, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843 792-0404
Facsimile: 843 792-3843

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Progress Notes**Page: 1**

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 02/13/09

ID: 2581962 SEX:M AGE:28

02/04/09 : 00:00am

MUSC ORTHOPAEDICS INITIAL NOTE - MT PLEASANT

2FG

D99

REFERRING PHYSICIAN: Dr. Shane Woolf.

CHIEF COMPLAINT: Left-sided neck pain and shoulder pain.

Dear Dr. Woolf:

Thank you for allowing me the opportunity to serve in consultation regarding Mr. Gomez-Fragoso.

HISTORY OF PRESENT ILLNESS: As you know, he is a 28-year-old man with a history of left-sided neck pain and shoulder pain since November 2007. He works in construction and a cable broke and struck his head and left shoulder. Since then, he has had difficulties with pain. His pain is worse with shoulder abduction as well as with general range of motion of the neck. It is present at all times of the day and does interfere somewhat with sleep. He has been using Neurontin 300 mg nightly which is helping minimally. He has had cortisone injection as well as physical therapy and that is not helping too significantly as yet. He endorses left-sided five-finger numbness and tingling and this extends into the forearm as well. This is present all the time. No bowel or bladder incontinence. No other trauma is endorsed.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: He is in construction, single. He smokes one cigarette daily. He does not drink alcohol.

FAMILY HISTORY: Heart problems, diabetes.

MEDICATIONS: Include a pain medication as well as Neurontin 300 mg nightly.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling, especially in his thumb and middle finger. He does have a history of balance problems, blurry vision, breathing difficulties, bladder problems, and problems with hearing. Systems are otherwise negative.

PHYSICAL EXAMINATION: Blood pressure 113/75, heart rate 70, respiratory rate 12. In no apparent distress. Alert and oriented x3. Bright affect, normal mood. He speaks Spanish and has a translator with him today. He is relatively comfortable in the chair. Shoulder range of motion is fairly well preserved. Hawkins is negative. Biceps tendon is nontender. AC joint is nontender. His most tenderness is located at the superior trapezius with a small well-circumscribed trigger point identified in this region. His cervical paraspinals are also somewhat tender. Cervical range of motion is minimally reduced with leftward rotation. Spurling's is positive on the left, negative on the right. Reflexes are normal at the biceps, brachioradialis, and the triceps. Light touch sensory loss is present with pinprick and light touch predominantly at C6 distribution on the left. No hand intrinsic wasting is noted. Wrist extension is somewhat weak on the left compared to the right, but ADM testing is 5/5. Elbow and wrist range of motion otherwise within normal limits. Radial pulses 2+ bilaterally. No digital cyanosis.

RADIOGRAPHIC REVIEW: MRI of the cervical spine was reviewed and this was from an outside facility. According to my reading, he has disc protrusion just left to midline at C5-C6 as well as C7-T1. MRI of the left shoulder not reviewed today.

ASSESSMENT: Cervicalgia with symptoms consistent with possible left-sided C6 radiculitis.

PLAN:

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Progress Notes**Page: 2**

Date Printed: 02/13/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

1. Discussed the possibility of a trapezius trigger point injection, and he would like to defer at this time.
2. I did prescribe Neurontin at an increased dose of 300 mg three times per day for improving neurogenic pain relief.
3. Naproxen also prescribed at 500 mg twice daily for anti-inflammatory and analgesic effect.
4. Physical therapy is the best way to go at this point for range of motion and modalities as tolerated. Particular attention should be addressed at the left superior trapezius with manual massage techniques as tolerated. Modalities if needed.
5. If he does not improve in the next four weeks or so, we may reconsider trapezius trigger point injection with a possibility of selective nerve root block at C6 on the left side.

Thank you for allowing me to participate and plan in the care of Mr. Gomez-Fragoso. I look forward to seeing him back in the next four weeks.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:578
1020783

cc: Dr. Shane K. Woolf, 650 Ellis Oaks Drive, Charleston, SC 29412

SIGNED BY REBECCA BUFFUM (RB9) 02/05/2009 12:45PM
SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 02/05/2009 12:46PM
REVIEWED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 02/09/2009 08:52AM

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Progress Notes**Page: 1**

Date Printed: 03/12/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX: M AGE: 28

03/04/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

CHIEF COMPLAINT: Left sided neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man who returns for follow up today regarding his left sided neck pain and shoulder pain. It has been present since November 2007. He is a construction worker and a cable broke and struck his head and left shoulder and since then he has had these symptoms. He was previously seen by Dr. Woolf and is here now with more myofascial type complaints including left paraspinal tenderness as well as superior trapezius tenderness. He has had subacromial injections with some benefit and he has undergone physical therapy and continues at Atlantic Physical Therapy which he further reports today suggested he is continuing to have pain difficulties most notably at the upper trapezius area. With self massage, he can reproduce these symptoms. He feels that his neck range of motion is fairly well preserved.

PAST MEDICAL HISTORY: None.

PAST SURGICAL HISTORY: None.

SOCIAL HISTORY: Construction worker, single, smokes occasionally, no alcohol use.

FAMILY HISTORY: Heart disease and diabetes.

MEDICATIONS: Neurontin 300 mg three times per day as well as Naproxen 500 mg twice daily.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling in all five digits on the left side. He feels that his left hand is somewhat weak as well. Systems otherwise negative.

PHYSICAL EXAMINATION: No apparent distress. Alert and oriented x3. Bright affect, normal mood. Grip strength is 4/5 on the left side with fair effort. Superior trapezius is tender and a well circumscribed 1 cm diameter trigger point is identified at superior trapezius location. Cervical paraspinals on the left side is somewhat tender as well. However, cervical range of motion is well preserved. Spurling's positive on the left, negative on the right. Hawkins' test negative bilaterally. Yergason's negative bilaterally and Speed's test also negative. Upper extremity strength 5/5. Sensation to light touch is minimally reduced in glove distribution on the left side. Reflexes normal at the biceps, brachioradialis, and the triceps.

RADIOGRAPHIC IMAGING: MRI of the C-spine from an outside facility has been reviewed and revealed disc protrusion, left in midline at C5-C6 as well as C7-T1. There was an MRI of the left shoulder as well, however, I had not seen this.

ASSESSMENT:

1. Myofascial superior trapezius pain.
2. Cervicalgia with possible left sided C6 radiculitis versus C7 radiculitis.

PLAN:

1. As most of her symptoms are at the superior trapezius, discussed risks and benefits of a trigger point injection. He would like to proceed. Consent was obtained. Skin was cleansed with alcohol and anesthetized with ethyl chloride and utilizing 25-gauge 1.5-needle, 2 mL of 0.5% bupivacaine, 2 mL 1% lidocaine without epinephrine, 40 mg of Depo-Medrol was instilled in a sterile fashion and needling was pursued afterwards.
2. Continue with transition to home exercise program.
3. Continue Neurontin 300 mg three times per day and Naproxen 500 mg twice daily for anti-inflammatory and analgesic effect.
4. If the above is ineffective, I will have him follow up within the next one to two months and if no better, may consider SNRB of C6 versus C7 on the left side depending upon his symptoms.
5. May also consider nerve conduction studies depending upon his hand numbness. He does endorse it is worse

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20:28 MAR 15, 2009 ID: REF REQUEST

FAX NO: 866-560-8109

#150128 PAGE: 4/4

Progress Notes**Page: 2**

Date Printed: 03/12/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962

SEX:M AGE:28

nocturnally and this may be more of an ulnar neuropathy type picture.

6. He also complains of incidentally a right sided superior trapezius tenderness somewhat tender down to the left and may consider trigger point injection on the right side if the left side helps.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:576
1164741

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 03/05/2009 01:06PM

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03/24/2009 16:05 792734

DEBRA WRIGHT

PAGE 02/02

Progress Notes

Name GOMEZ-FRAGOSO, HECTOR

P: :
Date Printed: 0:
ID: 2581962 SEX: M A

03/16/09: 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

D89

CHIEF COMPLAINT:

1. Shoulder pain.
2. Neck pain.
3. Right foot pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso returns accompanied by his interpreter on follow up, rege his shoulder and cervical spine issues. He had seen Dr. Merrell, who performed a superior trapezius trigger point in and continued him on Neurontin plus Naprosyn. He also continues having pain on the dorsum of his foot. He never begin using corn pads to float the area.

PHYSICAL EXAMINATION: His shoulder remains tender with active motion but generally he can reach overhead, externally rotate equally bilaterally with less pain. He remains tender around the trapezius on the left side. The dors his foot is tender over the fourth ray, along the scar. He has negative Tinel's. Otherwise, this stump looks good and not appear infected.

IMPRESSION:

1. Painful right transmetatarsal amputation stump with metatarsalgia.
2. Small partial thickness infraspinatus tear, left shoulder.
3. C7 and T1 left sided disk protrusion with possible radiculitis.

PLAN: Concerning his foot, a prescription is provided for a pad which he can use at nighttime to manage dorsal foot caused by his shoe covers along the scar. He is again counseled to float the area with a corn pad as well and is pro prescription for such. I agree with Dr. Merrell's plan of considering a selective nerve root injection at the next visit sir did not respond to the trigger injection. Concerning his shoulder, his abduction and flexion have continued to improv the past three months in general, although his strength remains fairly weak. I would like to get his cervical issues fur clarified or resolved before considering any intervention for the rotator cuff issue, as I do not think that is a dominant source of his pain symptoms. Follow up with me in a month or two once he has had adequate follow up with Dr. Mer

Shane V. Wolf, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
66 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843 792-0404
Facsimile: 843 792-3843

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MT.PLEASANT

09:3

1.m.

04-21-2009

3/4

Progress Notes**Page: 1**

Date Printed: 04/21/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

04/08/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

CHIEF COMPLAINT: Left-sided neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man who returns for follow-up today regarding his neck and shoulder pain. He also endorses some numbness into the fingertips of all five digits on the left side. He feels that his left hand is weak and forearm is weak as well and it is worse with rotating his head. His pain is described as 8/10 in intensity and this is keeping her up at nighttime. He uses naproxen as well as Neurontin and feels that these both help somewhat. He is also seeing physical therapy for his symptoms and they are making some headway regarding his range of motion particularly at his shoulder. His strength is also somewhat improved with external rotation. He had a trigger point injection on the last visit, which reduced her symptoms but only for a day before her symptoms returned.

PAST MEDICAL HISTORY: None.**PAST SURGICAL HISTORY:** None.**SOCIAL HISTORY:** Construction worker, single, smokes occasionally, no alcohol use.**FAMILY HISTORY:** Family history of heart disease and diabetes.**MEDICATIONS:** Neurontin 300 mg three times per day and naproxen 500 mg twice daily.**ALLERGIES:** Penicillin.

REVIEW OF SYSTEMS: Numbness and tingling again in to all five digits without particular finger preference. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Strength is 4/5 on the left again with questionable effort. ADM and FDI are also 4/5. Wrist extension is additionally 4/5. Upper limb involving the biceps and triceps is 5/5. No light touch sensory loss is apparent except at the fingertips, which is mostly at the index, thumb and middle finger. Tinel's is negative at the carpal tunnel. Hawkins test is negative bilaterally. Speed's test is negative. No muscular atrophy is noted. Spurling's is positive on the left. Cervical paraspinal is tender on the left from C4 to C7.

RADIOGRAPHIC REVIEW: MRI of the C-spine from outside facility revealed disc protrusion left of midline at C5-C6 and C7-T1.

ASSESSMENT:

1. Cervicalgia with left C6 versus C7 radiculitis symptoms.
2. Myofascial superior trapezius pain.

PLAN:

1. Discussed risks and benefits of epidural steroid injection. He would like to proceed. We will get him off his naproxen one week prior to scheduled epidural injection likely to be performed at the left paramidline at the C6-C7 versus C7-T1 junction.
2. Continue Neurontin 300 mg three times per day for neuropathic pain relief.
3. Hold off on naproxen as described above.
4. May consider nerve conduction studies if the epidural steroid injection does not give him any relief. This may give us more insight as to the actual level of the pathology and rule out any more peripheral nerve problems.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina

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8432168008

MT.PLEASANT

09:

a.m.

04-21-2009

4/4

Progress Notes

Page: 2

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 04/21/09

ID: 2581962 SEX:M AGE:28

96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:429
1280425

#	SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG)	04/10/2009 09:50AM
#	REVISED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG)	04/16/2009 10:36AM

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MT.PLEASANT M.

09:31 a.m. 04-21-2009

2/4

Progress Notes**Page: 1**

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 04/21/09

ID: 2581962 SEX:M AGE:28

04/16/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

PROCEDURE NOTE

PROCEDURE DIAGNOSIS: Cervicalgia with C6 versus C6 radiculitis symptoms, and disc protrusion at C3-6 and C7-T1.

PROCEDURE: Risks and benefits were explained with the assistance of the interpreter and written consent was obtained. The patient escorted to fluoroscopy suite and placed in prone position. Skin was prepped with ChlorPrep and draped in sterile fashion. AP view identified the C6-7 interspace and the left paramidline approach was marked. Skin and subcutaneous tissues overlying the site was instilled with 1% lidocaine without epinephrine. Tip of a 20-gauge Tuohy needle was advanced under intermittent fluoroscopic guidance to this intended target site. Confirmation of proper needle placement was confirmed with lateral view, and after epidural space was identified on first pass with the loss of resistance technique, a small amount of nonionic contrast agent was injected and revealed the epidural space. Again after aspiration was negative, 15 mg dexamethasone along with 3 mL of normal saline without preservative was instilled. Needle was then restyletted and removed. Bandages were applied. He was re-examined at 30 minutes, found to have stable vital signs and no new neuromuscular findings, and was subsequently discharged to follow up with me in one to two months or sooner if needed.

Christopher Merrell, MD

Assistant Professor

Department of Orthopaedic Surgery

Medical University of South Carolina

96 Jonathan Lucas Street, Suite CSB 708

Charleston, South Carolina 29425

Telephone: 843-792-0601

Facsimile: 843-792-3674

CM/AM:578

1281678

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 04/20/2009 09:47AM

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Progress Notes**Page: 1**

Date Printed: 06/23/09

ID: 2581962 SEX:M AGE:28

Name: GOMEZ-FRAGOSO, HECTOR

06/17/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

CHIEF COMPLAINT: Left-sided shoulder pain, neck pain and hand numbness.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old Hispanic male with a history of left-sided shoulder and neck pain present since a work-related injury. He says that his left hand continues to be weak and slightly clumsy. His right hand appears to be okay. Occasionally, he gets symptoms in his right shoulder, however, for the most part, his symptoms are on the left side. His forearm also feels to be weak on the left side. He has had physical therapy which did not seem to benefit him significantly. He has had an epidural steroid injection at the cervical spine, which also did not seem to give him any relief. The Neurontin seems to be helping some and this is giving him only minimal somnolence. His numbness involves all five fingers on the left side and can be present during the day, but particularly when he lies on his back at nighttime.

PAST MEDICAL HISTORY: None.**PAST SURGICAL HISTORY:** None.**SOCIAL HISTORY:** He is a construction worker, single, smokes occasionally, no alcohol use.**FAMILY HISTORY:** Family history of heart disease and diabetes.**MEDICATIONS:** Neurontin 300 mg three times per day and naproxen 500 mg twice daily.**ALLERGIES:** Penicillin.**REVIEW OF SYSTEMS:** Numbness and tingling in all five fingers on the left side. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Translator has been present. He has FDI and ADM weakness at 4/5 on the left side and wrist extension also 4/5. Full range of motion at the wrist is noted, however, and radial pulses are present and equal. No digital cyanosis or skin abnormalities are identified. Cervical range of motion is within normal limits and Spurling's is positive on the left. Reflexes are normal at the biceps, brachioradialis and the triceps. No thenar or hypothenar wasting is identified and no muscular atrophy is noted elsewhere. He does have some perceived numbness and sensory deficits particularly at the index finger. Tinel's is negative at the wrist. Phalen's is negative. Tinel's is negative at the elbows as well.

RADIOGRAPHIC REVIEW: MRI of the C-spine from outside facility revealed disc protrusion left of midline at C5-C6 and C7-T1.

ASSESSMENT:

1. Cervicalgia with possible radiculitis symptoms.
2. Hand numbness including differential of radiculitis of the cervical spine versus ulnar and median neuropathy.
3. Myofascial superior trapezius pain.

PLAN:

1. Increase Neurontin to 600 mg three times per day for neuropathic pain relief.
2. Continue naproxen for anti-inflammatory and analgesic effect.
3. Obtain nerve conduction studies and EMG to evaluate for ulnar neuropathy, median nerve neuropathy, or cervical radiculopathy.
4. Based upon the outcome of the EMG and nerve study, may consider possible cervical consultation depending upon the etiology.

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2a.m. 07-09-2009

2/2

Progress Notes**Page: 1**

Date Printed: 07/09/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

06/29/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

D99

CHIEF COMPLAINT:

1. Left shoulder pain.
2. Neck pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is back with an interpreter on follow-up stating that his neck continues to be symptomatic. He mentioned shoulder pain, but actually localizes his pain to the supraspinatus fossa and adjacent to the SCM and trapezius junction. He has some pain with rotation of his neck and lateral bending. When he raises his arm overhead, he has no pain about the shoulder but has pain at the trapezius as well.

PHYSICAL EXAMINATION: Active total elevation of the shoulder is 168, ER is 42, and IR is about 45 degrees. Extension is 52 and adduction is 38. Forward flexion is 173. There is no instability. His strength is 5 in abduction and ER, IR, extension, and forward flexion about the shoulder. He is neurovascularly intact otherwise.

IMPRESSION:

1. Neck pain with radicular symptoms.
2. Small partial thickness infraspinatus tear, left shoulder.
2. Painful right transmetatarsal amputation stump with improved metatarsalgia.

PLAN: I do not think that his pain is accounted for by the shoulder. The reported rotator cuff tear was not even acknowledged by the radiologist. I do not think that this is a major source of pain, but rather is coming from the neck and base of the trapezius. He is followed by Dr. Christopher Merrell, who has done a trigger point injection in the trapezius as well as what appears to be a selective nerve root injection. He is planning on performing an EMG nerve conduction study of the left upper extremity, which I think is appropriate, to further assess his radicular symptoms. He did not have reproduction with Durkan's or Phalen's, but possibly mild increase with Tinel's which he reported radiated toward the shoulder and trapezius. We will not plan on formal follow-up with me until after he has been completely worked up by Dr. Merrell. Regarding the shoulder, he is permitted activity to his tolerance without any restrictions, as I think most of his issue is coming from the neck.

Shane Woolf, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 703
Charleston, South Carolina 29425
Telephone: 843 792-0404
Facsimile: 843 792-3843

SW/AM:243
1497390

cc: Workman's Compensation

SIGNED BY SHANE K WOOLF, M.D. (ATTENDING) (D99) 07/01/2009 12:45PM

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8432168009

MT.PLEASANT MI

3 p.m.

09-01-2009

2/3

Progress Notes**Page: 1**

Date Printed: 09/01/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

08/26/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

CHIEF COMPLAINT: Left-sided shoulder pain and arm pain.

HISTORY OF PRESENT ILLNESS: Mr. Gomez-Fragoso is a 28-year-old man, who speaks Spanish, with interpreter who returns today for follow-up regarding his shoulder and neck pain. His pain is worsened with neck range of motion and extension and it is better at rest. He has seen Dr. Woolf as well for a small partial thickness Infraspinatus tear of the left shoulder but most of the symptoms seem to be occurring at the neck. It is not giving any numbness or tingling, no focal weakness. The pain will refer into the trapezius as well as the scapular region on the left side. He feels that his left arm is somewhat weak, but no loss of hand dexterity or weakness. He does have some hand numbness which has for the most part been relieved with time. He uses gabapentin as well as Aleve and this has not been helping significantly.

PAST MEDICAL / SURGICAL HISTORY: Reviewed, unchanged.

SOCIAL HISTORY: Reviewed as per Practice Partner.

FAMILY HISTORY: Reviewed as per Practice Partner.

MEDICATIONS: Reviewed, unchanged.

REVIEW OF SYSTEMS: No hand numbness or tingling, no contralateral symptoms. Systems are otherwise negative.

PHYSICAL EXAMINATION: Mild distress, alert and oriented x3, bright affect, normal mood. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in the upper extremities, and no focal weakness or wasting are noted. Leftward and rightward rotation reproduces his symptoms. No scapular winging is identified. Hawkins test is positive. Speed's is negative. Bicipital tendon is nontender.

RADIOGRAPHIC REVIEW: MRI of the cervical spine from Long Bay Diagnostic Imaging from January 2009 revealed C4-C5 neuroforaminal narrowing on the left side, moderate in severity.

ASSESSMENT:

1. Left C5 radiculitis.
2. Neuroforaminal narrowing at C4-C5.

PLAN:

1. Discussed risks and benefits of left-sided C5 SNRB and he would like to proceed. Please see below note for details.
2. Continue gabapentin.
3. Continue Aleve for anti-inflammatory and analgesic effect.
4. Hold off from physical therapy for now.

PROCEDURE NOTE

PROCEDURE DIAGNOSIS: C4-C5 neuroforaminal narrowing and suspected C5 radiculitis.

PROCEDURE: Left-sided C5 selective nerve root block.

DESCRIPTION OF THE PROCEDURE: Risks and benefits were explained and consent was obtained. The patient was escorted to the fluoroscopic suite and placed in the right lateral position. The skin was prepped with ChlorPrep and draped in sterile fashion. Oblique view identified the neuroforamen between C4 and C5. The skin and the subcutaneous tissues overlying this site were instilled with 1% lidocaine without epinephrine. The tip of a 25-gauge spinal needle was advanced under intermittent fluoroscopic guidance to the C5 superior articular process. Periosteum was encountered and the needle was adjusted slightly and walked anteriorly about 2 mm from this point. Confirmation of proper needle

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MT.PLEASANT MU.

04 p.m.

09-01-2009

3/3

Progress Notes**Page: 2**

Date Printed: 09/01/09

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

placement was confirmed with the lateral and AP view. Aspiration was negative, and a small amount of nonionic contrast agent was injected and revealed the outline of the C5 spinal nerve with some proximal spread into the epidural space. Again after aspiration was negative, 2 mL of 0.25% bupivacaine and 10 mg of dexamethasone was instilled. The needle was restyletted and removed, bandages were applied. He was reexamined at 30 minutes, found to have stable vital signs and no new neuromuscular findings and was subsequently discharged with follow-up with me in two to three months or sooner if needed.

Christopher Merrell, MD
Assistant Professor
Department of Orthopaedic Surgery
Medical University of South Carolina
96 Jonathan Lucas Street, Suite CSB 708
Charleston, South Carolina 29425
Telephone: 843-792-0601
Facsimile: 843-792-3674

CM/AM:578
1665325

SIGNED BY CHRISTOPHER MERRELL, MD (ATTENDING) (2FG) 08/27/2009 08:54AM

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8432168009

02: 37 p.m. 12-08-2009

2/2

Progress Notes**Page: 1**

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 12/08/09

ID: 2581962 SEX:M AGE:29

12/02/09 : 00:00am

MUSC ORTHOPAEDICS FOLLOW-UP NOTE - MT PLEASANT

2FG

CHIEF COMPLAINT: Left neck pain and shoulder pain.

HISTORY OF PRESENT ILLNESS: Mr. Hector Gomez-Fragoso is a Spanish-speaking man who returns for follow-up today regarding his pain. It is again worse with neck rotation and better at rest. He was previously seen by Dr. Woolf and this was thought not to be shoulder related pain. For this reason, we had performed an EMG and nerve conduction study to evaluate for C5 radiculopathy which was negative. MRI previously performed at Long Bay Diagnostics was reviewed and report stated C4-C5 neuroforaminal narrowing in the left which is moderate in severity. For that reason, initially we did an epidural steroid injection which gave him about two weeks to three weeks of relief before symptoms recurred. Thereafter, we tried a C5 selective nerve root block with no significant benefit. He uses gabapentin and Aleve for symptoms and this is helping minimally.

PAST MEDICAL / SURGICAL HISTORY: Reviewed and unchanged.

SOCIAL HISTORY: Reviewed and unchanged.

FAMILY HISTORY: Reviewed and unchanged.

MEDICATIONS: As per Practice Partner.

REVIEW OF SYSTEMS: Occasional hand numbness into the fourth and fifth digits. Systems are otherwise negative.

PHYSICAL EXAMINATION: No apparent distress, alert and oriented x3, bright affect, normal mood. Hawkins is negative. Empty can test is negative. Shoulder range of motion is within normal limits. Cervical range of motion is reduced with end rotation bilaterally. Spurling's is positive on the left and negative on the right. Reflexes are normal at the biceps, brachioradialis and the triceps. Light touch sensation is intact in all dermatomes at the upper limbs and no wasting is noted. AC joint is nontender. Paraspinal musculature is nontender. Facets are relatively nontender.

RADIOGRAPHIC REVIEW: MRI report of the cervical spine from Long Bay Diagnostics revealed C4-C5 neuroforaminal narrowing on the left, moderate in severity.

ASSESSMENT:

1. Presumed left C5 radiculitis.
2. Neuroforaminal narrowing at C4-C5.
3. History of mild rotator cuff pathology as well.
4. Symptoms consistent with ulnar neuropathy although EMG and nerve conduction study was negative. This is primarily a nocturnal phenomenon.

PLAN:

1. Continue gabapentin and Aleve for anti-inflammatory and analgesic effect and neuropathic pain relief.
2. Continue home exercise program.
3. Obtain a new MRI of the cervical spine as the last one was obtained almost a year ago. If symptoms are persistent, I would like to see these images for ongoing foraminal narrowing at C4-C5. This may be related to his symptoms.
4. I feel that the ulnar neuropathy symptoms that he experiences are predominantly positional in nature and has not given him any significant weakness or daytime symptoms.
5. Follow up with me after MRI and I would also at that point like to have Dr. Glaser review this patient as well as my treatments thus far have been particularly ineffective. If he does have foraminal narrowing, he may be a candidate for surgery.

Christopher Merrell, MD

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PATIENT: Gomez Fragoso, Hector
DOB: 10/4/1980
MRN: 590338
PHYSICIAN: Christopher Merrell, MD
DATE: 12/8/2009

EXAM: CERVICAL MRI WITHOUT CONTRAST

HISTORY: Pain in the left side of the neck and shoulder.

COMPARISON STUDIES: None.

TECHNIQUE: Sagittal T2 FSE, sagittal T2 FSE with fat suppression, sagittal T1 FSE, coronal T1 FSE, axial T2 FSE, axial T2* gradient echo. No contrast.

FINDINGS:

OVERVIEW: No soft tissue mass or abnormal fluid collection is identified. Signal intensity in the musculature is normal and the muscles are symmetric. Lung apices are grossly clear. Central brachial plexus appears unremarkable.

CERVICAL SPINE: No acute fracture or subluxation. Vertebral body heights are preserved and the bone marrow signal intensity is normal. Asymmetric moderate to advanced hypertrophic facet arthropathy is seen on the left side at the levels of C3/4 and C4/5. Remaining facets appear unremarkable. Mild anterior osteophyte formation is seen at the level of C5.

DISC LEVELS: The intervertebral discs of the cervical spine and upper thoracic spine demonstrate normal signal intensity with the exception of C5/6 which is mildly desiccated. Heights of the intervertebral discs are normal. No focal or broad based disc protrusions identified.

On the left at the levels of C3/4 and C4/5 there is asymmetric uncovertebral joint hypertrophy. This combined with the degenerative facet changes results in neural foraminal stenosis at both levels which is mild to moderate. Remaining neural foramen and central canal are patent.

SPINAL CORD: The cord is normal in size, shape and signal intensity. No cord mass or edema.

IMPRESSION:

1. There is asymmetric degenerative facet arthropathy and uncovertebral joint of hypertrophic changes present on the left at C3/4 and C4/5 and degenerative facet changes present on the left. These changes result in a mild to moderate neural foraminal stenosis on the left at both levels.
2. Mild degenerative disc changes present C5/6.

Richard Clinton, MD
RC/ng

DD: 12/9/2009
DT: 12/9/2009
Job: 9394688

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

Patient: Gomez Fragoso, Hector
MRN: 590338
Exam: CERVICAL MRI WITHOUT CONTRAST

This document has been electronically reviewed and signed by Richard Clinton, MD.

Confidential

Page: 4

Date Printed: 12/18/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:28

functional limitations, and reported that the pain adversely affects his mood. He was unable to understand the Likert Scale and was given a true-false mood inventory to assess his mood. He scored in the extreme range with 27/30 positive and his is consistent with severe depression. He denied any suicidal ideation or attempt.

IMPRESSION:

1. Postconcussive syndrome, mild.
2. Chronic pain disorder.
3. Situational depression.

DISCUSSION: Mr. Gomez had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the the brain. Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury. He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive syndrome. The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. I do not think that the severity of his cognitive deficits represents a major barrier for return to work, especially manual labor. Additionally, he does have findings positive for situational depression and pain are also contributing to his functional disability.

In terms of recovery, Mr. Gomez is most likely at maximum medical improvement in terms of his neurologic/brain status. Fortunately, his cognitive deficits are relatively mild. Pain, dizziness, and balance will probably be the major limiting factor for his capacity to return to manual labor, but I would defer to his neurologist about work-related restrictions in this domain.

The most treatable aspect of the claimant's current syndrome is pain and depression, but unfortunately he has been variably noncompliant with his medications. Something like Cymbalta or another SSRI might double for treatment of both mood and pain related problems. Compliance with this type of treatment may reduce some of his functional disability.

Mark Wagner, PhD
Clinical Neuropsychologist
Associate Professor of Neurology

MW/am1251
dd: 10/31/2008
dt: 11/01/2008
JobID: 760927

cc:Mr. Michael Burkett, Willson Jones Carter Baxley LLC, 501 Wando Park Boulevard, Mount Pleasant, SC 29464

THIS NOTE IS CONFIDENTIAL

SIGNED BY MARK WAGNER, Ph. D. (ATTENDING) (D69) 11/04/2008 11:47AM

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Progress Notes**Page: 1**

Name: GOMEZ-FRAGOSO, HECTOR

Date Printed: 01/20/09

ID: 2581962 SEX:M AGE:28

01/12/09: GOMEZ-FRAGOSO, HECTOR: 2581962
OTOLARYNGOLOGY-HEAD AND NECK SURGERY
MEDICAL UNIVERSITY OF SOUTH CAROLINA
4EN

MEDICAL UNIVERSITY OF SOUTH CAROLINA
DEPARTMENT OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY
135 Rutledge Avenue
MSC 550
Charleston, SC 29425-5500
(843) 792-8299

MUSC ENT Associates East Cooper Office

HISTORY:

Mr. Gomez-Fragoso is a 28-year-old Hispanic gentleman I saw for the first time on December 1, 2008 for evaluation of ear pain and dizziness following a work accident in November 2007. When I saw him in December, he was complaining of ear pain, hearing loss, ringing, disequilibrium, vertigo, and blurry vision. His examination at that time was unremarkable. He has since undergone an ENG that demonstrates a right-sided vestibulopathy. An audiogram obtained today was entirely normal. The patient continues to complain of left greater than right ear pain both around and behind the ear and persistent dizziness and disequilibrium.

PHYSICAL EXAM:

General: He is an overweight Hispanic male.

Oral Cavity: Benign.

Neck: Soft and supple with no masses.

Nose: Septum slightly deviated.

Ears: The ear canals are clear. The drums and middle ear spaces are essentially normal.

IMPRESSION:

1. Right vestibulopathy.
2. Normal hearing.
3. Complaints of otalgia.

RECOMMENDATIONS:

I reviewed the ENG results with the patient and have encouraged him to begin Cawthorne vestibular rehabilitation exercises at home. I have stressed the need for doing these several times a day for several months. I will have him return to the clinic in three months for reassessment.

Mark J. Hoy, M.D.
MJH/NK1/VB

SIGNED BY MARK HOY, MD (ATTENDING) (4EN) 01/14/2009 08:34AM

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Physician's Statement

Claimant's Name: Hector Gomez-Fragoso

Employer's Name: Kade Construction

Physician's Name: Dr. Mark Hoy

Insurance Carrier: Key Risk Insurance Company

Practice/Clinic: MUSC - Otolaryngology Head and Neck Surgery

SCWCC File No: 0717624

Preparer's Name: Dr. Mark Hoy

Phone: (843) 792-8299

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 11-01-07

Date of first office visit: 12-1-08

Date of last visit: 4-13-09

Diagnosis or nature of injury or illness: HEMO INJURY / DIZZINESS / EAR PAIN

Body part(s) injured: EAR

Body part(s) affected: EAR

Date of Maximum Medical Improvement: 4-13-09

Based on the AMA Guidelines, the claimant has sustained a ? % medical impairment to ? injured body part(s) and a ? % medical impairment to ? other affected body part(s).

☒ The claimant is able to return to work without restriction.

☐ The claimant is able to return to work with the following restrictions:

☐ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Mark Hoy
treating Physician

3-16-10
Date

**STRAND REGIONAL SPECIALTY ASSOCIATES
CONSULTATION**

Patient Name: Hector Gomez Fragoso

Date of Birth: 1/1/1951

Date of Exam:

Chart #: 81323

SSN:

RECEIVED SEP 03 2008

CONSULTATION REQUESTED BY: Key Risk.

Linda Renew

P.O. Box 1918

Columbia SC 29202

Fax #: 336-665-8052

The patient's medical record from MUSC from 11/01/2007 until 04/21/2008. Evaluations by Medical University of South Carolina, traumatic critical surgery unit followup visits, CT scans performed throughout his hospital stay. Operative reports from his foot injury as well for the evaluation that was done for the traumatic brain injury that the patient is having, a rehabilitation was made as well for the intake sheet that was performed here at Strand Regional Specialty Associates on 08/29/2008.

CHIEF COMPLAINT: "I am doing poorly."

HISTORY OF PRESENT ILLNESS: The patient is a 57-year-old Hispanic-speaking male who has come in here for evaluation of his condition. The patient has been complaining of severe and persistent headaches. These are prominent, persistent. This is described being 9-8/10. This is going to the top of the head particularly where he has the scar. All in all, the patient has also complaining of foot pain described being 8/10. The patient is having significant dizziness particularly when he moves around and perform any type of activities. Superimposed to the symptoms that the patient is having there are neck pain with tightness that unable him to ambulate and perform very well that is shooting into his left hand.

The patient has also been complaining of difficulty with shortness of breath. The worse when he lays down and he is not able to hold the saliva and start coughing, prominent, persistent, that are present all the time. He also has difficulty with concentration and performing complex tasks. He feels sometimes irritable and slowly and steadily getting worse. He has not been taking any medication because he felt that it was helping him, but he is taking too much. This is something that is prominent. Nothing makes it better or worse. It just remained the same. This problem was started on 11/01/2007. He was working Marion County and sitting up a roof and apparently the threshold roof that the patient was laying up the crane cables dislodged and broke in the mid air and hit him on the head and fractured his foot. The patient is amnestic over the whole event. Last thing he remembers is settling everything on the roof to set up the threshold himself. The next thing he remembers is two weeks state of waking up in the hospital and since then this

Hector Gomez Fragoso

Page 2

appears to be present. The patient has been transferred to MUSC where he was taken care until discharge and followups.

ALLERGIES: Significant for no known drug allergy.

PAST MEDICAL HISTORY: He has no medical problems, has not had any surgeries. He has never been in the hospital.

CURRENT MEDICATIONS: Current medications that he is taking were none.

FAMILY HISTORY: Significant for the mother's age 44, has a history of high blood pressure. Dad is aged 45. He is without any medical problems.

SOCIAL HISTORY: There are two brothers. No sisters and no kid. The patient smokes a couple of cigarettes a day. He said that he was discharged from the hospital he had not smoked until recently. He has only been half a pack per day for the last four years. The patient drinks four to six beers a month. There is no drug use. He never had any blood transfusions that he knows. He is single. He is from the Department of Mexico, in Mexico, and he is a construction worker.

REVIEW OF SYSTEMS: General: The patient has some difficulty with weakness, fatigues. Dermatological: There is not problem noted there. HEENT: The ear, nose, and throat is negative. GU: Review of systems has been negative. Pulmonary: The patient has been complaining of wheezing and cough. Cardiovascular: Negative. GI: Negative. Rheumatological: The patient is complaining of stiffness and swelling of the neck. There is foot pain on the right. Neurological: There is headaches, dizziness that are present, and visual disturbances when the headaches happen. Endocrine: Negative.

PHYSICAL EXAM:

VITAL SIGNS:

Weight: 185 pounds. Height is 5 feet 6 inches. Blood pressure: 124/80.

GENERAL:

The patient is in no apparent distress, well groomed, adequate for stated age. Mini-Mental status was performed in Spanish and this is one out of three at five minutes. He has difficulty performing complex drawings and serial seven is four out of five. He has good drawing. Good repetition. He is able to write normally. Good orientation to time, date, and space.

HEENT:

Ears are clear.

SKIN:

The wounds appeared to be well healed. Tracheostomy and amputation on foot appears to be well healed.

NEUROLOGIC EXAMINATION:

GENERAL:

Neurologically he is alert, oriented x3, MMS 28/30, 2/3 at 5 min, poor drawing.

Hector Gomez Fragoso

Page 3

CRANIAL NERVES: Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR: Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION: The patient is lurching forward.

SENSORY: Intact for pinprick, touch, and position.

DTRs: 2+ from the right side with downgoing toes, 3+ from the left side with downgoing toes.

CEREBELLAR: Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL: Pain with hyperextension of the neck.

MEDICAL DECISION MAKING: The patient is a 27-year-old Hispanic speaking male status posttraumatic brain injury with associated headache. This headache appeared to be musculoskeletal and s/p skull fracture in nature. The patient had a skull based fracture with a frontal bone fracture with superimposed subdural and epidural hematomas that have resolved. He also had frontal lobe contusion. At this moment there is not available in the report any MRIs nor electroencephalograms present. The dizziness appeared to be directly related to an inner ear injury most likely from his skull based fracture. The patient had difficulty concentrating and that appears to be directly related to the injury that he has suffered and after effect typical of this type of injury. The shortness of breath that the patient has presented could be anxiety attacks or could be damage from the tracheostomy that the patient is had. The foot pain is from the injury that he has suffered. We will defer to orthopedics for evaluation of the patient condition. The difficulty concentrating and performing tasks with irritability is directly aftereffects from the injury that he suffered. Apparently the neck pain that the patient has presented has been never evaluated and possibility of cervical disc and joint disease and/or spinal stenosis in this patient is present.

RECOMMENDATIONS: At this moment a neuropsychological evaluation in Spanish should be done to see which areas have deficit and what can be done to improve or maximize the recovery and function of this patient. An MRI of the brain to see if there is any lingering effects from the injury that he has suffered will be indicated as well for the cervical spine to make sure that there is no cervical pathology as a culprit for the patient findings. An EMG of the left upper arm and right lower extremity to evaluate the possibility of having a lumbar and cervical radiculopathy should be performed. An auditory evoked potential and electronystagmogram and 24 hrs. EEG to evaluate the inner ear and make sure that this paroxysmal event that the patient is having is not associated with seizure, as well for the irritability that the patient has presented to see how the brain

Hector Gomez Fragoso

Page 4

is functioning. For the treatment of the patient condition Robaxin 500 mg three times a day for treatment of the headache and the musculoskeletal component that the patient is suffering will be ordered, Neurontin 300 mg three times a day, not only to stabilize his mood, but more important to control the symptoms of paresthesias, headaches and dizziness will be indicated. Vicodin ES p.r.n. for pain will be prescribed. Pulmonary evaluation to make sure that his trachea and lungs are working properly will be indicated. I agree with the orthopedic evaluation. At this moment vestibular desensitization exercises will be prescribed. The patient has blurred vision that he had presented to me to be evaluated if the treatment and symptomatology of the dizziness does not resolve completely. A followup appointment will be arranged to see the result and course of his injuries. At that time we will reassess the need for further treatment or investigation.

George Sandoz, MD

GS/smw



PATIENT: Frago, Hector
DOB: 10/4/1980
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 9/16/2008

EXAM: MRI BRAIN WITH CONTRAST

HISTORY: Pain. Complaining of headaches, memory loss, slurred speech since injury at work November 2007.

COMPARISON STUDIES: None given.

TECHNIQUE: Axial T2, FLAIR, gradient echo, diffusion, and T1 pre- and postcontrast and sagittal T2 of the brain.

FINDINGS: The brain parenchyma is normal. There are no abnormal areas of enhancement. There are no T2 weighted or acute diffusion weighted abnormalities. There are no extraaxial fluid collections and the sulci, cisterns, and ventricles are normal. The major vessels of the circle of Willis are patent. The midline structures including the corpus callosum, basal ganglia, pineal gland, quadrigeminal plate, brainstem, and visualized cord are normal. Incidental note is made of severe right mastoiditis. The paranasal sinuses are otherwise clear. Susceptibility artifact in the subcutaneous tissues of the left scalp could be from the prior trauma. No areas of susceptibility artifact are seen within the cranial vault to suggest prior intracranial hemorrhage.

IMPRESSION:

1. Right mastoiditis.
2. Otherwise, unremarkable MRI of the brain.

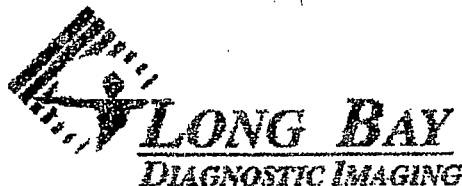
Robb Hoshle, MD
RH/rc

DD: 9/17/2008
DT: 9/17/2008
Job: 6359428

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900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX



PATIENT: Fragoso, Hector
DOB: 10/4/1980
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 9/16/2008

EXAM: MRI CERVICAL SPINE WITHOUT CONTRAST

HISTORY: Pain after heavy object fell onto head in November 2007.

COMPARISON STUDIES: None given.

TECHNIQUE: Sagittal T1 and T2, coronal STIR, and axial T2 and gradient echo of the cervical spine.

CONTRAST: None.

FINDINGS: The alignment, visualized posterior fossa, cervical cord, marrow, and paraspinous soft tissues are normal.

C2-3 and C3-4: Normal.

C4-5: There is a 3 mm left intraforaminal high T2 signal probable disc protrusion (image 10 series 105 and image 8 series 102). This appears to significantly narrow the left neuroforamen and likely compresses the supradjacent nerve root. The right neural foramen and central canal are normal.

C5-6: There is early disc desiccation with a minimal disc osteophytic bulge but no significant stenosis.

C6-7: Normal.

C7-T1: Mild disc desiccation with a minimal disc osteophytic bulge slightly asymmetric to the right without significant stenosis.

T1-2 through T4-5: Normal.

IMPRESSION: There is a probable left intraforaminal focal disc protrusion at C4-5 resulting in moderate left neural foraminal stenosis. The protrusion is located beneath the exiting left C5 nerve root. A CT myelogram could be helpful if this is clinically ambiguous.

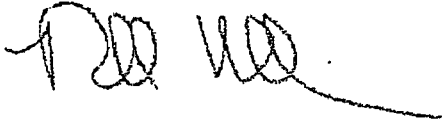
Robb Hoeblein, MD
RH / sl

DD: 9/17/2008
DT: 9/17/2008
Job: 6859479

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

Patient: Frago, Hector
MRN: 584760
Exam: MRI CERVICAL SPINE WITHOUT CONTRAST

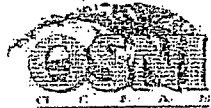
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Page 2 of 1



Strand Regional Specialty Associates, LLC



**SPINE & NEUROLOGIC
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EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

September 16, 2008

Jeff Chandler

Re: Hector Gomez Fragoso
DOB: 1/1/1951
SSN: N/A

Dear Mr. Chandler:

As you know after reviewing the findings that the patient is having and after reviewing the complaints that the patient had presented, he is noted to have a transverse process injury at the level of L3-L4 and also a transverse spinous process at the level of C7. Upon reviewing the patient complaints and the major symptoms that he has are located on the cervical spine, there was no complaints from the lumbar spine. Regarding the treatment, medications as before were given to the patient and see how he has performed under those conditions and the therapy was given with medication. The rest of them appear to be resolved except the one in the neck and an MRI for that area and evaluation was scheduled.

Please do not hesitate to call me if you have any other further question regarding this patient condition.

Sincerely,

George Sandoz, MD

GS/smw

MYRTLE BEACH LOCATION
8170 Beach Blvd.
Myrtle Beach, SC 29572
ph (843) 437-2335
fax (843) 437-2303

MUSKIELS INLET LOCATION
4567 Silverwood Blvd. #100
Muskies Inlet, SC 29576
ph (843) 557-9600
fax (843) 557-3610

CONWAY LOCATION
2376 Cypress Creek, Suite 200
Conway, SC 29526
ph (843) 234-1710
fax (843) 234-1715

LITTLE RIVER LOCATION
4000 Hwy. 9 East, Suite 200
Little River, SC 29568
ph (843) 390-0033
fax (843) 390-0038

LCRIS LOCATION
3017 Casey St., Suite D
Lake, SC 29569
ph (843) 756-9729
fax (843) 390-0038

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso
Date of Birth: 10/4/1980
Date of Exam: 10/2/2008
Chart: 81323
SSN:

CHIEF COMPLAINT: "I have been doing fairly well."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic speaking male who has come in here secondary to the complaint of having dizziness. Since the last visit and given antibiotic, there is some relief of symptomatology, but it continues to be persistent. The headache continues to do well, controlled with the Percocet. The neck is described being 8/10, into the left, more significant. This is associated recently with more low back pain and thoracic pain, but has worsened with activity and when he does activity, he stop, and then he wants to retry. It is very significant. This has happened four to five times a week. This unable him to perform any of his ADLs. Still has not been to neuropsychological testing. He has been having difficulty getting his medication, not because they are not being ___, but because he is not able to get a valid ID.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:**VITAL SIGNS:**

Weight: 189 pounds. Height is 5 feet 7 inches. Pulse: 80.

GENERAL:

The patient is in moderate distress, well groomed, well kept.

NEUROLOGIC EXAMINATION:**CRANIAL NERVES:**

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR:

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION:

The patient is lunched forward.

SENSORY:

Intact for pinprick, touch, and position.

DTRs:

3+ throughout downgoing toes.

CEREBELLAR:

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL:

Pain with hyperextension and hyperflexion of the neck.
Positive for straight leg raise. Trigger point located on the thoracic area.

MEDICAL DECISION MAKING:

1. The patient presented here with headaches and vertigo. Inner ear damage, we will check electronystagmogram and an abnormal mastoid process is present on MRI. This appears to be inflammatory, possibility of infection is present, although unlikely.
2. Neck pain. MRI of the cervical spine shows herniated disc at the level of C5 particularly at the level into the left, which correlate with the clinical findings the patient is having. The symptomatology that he has presented with his back might represent worsening condition of his neck or previous injury as he did before.

RECOMMENDATIONS: We will reorder his Percocet. No seizure medication will be given just because the patient had a normal electroencephalogram. An MRI of the lumbar and thoracic spine will be scheduled, and according to those findings, we will see if it is necessary to pursue any treatment. We will continue with the medication that he is on.

George Sandoz, MD

GS/smw

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso

Date of Birth: 10/4/1980

Date of Exam: 10/10/2008

Chart: 81323

SSN:

CHIEF COMPLAINT: "I continue to have spells."

HISTORY OF PRESENT ILLNESS: The patient is a 27-year-old Hispanic speaking male, status post work related injury on 11/01/2007 where he had an injury to his back, neck, right foot, and had spell with dizziness, difficulty performing his ADLs. Since the last visit, the patient has started on Neurontin. The symptoms that he has from pain has improved. He continues to rely on the Vicodin approximately four times a day to control the symptoms and he is tolerating the methocarbamol well.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:**VITAL SIGNS:**

Are not taken.

GENERAL:

The patient appears to be in no apparent distress, well groomed, well kept; adequate for stated age.

NEUROLOGIC EXAMINATION:**CRANIAL NERVES:**

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Weber to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR:

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION:

Normal gait and tandem walk.

SENSORY:

Intact for pinprick, touch, and position.

DTRs:

Normoreflexive with plantar flexor response.

CEREBELLAR:

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL:

Pain with hyperextension and hyperflexion of the neck.

MEDICAL DECISION MAKING: The patient presented here with the complaint of dizziness, spells that suggest that the patient is having seizures, low back pain, but by history the patient had an injury on the lumbar spine, no evidence of any damage at this moment, no neuropathy. From the cervical standpoint, the patient has presented here

Director Gomez-Ris

10/10/2008

Page 2

with mild disc bulge. From the evidence of the brain, this was reviewed by me and it suggests that there is a right temporal lobe injury. Despite that, the cuts are not fine. This was reviewed with the radiologist and he feels that there is something in there, but is too soft with the findings that the patient is having, which correlates with an injury.

RECOMMENDATIONS: We are still awaiting for the 24-hour EEG. We will see how he performs with the increase of the dose of the Neurontin, and if increased dose control the symptoms, then no further treatment will be indicated. If it does not, an epidural steroid injection will be indicated. Followup appointment will be arranged. Medication in the form of gabapentin 600 mg three times a day, Vicodin ES four times a day, and Robaxin 500 mg three times a day will be given. Followup appointment will be arranged.

George Sandoz, MD

GS/smw



PATIENT: Fragoso, Hector
DOB: 10/4/1980
MRN: 584760
PHYSICIAN: George Sandoz, MD
DATE: 10/17/2008

EXAM: MRI OF THE THORACIC SPINE WITHOUT CONTRAST

HISTORY: Pain. Injury one year ago.

TECHNIQUE: Sagittal T1, T2 and STIR, coronal T1 and axial T2 of the thoracic spine.

CONTRAST: None.

FINDINGS: The alignment, thoracic cord, marrow and paraspinous soft tissues are normal. There may be an old T7 superior endplate compression versus Schmorl's node without significant height loss. The T6-T7 disc is mildly desiccated as well. There are no other significant degenerative changes. The central canal and neural foramina are normal throughout.

IMPRESSION: Nearly normal thoracic spine MRI with potentially an old mild superior endplate compression fracture of T7 versus a Schmorl's node.

Robb Hoehlein, MD
RH / lb

DD: 10/20/2008
DT: 10/20/2008
Job: 7014625

This document has been electronically reviewed and signed.

A handwritten signature in black ink, appearing to read "Robb Hoehlein", is written over a horizontal line.

900 21ST AVENUE NORTH
MYRTLE BEACH, SC 29577
(843) 916-1700
(843) 916-9460 FAX

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso
Date of Birth: 1/1/1951
Date of Exam: 10/24/2008
Chart: 81323
SSN:

RECEIVED NOV 13 2008

CHIEF COMPLAINT: "I continue to do about the same."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic speaking male who is coming here secondary to the complaint of having neck pain, back pain, ear pain and recently is noted to have right shoulder pain. The more he does the more it hurt. The less he perform the better it is, but it is always there. All in all, the symptoms that the patient is having is significant, persistent, exacerbated by movement, improved somewhat by rest. Medication is giving some relief and he continues to rely heavily on it.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient's database.

PHYSICAL EXAM:**VITAL SIGNS:****GENERAL:****CRANIAL NERVES:****MOTOR:****GAIT/STATION:****SENSORY:****DTRs:****CEREBELLAR:****MECHANICAL:**

Stable.

The patient is in moderate distress well groomed, well kept, adequate for stated age.

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Rinne to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

Normal gait and tandem walk.

Intact for pinprick, touch, and position.

Normoreflexive with plantar flexor response.

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

Pain with hyperextension and hyperflexion of the neck.

MEDICAL DECISION MAKING: The patient presented here secondary to the complaint of having symptom status post work related injury with neck pain with episodes of dizziness, episode of syncope in the past. This has been worked up and has shown no evidence of any seizure and nor any evidence of any damage of the brain. Despite that review of the MRI shows some mild abnormality in the temporal lobe. No fine _____ over this area. The back pain and neck pain appeared to be just associated

REC'D BY GOMEZ-PRADO

10/24/2008

Page 2

with cervical spondylosis. No evidence of any fracture process or pedicles is noted on the MRI on the lumbar or in the cervical spine.

RECOMMENDATIONS: At this moment, the patient is only taking over-the-counter medication. Apparently, he is not able to obtain any payment for the medications from workman comp standpoint. At this moment, symptomatology of ear pain is significant. Reason why ear, nose, and throat consultation will be given, an orthopedic consult for the right shoulder pain will be scheduled. Followup appointment will be arrange.

George Sandoz, MD

DICTATED BUT NOT READ

GS/ams

cc: Workman Compensation.

Mr. _____

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso
Date of Birth: 10/4/1980
Date of Exam: 11/25/2008
Chart: 81323
SSN: 999-99-9999

CHIEF COMPLAINT: "I continue to hurt."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic-speaking male who has come in here status post work-related injury where he was hit in the head with severe injuries throughout. Recently, he has undergone neuropsych testing. Today, this has not been available. He continues to have a headache. This is described being 7/10, prominent, persistent. Foot hurting, this is described being 7-8/10. The symptom that the patient is having is into his neck. This is 8/10 when turning, difficulty sleeping, unable him to ambulate and perform any of his activity. The patient has been also complaining of low back pain due to worsening and sitting down longtime position. It takes a while for him to keep going. He continues to have difficulty hearing on the right ear. He gets short of breath every time that he start working.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:**VITAL SIGNS:****GENERAL:**

Weight: 192 pounds. Height: 5 feet 5 inches.

The patient is well groomed, well kept; adequate for stated age, obese, having moderate distress.

NEUROLOGIC EXAMINATION:**CRANIAL NERVES:**

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Weber to the right. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR:

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION:

The patient is lurching forward.

SENSORY:

Intact for pinprick, touch, and position.

DTRs:

3+ throughout downgoing toes.

CEREBELLAR:

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL:

Pain with hyperextension and hyperflexion of the neck.

Hector Gomez-Frag

11/25/2008

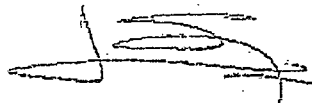
Page 2

Positive for trigger point throughout the neck. Positive for straight leg raise. Pain with hyperextension of the back.

MEDICAL DECISION MAKING:

The patient is a very complex white male who appears to have traumatic brain injury. At this moment, the patient has not had any of the further spells. He is tolerating the Robaxin and Neurontin well. Prescription for pain medication with control substance that has not been able to done due to lack of ID here in the United States. Headache does appear to be related to the contusive injury that the patient is having. Foot pain evaluated by the orthopedics. Cervical spinous process fracture that continue to bother him. No surgical pathology was noted on the MRI. Treatment will be indicated. Low back pain. This appears to be associated with a compression fracture and transverse process fracture as noted in the past. This appears to be doing fairly stable at this moment, but continue to bother him. Traumatic brain injury. Still awaiting the evaluation by the neuropsychology testing. Shortness of breath that might be associated with tracheomalacia. Vertigo with mastoiditis present.

RECOMMENDATIONS: An epidural steroid injection of the cervical spine will be given. Physical therapy will be scheduled. Percocet 10/650 mg will be given. Treatment for his mastoiditis with Augmentin 500 mg to one tablet three times a day for 10 days will be given. We are still awaiting for the pulmonary consult to evaluate his trachea and ear, nose, and throat evaluation for the mastoiditis is still pending. Followup appointment will be arranged.



George Sandoz, MD

GS/smw

cc:

Mr. Chandler.

Linda _____, case nurse manager.

Fax #: 336-665-8052

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso
Date of Birth: 10/4/1980
Date of Exam: 1/6/2009
Chart: 81323
SSN:

CHIEF COMPLAINT: "I continue to do poorly."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic male status post work-related injury in May 2008. Since his last visit, he has been doing about the same. The headaches that he has are described being 8/10, comes and goes every two to three days. Nothing makes it better. Nothing makes it worse. He has recently been taking Neurontin and Voltaren without great deal of relief. He continues to have difficulty obtaining the Percocet for the control of this pain secondary to lack of documentation. The neck pain is described being 8/9, sharp in nature that is shooting mostly into the left leg. The low back pain is described being 8/10, going up into his back. This is something that is prominent, persistent. Nothing makes it better or worse. At this point, he still has not known if he has virtual results of the neuropsychological testing and no notes were noted.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:**VITAL SIGNS:**

Weight: 190 pounds. Blood pressure: 124/74. Pulse: 72.

GENERAL:

The patient is in moderate distress, well groomed, well kept; adequate for stated age.

NEUROLOGIC EXAMINATION:**CRANIAL NERVES:**

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extracocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR:

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION:

Normal gait and tandem walk.

SENSORY:

Intact for pinprick, touch, and position.

DTRs:

2+ throughout downgoing toes.

CEREBELLAR:

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

Hector Gomez-Fragoso

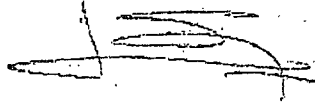
1/6/2009

Page 2

MECHANICAL: Trigger point located in mid spine in the cervical and lumbar area. Pain with hyperextension of the back.

MEDICAL DECISION MAKING: The patient presented here status post work-related injury where he had a traumatic brain injury with the description that the patient suffer. At this moment, the headaches appear to be chronic, posttraumatic in nature. Cervical and lumbar disc disease with associated fracture of the spinous process, this fracture is noted in the CT scan done at MUSC.

RECOMMENDATIONS: At this point, an epidural steroid injection of the cervical spine will be made trying to control the pain. We will continue with the Neurontin and the Voltaren. Add to this treatment, Ultram 50 mg q.6h. or daily will be given. We will continue with the same prescription that the patient is having. A followup appointment will be arranged.



George Sandoz, MD

GS/smw

**STRAND REGIONAL SPECIALTY ASSOCIATES
FOLLOWUP**

Patient Name: Hector Gomez-Fragoso

Date of Birth: 10/4/1980

Date of Exam: 2/17/2009

Chart: 81323

SSN:

CHIEF COMPLAINT: "I continue to hurt."

HISTORY OF PRESENT ILLNESS: The patient is a 28-year-old Hispanic-speaking male status post work related injury. Since the last visit, the patient has been doing fairly well. Medication has given some relief, but continues to rely on it for the control of the symptoms. He still has not gotten the treatment that is required for an epidural steroid injection due to the neck injury, which has been taken care at MUSC. The dizziness has continued to be improved with the use of the meclizine. Headaches are still persistent and the patient has not had any other loss of consciousness.

CURRENT MEDICATIONS/DRUGS ALLERGY: Please refer to patient database.

PHYSICAL EXAM:**VITAL SIGNS:**

Stable.

GENERAL:

The patient is well groomed, well kept; adequate for stated age, obese.

NEUROLOGIC EXAMINATION:**CRANIAL NERVES:**

Normal visual fields. PERRL. EOM's full. No nystagmus. No elevation of the eye. Facial sensation is intact. Corneal reflex is intact. The extraocular movements appear to be full. Facial movements symmetric. Hearing is intact. Palate is in the midline. Normal sternocleidomastoid. Normal SCM/trapezius. Tongue is in the midline.

MOTOR:

Strength is 5/5 in the upper and lower extremities. Normal bulk and tone. No fasciculations or abnormal involuntary movements. Negative for cogwheel rigidity.

GAIT/STATION:

Normal gait and tandem walk.

SENSORY:

Intact for pinprick, touch, and position.

DTRs:

Normoreflexive with plantar flexor response.

CEREBELLAR:

Normal finger-nose-finger, rapid alternating movements and heel-to-shin testing.

MECHANICAL:

Pain with hyperextension and hyperflexion of the neck.

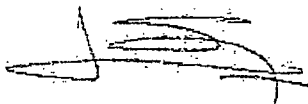
MEDICAL DECISION MAKING: The patient presented here secondary to the complaint of episodes of dizziness, headaches, episode of loss of consciousness, and

Hector Gomez-Fragoso

2/17/2009

Page 2

traumatic brain injury type of picture. All in all, the symptomatology that the patient is having continues to be improved with the usage of medication and the decision to continue taking Neurontin 600 mg will be given. We will increase the dose to three times a day, and according to those findings, we will see if it is necessary to pursue any other treatment or investigation. Followup appointment will be arranged.



George Sandoz, MD

GS/smw



PATIENT: Hector Gomez-Fragoso
 DATE OF BIRTH: 10/04/1980
 DATE: 05/19/2009 9:45 AM
 VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 28 year old male presents with headache, neck pain, dizziness, low back pain and back pain.

History of Present Illness

1. headache (follow-up)

Onset: 19 Month(s) ago. Severity: moderate. It occurs constantly, has 30-60 minutes duration, and is unchanged. Location was entire head. There was radiation to posterior. The describes it as debilitating, lancinating, pressure and worsening with laughter and almost loc. It occurred due to recent head trauma. Symptom is aggravated by valsalva. Relieving factors include prescription drugs. Associated symptoms include blurred vision, nausea and vertigo.

2. neck pain (follow-up)

Additional comments:

8/10 into both arms severe

3. dizziness (follow-up)

Additional comments:

with head movement.

4. low back pain

Onset: 19 Month(s) ago. Severity level is moderate-severe. The problem is stable. It occurs persistently. Location of pain was lower back and legs. The describes the pain as an ache, burning and deep. Context: bending forward and bending over. Symptoms are aggravated by ascending stairs, changing positions and coughing. Symptoms are relieved by pain meds/drugs and rest.

5. Back Pain

Additional comments:

abdominal area severe associated with UTI, started on left now on right.

Past Medical History

Reviewed, no changes. Last detailed document: 05/19/2009.

Family History

Yes / No Disease Detail	Family Member	Name	Age
Alive and well	Brother		
Alive and well	Brother		
Alive and well	Father		
Alive and well	Mother		

Social History

Tobacco:

Patient is a tobacco user.

4.00 years.

Alcohol:

There is a history of alcohol use.

Gomez-Fragoso, Hector

10/04/19801/3

Beer approximately 1 beer d was consumed occasionally -

Allergies

No known allergies.

Vital Signs

Height

<u>Time</u>	<u>Ft</u>	<u>In</u>	<u>Cm</u>	<u>Last Measured</u>	<u>Method</u>	<u>%</u>
9:41 AM	5.0	3.00				

Weight / BSA / BMI

<u>Time</u>	<u>Lb</u>	<u>Oz</u>	<u>Kg</u>	<u>Context</u>	<u>%</u>	<u>BMI</u>	<u>BSA</u>
9:41 AM	198.00					35.07	

Blood Pressure

<u>Time</u>	<u>BP</u>	<u>Position</u>	<u>Side</u>	<u>Site</u>	<u>Method</u>	<u>Cuff Size</u>
9:41 AM	138/72	sitting	left		manual	adult

Measured By

Time

9:41 AM Penny Powers

Physical Exam

Constitutional:

Level of distress is awake & alert, in pain. Nourishment type is obese. Overall appearance is age appropriate.

Musculoskeletal:

Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion

Neurological:

Level of Consciousness: Normal.

Orientation: Alert and oriented X 3. Grossly normal intellect.

Memory: Intact.

Cranial nerves: II-XII grossly intact.

Sensory: No sensory loss.

Motor: No motor weakness.

Balance & Gait: Balance and gait intact.

Coordination: Coordination intact.

Fine Motor: Skills normal.

Deep Tendon Reflexes: DTR's preserved and symmetric.

Babinski: Reflexes normal.

Kernig's sign: Negative.

Brudzinski's sign: Negative.

Clinical Assessment

The patient is a 28-year old male who presents with headache, neck pain and dizziness. The patient is compliant with medication. Not responding to current treatment. s/p esi on cervical spine without resolution

Assessment/ Plan

Lumbar / lumbosacral degenerative disc (722.52)

Cervical disc degeneration (722.4)

Migraine, unspecified (346.90)

Abdominal pain, epigastric (789.06)

Document generated by: george sandoz 05/19/2009

Gomez-Fragoso, Hector

10/04/19802/3

Strand Regional Specialty Associates
8170 Rourk Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

10/04/19803/3



PATIENT: Hector Gomez-Fragoso
DATE OF BIRTH: 10/04/1980
DATE: 06/02/2009 2:30 PM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 28 year old male presents with headache, dizziness and loss of consciousness.

History of Present Illness

1. headache

Onset: sudden. Severity: moderate. It occurs constantly, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to anterior. The patient describes it as debilitating, sharp and worst ever. Symptom is aggravated by head position and stress. Relieving factors include relaxation.

2. dizziness

3. loss of consciousness

Active Medications (started before visit)

None.

Allergies

No known allergies.

Vital Signs

Physical Exam

Constitutional:

Level of distress is mild distress, in pain. Well nourished. Well developed.

Musculoskeletal:

Cervical spine has muscle spasm, moderate pain w/motion

Lumbar spine has muscle spasm, moderate pain w/motion

Neurological:

Level of Consciousness: Normal.

Orientation: Alert and oriented X 3. Grossly normal intellect. .

Memory: Intact. .

Cranial nerves: II-XII grossly intact. .

Sensory: No sensory loss. .

Motor: No motor weakness. .

Balance & Gait: Balance and gait intact. .

Coordination: Coordination intact. .

Fine Motor: Skills normal. .

Deep Tendon Reflexes: symmetrically increased.

Babinski: Reflexes normal. .

Gomez-Fragoso, Hector

10/04/19801/2

Clinical Assessment

The patient is a 28-year old male who presents with headache, dizziness and loss of consciousness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Intracranial injury of other and unspecified nature (854.01)

Variants of migraine with intractable migraine, so (346.21)

Dizziness and giddiness (780.4)

Degeneration of lumbar or lumbosacral intervertebral (722.52)

discussed findings still c/o having kidney pain, work up negative in the past. Continue with management, also awaiting neuropsych evaluation, interview in Spanish. MMI and Impairment rating given.

Office Services

<u>Status</u>	<u>Order</u>	<u>Reason</u>	<u>Interpretation</u>	<u>Value</u>
completed	Diet plan: weight reduction			
completed	Discussed risk/benefits/side effects of treatment			

Instructions / Education

<u>Status</u>	<u>Completed</u>	<u>Order</u>	<u>Reason</u>
completed	08/07/2009	Continue current medication	
completed	08/07/2009	Activity as tolerated	
completed	08/07/2009	Risks/ benefits of treatment plan	
completed	08/07/2009	Potential for abuse	
completed	08/07/2009	Reviewed medications	
completed	08/07/2009	Pain management	
completed	08/07/2009	Medication side effects	

To be scheduled/ordered

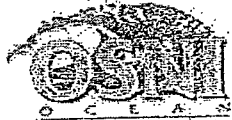
<u>Status</u>	<u>Order</u>	<u>Reason</u>	<u>Assessment</u>	<u>Timeframe</u>	<u>Appointment</u>
completed	Follow-up for increased symptoms		854.01	-today	08/07/2009
completed	Follow-up for medication side effect		854.01	-today	08/07/2009

Document generated by: George Sandoz 08/07/2009

Strand Regional Specialty Associates
8170 Rourke Street, Myrtle Beach, SC 29572



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INSTITUTE

NEUROLOGICAL SURGERY

David B. Keck, Jr., M.D.

Eugene M. Ciddens, M.D.

C. Todd Beeth, P.A.-C

NEUROLOGY

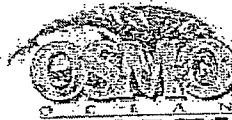
Julian N. Hayes, M.D.

Barbara L. Sarb, D.O.

Michael McCaffrey, M.D.

George M. Sandoz, M.D.

Jeff A. Benjamin, D.O.



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ORTHOPAEDIC SURGERY

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Thomas J. Chambers, M.D.

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David Evenman, M.D.

Erin L. Kirby, P.A.-C



VISION
& EYE SURGERY

EYE PHYSICIAN & SURGEON

George M. Sandoz, M.D.

June 03, 2009

To Whom It May Concern:

Re: Hector Gomez Fragoso

DOB: 10/4/1980

SSN:

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who was involved in a work-related injury on 11/01/2007. At this moment, he was seen by MUSC Orthopaedics for cervical and lumbar injury as well for a traumatic brain injury. The patient continued to have headaches and required to take medications. Today, he was started on pain management. After evaluation of the AMA Guidelines, Sixth Edition from the standpoint of the headache, the patient has 3% impairment of the whole body. From the standpoint of the dizziness, the patient has a class II as noted on table 11-4 of 9% impairment of the whole body. From the traumatic brain injury, the patient's impairment rating is of 20% as noted on the table 13-8. This still has pending impairment ratings from the lumbar and cervical spine and this will be addressed by MUSC Orthopaedics. The patient will require to take medication on a chronic basis. Assessment of his memory changes and inability to perform ADLs will be indicated. Pain medication add to the present and medication for the treatment of attention deficit disorder is required for the care of this patient. He will be required to be evaluated on a quarterly basis minimally for refill of prescriptions. Followup appointment will be arranged in a month to reassess the condition.

Sincerely,

George Sandoz, MD

GS/mlp

cc: Jeff Chandler

MYRTLE BEACH LOCATION
6170 Roark Street
Myrtle Beach, SC 29572
ph: (843) 340-2536
fax: (843) 347-2505

MURRELLS INLET LOCATION
4587 Riverwood Drive, #1107
Murrells Inlet, SC 29576
ph: (843) 557-0003
fax: (843) 557-0010

CONWAY LOCATION
2370 Cypress Circle, Suite 200
Conway, SC 29525
711 234-1719
fax: 234-1715

LITTLE RIVER LOCATION
4000 Hwy 2, 9 East, Suite 285
Little River, SC 29566
ph: (843) 390-0033
fax: (843) 390-0038

LORIS LOCATION
3617 Casey St., Suite D
Loris, SC 29569
ph: (843) 756-9729
fax: (843) 390-0038



PATIENT: Hector Gomez-Fragoso
 DATE OF BIRTH: 10/04/1980
 DATE: 07/07/2009 2:30 PM
 VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 28 year old male presents with head injury, dizziness and headache.

History of Present Illness

1. head injury (follow-up)

Onset: sudden. The severity of the symptoms is moderate. The symptoms have 11-1-07. Ventilator support was used in the hospital. The location of the injury is in the bilateral frontal region and bilateral cervical region. The location of pain is facial, head and neck. The patient describes the pain as aching and burning. The mechanical force causing the injury was contra-coup and coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Other relieving factors tried: unable to get control substance. Associated symptoms include incoordination, irritability, memory difficulty and speech difficulty.

2. dizziness

Onset was sudden. Severity is moderate. The duration of each episode is Year(s). The problem is unchanged. It occurs persistently. The patient describes it as (an) imbalance and spinning. It occurs while. The patient has sustained a head injury in the past. Symptom is aggravated by bending. Relieving factors include VDE.

3. headache

Onset: sudden. Severity: moderate. Duration: Year(s). The problem is unchanged. Location was entire head. There was radiation to anterior. The describes it as blinding. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position.

Active Medications (started before visit)

None.

Allergies

No known allergies.

Vital Signs

Height

Time	Ft	In	Cm	Last Measured	Method	%
3:35 PM	5.0	2.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
3:35 PM	200.00					36.58	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
3:35 PM	148/88	sitting	left		manual	adult

Gomez-Fragoso, Hector

10/04/19801/2

Temp / Pulse / Respiration

<u>Time</u>	<u>Temp F</u>	<u>Temp C</u>	<u>Temp Site</u>	<u>Pulse</u>	<u>Pattern</u>	<u>Resp</u>
3:35 PM				80	regular	

Measured ByTime

3:35 PM Penny Powers

Physical ExamConstitutional:

Level of distress is irritable, in pain, moderate distress. Nourishment type is obese. Well developed.

Musculoskeletal:

Cervical spine has muscle spasm, moderately reduced ROM

Thoracic spine has muscle spasm, mildly reduced ROM

Lumbar spine has muscle spasm, moderately reduced ROM

Neurological:Level of Consciousness: Normal.Orientation: Alert and oriented X 3. Grossly normal intellect. .Memory: Intact. .Cranial nerves: II-XII grossly intact. .Sensory: No sensory loss. .Motor: No motor weakness. .Balance & Gait: Balance and gait intact. .Coordination: Coordination intact. .Fine Motor: Skills normal. .Deep Tendon Reflexes: symmetrically increased.Babinski: positive right.

Comments: MMS26/30

Clinical Assessment

The patient is a 28-year old male With Traumatic brain Injury, Headache, dizziness difficult with complex tasks. The patient is compliant with medication. Compliant with current therapy. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan

Dizziness (780.4)

Migraine, intractable, variants (346.21)

Intracranial injury of other and unspecified nature (854.01)

Late effect of intracranial injury without mention (907.0)

S/p TBI, with complicated Migraine, Dizziness and Cervical and Lumbar pain, Patient has not had his Neuropsych evaluation, unable to obtain control substance that is not having the treatment needed to maximize his recovery and improve his condition to reinstate this patient to get gainful employment, sample of Ultram and rx given. Interview was performed in Spanish.

Document generated by: George Sandoz 08/04/2009

Strand Regional Specialty Associates
8170 Rourke Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

10/04/19802/2



PATIENT: Hector Gomez-Fragoso
DATE OF BIRTH: 10/04/1980
DATE: 08/12/2009 9:45 AM
VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 28 year old male presents with head injury, headache and dizziness.

History of Present Illness

1. head injury (follow-up)

Onset: sudden. The symptoms are severe. The symptoms have not changed. Ventilator support was used in the hospital. The location of the injury is in the bilateral temporal region. The location of pain is facial and head. The mechanical force causing the injury was coup. Context includes fall. The patient does not use alcohol. The patient does not use drugs. Aggravating factors include bending over. Relieving factors tried include narcotic analgesics. Associated symptoms include Battle's sign, headache, personality change, stiff neck and visual disturbance.

2. headache (follow-up)

Onset: sudden. Severity: mild-moderate. It occurs daily, has Year(s) duration, and is unchanged. Location was entire head. There was radiation to posterior. The patient describes it as debilitating and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by head position and stress. Relieving factors include prescription drugs. Associated symptoms include dizziness.

3. dizziness (follow-up)

Onset was sudden. Severity is mild. The duration of each episode is 5-15 minutes. The problem is unchanged. It occurs intermittently. The patient describes it as (an) imbalance. It occurs spontaneously. It occurs while exercising and sitting. Symptom is aggravated by rapid movement. Relieving factors include position change.

Active Medications (started before visit)

None.

Allergies

No known allergies.

Vital Signs

Physical Exam

Constitutional:

Level of distress is mild distress, due to pain. Nourishment type is overweight. Well developed.

Musculoskeletal:

Cervical spine has muscle spasm, moderately reduced ROM

Lumbar spine has muscle spasm, moderately reduced ROM

Neurological:

Level of Consciousness: Normal.

Orientation: Alert and oriented X 3. Grossly normal intellect.

Memory: Intact.

Cranial nerves: II-XII grossly intact.

Gomez-Fragoso, Hector

10/04/19801/2

Trigeminal:
Motor and Reflexes: normal.
Facial: normal.
Acoustic: Weber test abnormal, lateralizes to the left
Glossopharyngeal: normal.
Vagus: normal.
Sensory: No sensory loss. .
Motor: No motor weakness. .
Balance & Gait: Balance and gait intact. .
Coordination: Coordination intact. .
Fine Motor: Skills normal. .
Deep Tendon Reflexes: symmetrically increased.
Babinski: Reflexes normal. .

Clinical Assessment

The patient is a 28-year old male who presents with head injury, headache and dizziness. The patient is compliant with medication. Responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs. With moderate memory loss.

Assessment/ Plan

Intracranial injury of other and unspecified nature (854.01)
Awaiting for Neuro psych eval before give patient MMI and IR
Variants of migraine with intractable migraine, so (346.21)
continue with ultran for treatment of headache.
Dizziness and giddiness (780.4)
Tolerating VDE's and interview was conducted in spanish.

Document generated by: George Sandoz 08/12/2009

Strand Regional Specialty Associates
8170 Rourke Street, Myrtle Beach, SC 29572

Gomez-Fragoso, Hector

10/04/19802/2



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NEUROLOGICAL SURGERY

David B. Kee, Jr., M.D.
Eugene M. Ciddens, M.D.
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Erin L. Kirby, P.A.-C



OSV
EYE PHYSICIAN & SURGEON
George M. Sandoz, M.D.

August 20, 2009

To Whom It May Concern:

RE: Hector Gomez Fragoso
DOB: 10/4/1980
Chart: 81323

Dear Sir or Madam:

Mr. Fragoso is a patient of mine who I have seen since 09/16/2008 secondary to a traumatic brain injury on 11/01/2007. He _____ for a traumatic brain injury. At this moment from the injury that the patient has suffered, he is totally and permanently disabled. After evaluation of the AMA Guidelines, Guides to Evaluation of the Permanent Impairment Rating, fifth edition as in table 13-5, the patient has a 29% of whole person. Superimposed to this is associated with the headaches that the patient has presented and this correlates to 2% impairment of the whole body. From the standpoint of the dizziness, the patient has 10% impairment of the whole person. Utilizing a combined value chart, this is a 46% impairment of the whole body. This does not attend to the damage that the patient has suffered from his neck and back as well for his foot.

Please do not hesitate to call me if you have any other further question or investigation in this patient.

Sincerely,

George Sandoz, MD

GS/smw

cc: Jeff Chandler

MYRTLE BEACH LOCATION
8170 Beach Street
Myrtle Beach, SC 29577
ph (843) 440-2335
fax (843) 497-2505

MURRELLS INLET LOCATION
4307 Riverwood Drive, #129
Murrells Inlet, SC 29576
ph (843) 357-1109
fax (843) 357-5619

CONWAY LOCATION
2376 Cypress Circle, Suite 200
Conway, SC 29526
716 234-1710
234-1715

LITTLE RIVER LOCATION
2000 Hwy. 9 East, Suite 235
Little River, SC 29566
ph (843) 390-0033
fax (843) 390-0038

LORIS LOCATION
3517 Coxy St., Suite D
Loris, SC 29569
ph (843) 756-9729
fax (843) 390-0038



PATIENT: Hector Gomez-Fragoso
 DATE OF BIRTH: 10/04/1980
 DATE: 11/12/2010 11:30 AM
 VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 30 year old male presents with headache and dizziness.

History of Present Illness**1. headache**

Onset: sudden. Severity: moderate. Duration: Year(s). The problem is unchanged. Location was occipital. There was radiation to anterior. The patient describes it as blinding and debilitating. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights and noise. Relieving factors include prescription drugs. Associated symptoms include blurred vision, dizziness, memory loss, neurological symptoms, photophobia and vomiting.

2. dizziness

Onset was gradual. Severity is moderate. The duration of each episode is Month(s). The problem is unchanged. The patient describes it as (an) spinning. It occurs spontaneously. Denies aggravating factors. Denies relieving factors. Additional information: coughup blood.

Allergies

No known allergies.

Vital Signs**Height**

Time	Ft	In	Cm	Last Measured	Method	%
1:02 PM	5.0	7.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
1:02 PM	208.00					32.57	

Temp / Pulse / Respiration

Time	Temp F	Temp C	Temp Site	Pulse	Pattern	Resp
1:02 PM				70		

Measured By

Time
1:02 PM Penny Powers

Physical Exam**Clinical Assessment**

The patient is a 30-year old male who presents with headache and dizziness. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Needs some assistance with ADLs.

Gomez-Fragoso, Hector

717 10/04/19801/2

Assessment/ Plan

Dizziness and giddiness (780.4)

due to tbi doing fair with therapy.

Variants of migraine with intractable migraine, so (346.21)

Stop oxycodone and trial with nucynta and push up dose.

Intracranial injury of other and unspecified natur (854.01)

Trial with celexa and need to find prmd for couh blood etiology ? due to intubation.

Office Services

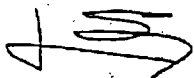
Status	Order	Reason	Interpretation	Value
completed		Adequate nutritional intake		
completed		Patient agrees with treatment plan & instructions		

Instructions / Education

Status	Completed	Order	Reason
completed	11/12/2010	Continue current medication	
completed	11/12/2010	Risks/ benefits of treatment plan	
completed	11/12/2010	Activity as tolerated	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment
completed	Follow-up for increased symptoms		780.4	-today	11/12/2010
completed	Follow-up if symptoms persist / worsen		780.4	11/12/2010	11/12/2010
completed	Follow-up for medication side effect		780.4	-today	11/12/2010
scheduled	Office visit	Continue current treatment	780.4	-today	11/12/2010
scheduled	Office Visit	Follow-up on medication	780.4	-today	11/12/2010



George M. Sandoz MD

Document generated by: George Sandoz 11/12/2010

Strand Regional Specialty Associates
8170 Rourke Street, Myrtle Beach, SC 29572



PATIENT: Hector Gomez-Fragoso
 DATE OF BIRTH: 10/04/1980
 DATE: 01/05/2011 4:30 PM
 VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 30 year old male presents with headache.

History of Present Illness**1. headache**

Onset: sudden. Severity: moderate-severe. It occurs daily, has Year(s) duration, and is worse. Location was occipital. There was radiation to anterior. The patient describes it as debilitating, sharp and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Relieving factors include prescription drugs.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Tylenol-codeine No.3 as needed	300mg-30mg	120	take 1 tablet by ORAL route every 6 hours
Amitriptyline Hcl every 6 hours	25 Mg	60	take 1 - 2 tablet (25MG) by ORAL route
Treximet	85mg-500mg	18	1 poq 12 hrs
Celexa day	20 Mg	30	take 1 tablet (20MG) by ORAL route every

Allergies

No known allergies.

Vital Signs**Height**

Time	Ft	In	Cm	Last Measured	Method	%
5:14 PM	5.0	5.00		05/19/2009		

Weight / BSA / BMI

Time	Lb	Oz	Kg	Context	%	BMI	BSA
5:14 PM	211.00					35.11	

Blood Pressure

Time	BP	Position	Side	Site	Method	Cuff Size
5:14 PM	138/78	sitting				

Measured By**Time**

5:14 PM Penny Powers

Physical Exam**Constitutional:**

Gomez-Fragoso, Hector

724 10/04/19801/2

Level of distress is moderate distress. Well nourished. Well developed.

Musculoskeletal:

Cervical spine has muscle spasm, moderate pain w/motion
Lumbar spine has muscle spasm, moderate pain w/motion

Neurological:

Level of Consciousness: Normal.

Orientation: Alert and oriented X 3. Grossly normal intellect. .

Memory: Intact. .

Cranial nerves: II-XII grossly intact. .

Sensory: No sensory loss. .

Motor: No motor weakness. .

Balance & Gait: Balance and gait intact. .

Coordination: Coordination intact. .

Fine Motor: Skills normal. .

Deep Tendon Reflexes: symmetrically increased.

Babinski: Reflexes normal. .

Clinical Assessment

The patient is a 30-year old male who presents with headache. The patient is compliant with medication. Not responding to current treatment. Need to alter current therapy. Having some difficulty with ambulation. Needs some assistance with ADLs.

Assessment/ Plan

Variants of migraine with intractable migraine, so (346.21)

Failure to control his symptoms, trial nucynta, consider botox and further w/u with new mri.

Office Services

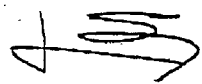
Status	Order	Reason	Interpretation	Value
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

Status	Completed	Order	Reason
completed	01/19/2011	Activity as tolerated	
completed	01/19/2011	Continue current medication	

To be scheduled/ordered

Status	Order	Reason	Assessment	Timeframe	Appointment	Value
scheduled	Office Visit	Follow-up on medication	346.21	-today	01/19/2011	
completed	Follow-up for medication side effect		346.21	-today	01/19/2011	
completed	Follow-up for increased symptoms		346.21	-today	01/19/2011	
completed	Follow-up if symptoms persist / worsen		346.21	-today	01/19/2011	
scheduled	Office visit	Continue current treatment	346.21	-today	01/19/2011	



George M. Sandoz MD

Document generated by: George Sandoz 01/19/2011

Strand Regional Specialty Associates
8170 Rourke Street, Myrtle Beach, SC 29572



PATIENT: Hector Gomez-Fragoso
 DATE OF BIRTH: 10/04/1980
 DATE: 01/19/2011 4:45 PM
 VISIT TYPE: Office Visit

Chief Complaint/Reason for visit:

This 30 year old male presents with headache.

History of Present Illness

1. headache

Onset: sudden. Severity: moderate-severe. It occurs daily, has Year(s) duration, and is worse. Location was occipital. There was radiation to anterior. The patient describes it as blinding, debilitating and throbbing. Timing of headache: daytime. It occurred due to recent head trauma. Symptom is aggravated by bright lights, head position and noise. Denies relieving factors. Associated symptoms include blurred vision, dizziness, memory loss, neurological symptoms and performance changes.

Active Medications (started before visit)

Drug Name	Dose	Qty	Description
Nucynta	100 Mg	60	take 1 tablet (100MG) by ORAL route every 6 hours as needed
Tylenol-codeine No.3	300mg-30mg	120	take 1 tablet by ORAL route every 6 hours as needed
Amitriptyline Hcl	25 Mg	60	take 1 - 2 tablet (25MG) by ORAL route every 6 hours
Treximet	85mg-500mg	18	1 poq 12 hrs
Celexa	20 Mg	30	take 1 tablet (20MG) by ORAL route every day

Allergies

No known allergies.

Vital Signs

Physical Exam

Constitutional:

Level of distress is moderate distress, due to pain. Well nourished. Well developed.

Musculoskeletal:

Cervical spine has tender, moderate pain w/motion

Lumbar spine has muscle spasm, moderately reduced ROM

Neurological:

Level of Consciousness: Normal.

Orientation: Alert and oriented X 3. Grossly normal intellect.

Memory: Intact.

Cranial nerves: II-XII grossly intact.

Sensory: No sensory loss.

Motor: No motor weakness.

Balance & Gait: Balance and gait intact.

Coordination: Coordination intact.

Fine Motor: Skills normal.

Gomez-Fragoso, Hector

726 04/19801/2

Deep Tendon Reflexes: symmetricaly increased.
Babinski: Reflexes normal. .

Clinical Assessment

The patient is a 30-year old male who presents with headache. The patient is compliant with medication. Not responding to current treatment. Having some difficulty with ambulation. Need to alter current therapy.

Assessment/ Plan

Variants of migraine with intractable migraine, so (346.21)

Failure again with nucynta, due to his neck pain and back pain and shoulder pain methadone 5 mg tid given, trial for botox also.

Office Services

<u>Status</u>	<u>Order</u>	<u>Reason</u>	<u>Interpretation</u>	<u>Value</u>
completed	Adequate nutritional intake			
completed	Patient agrees with treatment plan & instructions			

Instructions / Education

<u>Status</u>	<u>Completed</u>	<u>Order</u>	<u>Reason</u>
completed	01/19/2011	Continue current medication	
completed	01/19/2011	Risks/ benefits of treatment plan	
completed	01/19/2011	Activity as tolerated	

To be scheduled/ordered

<u>Status</u>	<u>Order</u>	<u>Reason</u>	<u>Assessment</u>	<u>Timeframe</u>	<u>Appointment</u>
completed	Follow-up for increased symptoms		346.21	-today	01/19/2011
completed	Follow-up for medication side effect		346.21	-today	01/19/2011
completed	Follow-up if symptoms persist / worsen		346.21	01/19/2011	
scheduled	Office Visit	Follow-up on medication	346.21	-today	01/19/2011
scheduled	Office visit	Continue current treatment	346.21	-today	01/19/2011



George M. Sandoz MD

Document generated by: George Sandoz 01/19/2011

Strand Regional Specialty Associates
 8170 Rourke Street, Myrtle Beach, SC 29572



Southern Reporting, Inc.

Transcript of the
Deposition of

George M. Sandoz, M.D.

8/6/2010

Fragosa vs. Kade Construction, LLC, et al.
0717624

COPY

Southern Reporting, Inc.

Phone: 803.749.8100

Fax: 803.749.9991

Email: SouthernReporting@sc.rr.com

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 0717624

Hector G. Fragosa, :
 :
Claimant, :
 :
vs. :
 :
Kade Construction, LLC, :
 :
Employer, :
 :
AND :
 :
Key Risk Management Services, :
Inc., :
 :
Carrier/Defendants. :
:

Deposition of GEORGE M. SANDOZ, M.D., taken before
Michele E. Starkey, Court Reporter and Notary Public in
and for the State of South Carolina, commencing at
the hour of 1:29 p.m., Friday, August 6, 2010, at
Strand Regional Specialty Associates, 8170 Rourk
Street, Myrtle Beach, South Carolina.

Reported by
Michele E. Starkey

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APPEARANCES

For the Claimant: Jeffrey C. Chandler, Esq.
Chandler Law Firm
2501 Oak Street
P.O. Drawer 1889
Myrtle Beach, SC 29578

For the Employer/Carrier: Michael W. Burkett, Esq.
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, SC 29209

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Re-examination by Mr. Burkett:	19

EXHIBITS

There were no exhibits marked during this deposition.

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Workers' Compensation Act and all applicable rules.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

GEORGE M. SANDOZ, M.D., being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. BURKETT:

Q Dr. Sandoz, my name is Michael Burkett and I represent the employer and its insurance carrier in this workers' compensation matter.

A You got it.

Q Have you had your deposition taken before?

A Yes, I have.

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1 Q And you understand the testimony you're going to
2 give today is sworn testimony just as if you were
3 testifying at a hearing for this matter?

4 A Yes, I'm aware.

5 Q And in fact, in workers' compensation, this
6 testimony will actually be your hearing testimony.
7 Are you aware of that?

8 A No, I wasn't, but okay.

9 Q Now you are. Okay, good. Just briefly, you're a
10 board certified neurologist?

11 A Yes, and ophthalmologist.

12 Q And ophthalmologist, okay. And how long have you
13 been in private practice here in Columbia -- I mean,
14 in Myrtle Beach?

15 A Myrtle Beach have been twelve years.

16 Q Twelve years? And how long have you been private
17 practice in general?

18 A Twelve years.

19 Q Twelve years, okay.

20 A I finished out my training in June of '98 and have
21 been in practice July '98 here in this practice.

22 Q All right. And just to make sure we establish this
23 for the record, it's my understanding you are fluent
24 in Spanish; is that correct?

25 A That's correct.

1 Q And that's probably, sounds like your native
2 language. Is that right?

3 A Yes, that's --

4 Q So did you have any trouble communicating with Mr.
5 Fragosa in this claim?

6 A No.

7 Q Okay. Basically want to talk to you a little bit
8 about the condition. You have diagnosed him with a
9 traumatic brain injury; is that correct?

10 A That's correct.

11 Q And it's my understanding that traumatic brain
12 injury is as a result of the blow he received to the
13 head which actually included a skull fracture; is
14 that correct?

15 A That's correct.

16 Q And the skull fracture itself is basically just a
17 break in the skull bone. Like if I were to break my
18 arm, I'd break the bone in my arm; you have a skull
19 fracture, you break your skull bone. Correct?

20 A Yes, it's a little bit more harder because the bone
21 is called -- it's protected a little bit more vital
22 organ, in this case the brain, so the force that it
23 need to go and inflict is much higher than let's say
24 for your hip.

25 Q Right.

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1 A Or your arm.

2 Q Okay. And but in this case, the records do not
3 indicate that it was a -- that there was no
4 indication of a depressed skull fracture; is that
5 correct?

6 A No. Basically appear to have just cracked open.

7 Q Just cracked open, all right. And just so we all
8 understand, the depressed skull fracture would
9 actually be where the -- some of that bone fragment
10 actually pressed into the brain itself?

11 A Well, or the architect of the bone is depressed.

12 Q Okay. All right. But no surgical intervention
13 required to repair the skull fracture in this case?

14 A That's correct.

15 Q All right. And the last note that I believe we all
16 have from you, as far as treatment dates for Mr.
17 Fragosa, is August of 2009. Does that sound
18 accurate to you, according to your records?

19 A 2009. Give me one second, I tell you. 12th of
20 August of '09, that's correct.

21 Q Okay. And you haven't seen him since then?

22 A No, he has not been seen since then.

23 Q Okay. And your -- if we look at -- do you have that
24 report in front of you, Doctor, or do you need my
25 copy?

1 A No, I do have -- sorry. I have everything is
2 electronic. We have electronic medical records and
3 I have, while I'm looking at the computer, it's --
4 I'm look at the notes.

5 Q All right, that's fine. I just want to make sure.
6 If you look at the August 12, 2009 note, where in
7 the section for physical exam.

8 A Yes.

9 Q And the subsection of neurological?

10 A Uh-huh.

11 Q You note "the level of consciousness is normal,
12 orientation is alert and oriented, memory is intact,
13 cranial nerves are intact. Motor reflexes, normal;
14 facial, normal." Looks like his hearing was normal.
15 For the most part, a normal neurological exam; is
16 that correct?

17 A Except that he has -- the test is where we testing
18 his inner ear function is lateralized into the left.

19 Q Okay.

20 A That's the damage -- that suggests that the inner
21 ear, the -- you have two inner ears. The one on the
22 right is damaged so he doesn't hear from that, and
23 that's the area that is damaged, so when you place a
24 tuning fork and give you a pitch sound, he's only
25 hearing on the left and not on the right; meaning

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George M. Sandoz, M.D.

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1 that the right inner ear is damaged.

2 Q Okay. Is that from the accident or from something
3 else?

4 A That is from the accident.

5 Q From the accident. All right.

6 A Or directly related to the accident.

7 Q And just by way of explanation, how is that related
8 to the accident, the damage to that inner ear?

9 A At the time the concussive injury that the patient
10 had suffered had created an inner ear damage.

11 Q Okay. I was looking, for example, if you can just
12 look at the May 19, 2009 note, and tell me when you
13 have that in front of you and I will ask you the
14 questions.

15 A May 19. You got it.

16 Q Okay. I was looking, unless I'm missing it here,
17 under the neurological -- in the physical exam and
18 neurological, I don't see acoustic listed there. Am
19 I missing it?

20 A Got it. No, it wasn't --

21 Q Is it something you test every time or just --

22 A Not all the time.

23 Q Okay.

24 A I mean, I know that the guy had an inner ear damage,
25 and I test if he complains, or like in this case,

1 the September was just to give him an impairment
2 rating, or a more significant --

3 Q Right. Now, one of his other complaints that
4 appears to be fairly consistent, and correct me if
5 I'm wrong, throughout the claim or throughout your
6 treatment with him has been some dizziness; is that
7 correct?

8 A That's the dizziness, exactly.

9 Q And some headaches that come -- that sometimes are
10 more consistent than other times; is that right?

11 A Exactly, that's correct.

12 Q Even though in your August 12th -- I'm just curious
13 about this. In your August 12th, 2009 note that we
14 looked at a minute ago, you've noted memory was
15 intact, and in your clinical assessment, you note
16 mild or moderate memory loss.

17 A Exactly. When I said, you know, he's alert and
18 oriented times three and intact, is like you ask him
19 what day is it, the place, and the name. Those are
20 the three things, but for anything more complex, you
21 know, no, I don't ask him all the time so that's why
22 I said it's alert and oriented times three.

23 Q Okay, now --

24 A And those are the three things that I ask him,
25 what's your name, what's your date of birth, what --

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1 sorry. What day is today, and what's the place that
2 we are.

3 Q All right. Now, when we talk about the clinical
4 assessment things he reports to you when he sees
5 you, the dizziness and the headaches, when you put
6 those in your report, those are things we can't test
7 for; is that right? We're relying on the subjective
8 complaints of the patient?

9 A Yeah, the suggestive complaint of the patient and
10 the history that he had presented with.

11 Q And that would be -- those complaints would be
12 consistent with the post concussive --

13 A After the effects of the trauma that he suffer in
14 his head, yes, that's correct.

15 Q All right. Same thing with memory loss? Do you
16 rely on his subjective information or do you
17 actually test for that memory loss?

18 A Well, I tested some of that, you know, I give it
19 where and ask him and what he does. One of the
20 things that has always been asked about this one was
21 to do a neuropsych evaluation, a neuropsychological
22 evaluation, but to determine, you know, if this is
23 something that is really directly related or not.

24 Q Right. Okay. But as far as your concern that
25 headaches and dizziness and that moderate memory

1 loss, those are the results of that -- do I call it
2 post concussive symptoms?

3 A Traumatic brain injury.

4 Q Okay. All right. Now, let's look at -- you wrote
5 two notes; one was August 20, 2009, and one is June
6 3, 2009.

7 A Sorry, one is --

8 Q We'll do August 20th first.

9 A September, give me one second. August 20th, 2009,
10 yes.

11 Q All right. And I'm going to start with this one
12 first only because I was looking at all of this and
13 my interpretation is there might be a little error
14 here but I just want you to tell me if I'm right or
15 wrong.

16 A Okay.

17 Q You reference the fifth edition and table 13-5 --
18 the fifth edition of the AMA Guidelines in table
19 13-5.

20 A Yes.

21 Q Now, 13-5 is the table for dementia.

22 A Well, that's the only thing that I have available
23 for him to go and do the injury.

24 Q Okay. Well, and the reason I ask, because in the
25 June 3rd, 2009 note, you've got one on the screen,

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1 you reference the sixth edition of the guidelines
2 and table 13-8, which measures the mental status,
3 cognition, highest integrative function.

4 A Exactly.

5 Q Is there -- I know there's a difference because the
6 books are different.

7 A That's correct.

8 Q This one on the June 2009 report, you basically put
9 him in class two which is, you know, a moderate
10 category basically.

11 A Uh-huh.

12 Q Is that still accurate? Was there a reason you went
13 to the fifth edition? I'm trying to distinguish
14 between the two of them.

15 A Just because, you know, when I get like in June, I
16 have now that one, in August, I had this one only.

17 Q Okay.

18 A So that's the only reason.

19 Q Is the -- since the June -- since the sixth edition
20 actually gives you a bigger range where you can test
21 alteration of mental status, cognition, highest
22 integrative function, is the June one probably the
23 more accurate assessment since it gave you better
24 guidelines to go by, or what would you say?

25 A Doesn't really matter, it's just by the edition.

1 Q Okay. All right.

2 A You know, this year we're going to go and do this
3 part, I go do the assessment, and when I do the
4 assessment at one time, it's -- this was available.

5 Q All right.

6 A And when I do the other one, it's the other one
7 available.

8 Q I got you. Now, would you agree that -- do you
9 still stand by the two reports, even though you're
10 using two different books? You still agree with
11 both of those reports?

12 A Yes.

13 Q Okay. And just for the record, for the sixth
14 edition, we can submit this later, it says
15 alteration in mental status, cognition, highest
16 integrative function that interferes with the
17 ability to assume some normal roles or perform
18 activities of daily living. Is that --

19 A That's correct.

20 Q -- a fair assessment of Mr. Fragosa? All right.
21 Now, we've arrived at this because of what you
22 called traumatic brain injury, correct?

23 A That's correct.

24 Q As far as physical findings on his brain, if you
25 were to look at scans, is it fair to say there is no

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1 physical damage to the brain that we can see; is
2 that right?

3 A There's no evidence of any damage on the brain that
4 we can go and see, that's correct.

5 Q Okay. So what we're dealing with here are these --
6 the traumatic brain injury, and sometimes I like to
7 call it because I don't know what else to call it,
8 but I see it often, is the post concussive
9 syndrome --

10 A Got it.

11 Q -- which is the same thing.

12 A This is not a concussion, this is an injury suffered
13 to the brain.

14 Q Injury suffered to the brain.

15 A That's why traumatic brain injury is the preferred
16 term.

17 Q What's the difference between the jar that a brain
18 takes in a concussion and what he may have had?

19 A The concussion should resolve.

20 Q Okay. So we're looking at -- so we call it
21 traumatic brain injury because it's a longer period
22 of time?

23 A Because there's been some damage and injury to the
24 function of the brain.

25 Q And we're aware of that because of --

1 A The history that he gives, the findings that he had
2 initially, and the clinical presentation that he
3 has.

4 Q Right, and that clinical presentation today is still
5 the moderate memory loss, the dizziness, the
6 headaches?

7 A The headaches.

8 Q All right. But just to clarify again, as far as the
9 physical damage to the brain, physical, something we
10 can physically see on a scan, CT, MRI or anything
11 else, we're not going to see anything; is that
12 correct?

13 A Not in this case.

14 Q Okay. All right. As far as ongoing, you haven't
15 seen him since August, was he on any medications
16 when you released him or can you tell?

17 A Initially had placed him on medications but he has
18 been for loss to follow up. Some of the medications
19 that he has were used for the treatment of pain,
20 and -- and that is going into the cervical spine
21 therapy, and I've been giving him for the treatment
22 of the headaches that he has, so I haven't seen him
23 since then.

24 Q All right.

25 A I don't know why, and I don't know why he has not

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1 presented.

2 Q Okay. Can you tell from your notes whether he's
3 called in for any refills or anything? I don't
4 think he has and I think he told me that, I'm just
5 checking with you.

6 A The last, you know, contact that I have with any of
7 them is the case nurse manager in 8/24.

8 MR. BURKETT: Okay. I don't have anything
9 else.

10 EXAMINATION

11 BY MR. CHANDLER:

12 Q Just want to ask you about the MRI findings, Dr.
13 Sandoz.

14 A Right.

15 Q You did one and it was -- you ordered one and it was
16 conducted on September 16, 2008. What is
17 significant at all about findings of severe
18 mastoiditis?

19 A Well, that's the part of the injury that he has
20 suffer and that's why he's dizzy.

21 Q Okay. So when the radiologist notes that he has
22 severe right mastoiditis, that's telling us what
23 about the injury to the brain?

24 A That suggests that he had an injury to his head, and
25 if you look, you know, there's also within the

1 dictation or within the body of the findings, in the
2 last paragraph, and it says sensitivity of the
3 artifact of the subcutaneous tissue of the left
4 skull could be from prior trauma.

5 Q What is artifact telling us?

6 A That there is some -- that there is things that
7 shouldn't be there because motion, metal, movement,
8 and it said that there is non-seen that will suggest
9 intracranial hemorrhage, but it doesn't mention
10 anything of sheer injury or what they call basically
11 damage to the brain in the more diffuse manner.

12 MR. CHANDLER: Okay. Do you --

13 MR. BURKETT: I don't have -- well, I
14 probably do but it's easier for me to look over your
15 shoulder. Do you have --

16 MR. CHANDLER: I don't have any other --
17 well, you know what, I do have a few.

18 Q I just wanted to clarify the one point about the MRI
19 studies because I thought there was an acute
20 finding.

21 A Exactly. This is after the, what do you call it,
22 this is here. Then he had done other testing at
23 MUSC.

24 Q Let me ask you some questions, Dr. Sandoz, about Mr.
25 Gomez Fragosa's cognitive deficits.

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George M. Sandoz, M.D.

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1 A Uh-huh.

2 Q You believe that the traumatic brain injury has
3 affected Mr. Fragosa's ability to return to
4 employment?

5 A To gainful employment, yes.

6 Q Okay. I believe the history that this guy gave you
7 was that he was a construction worker and he was
8 injured in the construction-related accident. Is
9 that your understanding?

10 A That's correct.

11 Q Based on the condition that he has now and the
12 limitations that he has, do you believe that he can
13 return to any kind of former construction-related
14 employment?

15 A No, I don't think he will be able to.

16 Q Okay. Would --

17 A The reason being is because -- not only because of
18 the traumatic injury, I don't think he's able to
19 follow any type of commands, but the most
20 significant change is the inner ear injury that he
21 suffer which is making him unsteady, so any type of
22 high work or ladder or scaffold is out of the
23 question.

24 Q Okay. Is it your opinion to a reasonable degree of
25 medical certainty that he will need to take

1 medications for life to control his condition?

2 A With a certain degree of medical certainty, I
3 believe that the patient will require to take
4 medications on a permanent basis to control the
5 symptoms that he has.

6 Q Okay. Will he need to have periodic neurological
7 office visits and/or diagnostic studies to kind of
8 monitor his condition?

9 A That's correct.

10 Q Okay. Periodic blood work to see how the
11 medications are affecting his body overall?

12 A Yes. That's correct. Sorry.

13 MR. CHANDLER: I don't have any other
14 questions.

15 RE-EXAMINATION

16 BY MR. BURKETT:

17 Q Doctor, I'm looking back at this September 16, 2008
18 MRI study. Explain again, mastoiditis indicates
19 that there -- you could tell -- is that the
20 radiologist picking up on the actual old skull
21 fracture or is that something else?

22 A No, this is new. The old skull fracture was on the
23 left side. All the -- you know, the brunt of his
24 trauma was in the left side so this injury to the
25 brain, because it's kind of like a solid mass, can

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1 transmit the energy on the -- of the impact of the
2 bang to the opposite side. So said you hit here,
3 sometimes the injury that you suffer is in the
4 opposite side.

5 Q Okay. So that's my question. What exactly is the
6 mastoiditis?

7 A The mastoid is, if you imagine the skull, it will be
8 too heavy if you make it solid bone, so there is the
9 mastoid process like the one that is behind the ear
10 that is full of caverns so it make it lighter, the
11 mastoid.

12 Q The skull itself?

13 A It's part of the skull.

14 Q Part of the skull?

15 A The temporal bone -- sorry to technical -- the
16 temporal bone has a, you know, has like a con --
17 like a wave. It has the mastoid process and the
18 temporal bone itself. There are three bones that
19 are stuck together. And one is just to make it,
20 first of all, the head lighter, protect it more, and
21 allow the inner ear to tolerate a change in
22 pressures. Like a sponge there, that in case you go
23 too high or too low, it absorbs the pressure there
24 instead of popping the ear or breaking the ear like
25 sometimes it happens when the pressure goes too high

1 too quickly. And that's been damaged from the
2 injury that he suffer.

3 Q Okay. So the mastoid isn't part of the brain, it's
4 part of the --

5 A Skull.

6 Q -- skull. Okay. So all right. And --

7 A Which is the part of the skull that the right inner
8 ear is located, which when we do the testing, the
9 right inner ear is the one that appears to be
10 damaged. So the complaint that the patient is
11 having, the clinical signs, clinical symptoms, the
12 complaint that he has, and the findings that we do
13 on the studies, they're all correlate.

14 Q All right. The inner ear problem correlates with
15 that mastoiditis?

16 A Exactly.

17 Q Which is, I guess, sounds like an inflammation of
18 that area. Is that --

19 A Well, it's like fluid of the inflammation from the
20 response to the injury that he suffer.

21 Q Okay. All right. And as far as the cognitive
22 deficits, are you talking academic ability or
23 just -- what kind of things are you talking about
24 with cognitive deficits?

25 A When I ask him, I mean, I'm asking simple stuff,

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1 like can you -- how many bricks are -- can you lay
2 in a day, and how many are in a foot, so stuff that
3 he's able to relate, how many feet are there to
4 this, and he's not able to figure that stuff out.

5 Q All right. And you didn't know him before this
6 accident, did you?

7 A No, this is the first time I've ever seen him.

8 Q All right. So is it fair to say he may not have
9 known that stuff before the accident, we just don't
10 know?

11 A Exactly, I don't know. He's a construction worker.
12 I expected him to know, you know, that stuff.

13 MR. BURKETT: All right. I don't have
14 anything else.

15 MR. CHANDLER: I don't have anything. Thank
16 you.

17 (Deposition was concluded 1:52 p.m.)

18 (*This transcript may contain quoted
19 material. Such material is reproduced as read or
20 quoted by the speaker.)

21 (**Certificate accompanies sealed original
22 only.)

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25

PSYCHOLOGICAL AND TRAINING SERVICES, P.A.

920 St. Andrews Rd., Columbia, SC 29210

bobnorabraham@bellsouth.net

PH: 803-731-0588 FAX: 803-731-0589

ROBERT E. BRABHAM, PH.D.LICENSED PSYCHOLOGIST
MASTER'S IN REHABILITATION COUNSELING
CERTIFIED BRAIN INJURY SPECIALIST
LIFE CARE PLANNER

ROB BRABHAM, MRC, CRC

NORA HEAPE, RN, BA

BETH BURNETT, BA, ED.

PSYCHOLOGICAL and VOCATIONAL EVALUATION

Name: Hector Gomez Fragoso

C/A No: 4:10-CV-00503-TLW

Date of Birth: 10-04-1980

Age at Evaluation: 30

Date of Evaluation: 10-27-2010

Date of Report: 11-02-2010

Due to Mr. Fragoso's limited English-speaking skills it was necessary to have a translator present throughout this evaluation. The translator was Mr. Jaime Cailson, hired for his services and not related to Mr. Fragoso. Mr. Fragoso seemed comfortable with this procedure and it is believed that the information reported here is an accurate account of his responses and information presented.

Referral and Background Information: Mr. Fragoso is a 30-year-old former Construction Laborer for Builders First Source. He was referred for an independent psychological and vocational evaluation to determine vocational implications, and earnings issues, if any, related to limitations resulting from severe on-the-job injuries, including obvious brain injuries resulting in a loss of consciousness sustained on 11-01-2007.

At the time of his on-the-job injuries, Mr. Fragoso was delivering construction material to a job site when the weight of a crane caused the load to fall onto his head. He experienced a loss of consciousness at the scene, as well as significant blood loss. Trauma records indicate initial vomiting and inability to speak following his injuries. Records indicate he sustained a traumatic brain injury, complex scalp laceration, skull fracture, epidural/ subdural hematoma, clavicular fracture, multiple right phalangeal fractures, open scalp wound, and right frontal contusions. He subsequently required a transmetatarsal amputation, toes 2-5, right foot, which became infected and required revision with irrigation and debridement. Mr. Fragoso continues to experience symptoms typically associated with brain injuries, as well as orthopedic difficulties. These include headaches, dizziness, neck pain, back pain, and shoulder pain, as well as difficulty with gait, balance, and memory loss. He has been unable to return to any gainful employment since the date of his on-the-job injuries.

With the passage of time, now more than 2.5 years after his injuries, behavioral and cognitive changes have persisted, as will be noted, sufficient to conclude that the brain injuries he sustained, described as post-concussion injuries in multiple records, has resulted in continuing and severe symptoms clearly associated with a physical traumatic brain injury, the result of his on-the-job injuries.

He has never been married and has no children. Mr. Fragoso arrived promptly for this evaluation and was driven by his interpreter. He does not have a valid South Carolina driver's license, but he knew how to drive prior to the TBI. He indicated that he would be unable to drive at this time due to difficulty with range of motion in his neck, arm pain, pain in his foot due to amputation, as well as cognitive deficits which would result in "errors" when driving. His cognitive mistakes include difficulty in recalling directions to destinations with which he would ordinarily be well familiar.

His general appearance, hygiene and personal grooming were good. He wore a beard. He is 5' 4" in height, and weighs about 190 pounds, a slight gain due, in his opinion, to reduced levels of activity resulting from his injuries. He does not wear glasses, but has begun experiencing blurred vision and photosensitivity since his TBI. As will be noted, this is frequently seen following brain injuries. He does not require the use of a hearing aid, but does now experience ringing in the left ear, as well as sensitivity to noise, other symptoms often associated with brain injuries. Finally, he also has significant mobility limitations due to balance difficulties and noted, "...I walk like a drunk...and I'm not...but I usually catch myself before I fall..." Balance difficulties not accounted for by orthopedic or muscular difficulties are also common following brain injuries. He wriggled and changed positions throughout the evaluation, citing low back, neck and shoulder pain.

At the time of this evaluation he was receiving \$266.00 per week in Worker's Compensation benefits, his only income. He continues to experience significant financial hardship as a result of the loss of income resulting from his on-the-job injuries.

Sources of Information:

Medical Records from:

Atlantic Physical Therapy & Rehabilitation, Inc.
Long Bay Diagnostic Imaging
Mark Wagner, Ph.D.
MUSC
MUSC Neurology
MUSC Neurosurgery Clinic
MUSC Trauma/Critical Care Surgery

MUSC Rehab Services – Physical Therapy
MUSC Rehab Services – Occupational Therapy
MUSC Radiology Services

MUSC Orthopedics

MUSC Otolaryngology

Melissa Gray, P.T.
Robb Hoehlein, M.D.

Monica Zilkoski, M.D.
Mark Wagner, Ph.D.
Istvan Takacs, M.D.
E. Douglas Norcross, M.D.
Christian Minshall, M.D.
Shane Woolf, M.D.
Stuart Leon, M.D.

Paige Thomas, MSRPT
Josie Craig, OTR/L
Daniel Zapton, M.D.
James Ravenel, M.D.
Marques Bradshaw, M.D.
Dobrinka Dimitrova, M.D.
Miguel Fernandez, M.D.
Shane Woolf, M.D.
Christopher Merrell, M.D.
Kyle Kokko, M.D.
Mark Hoy, M.D.

Strand Regional Specialty Associates

George Sandoz, M.D.

Psychological Testing and Evaluation Results:

Wechsler Adult Intelligence Scale – Fourth Edition
Wide Range Achievement Test – Revision 4
Bender-Gestalt
Clinical Interview and Behavioral Observations
Mental Status Examination
Brain Injury Screening

Activities of Daily Living: He shares an apartment with two male friends, a financial arrangement that was advantageous even prior to his significant reduction in income following his injuries. He has difficulty navigating the stairs located in the home due to right foot pain. He noted that he would have difficulty climbing ladders and also described phantom pain in the area of the amputation in his foot.

On most days, he gets up at about 9-10 AM and is able to handle his basic personal grooming and toilet needs without assistance, but finds most movement results in significant orthopedic pain. As a result, he has difficulty dressing. He must avoid tub baths due to difficulty pushing himself up in the tub due to shoulder pain. He must essentially perform all chores with the use of only one arm, as a result of the functional deficits in his left arm, as well as numbness and/or pain in the left hand. He also continues to experience a sensation he described as feeling as though he was "not getting enough air when breathing", which also interferes with his ability to perform any sustained activity.

He continues to perform light chores around the home, but only those that can be performed with the use of only one arm. However, he indicated that it is becoming more apparent that his right arm is also weakening due to possible overuse related to the functional deficits in his left arm.

He shops alone, but does not drive to the store, and then requires items be packaged for ease of carrying, essentially with only one hand. He holds onto the grocery cart for stability when shopping. He is unable to exercise due to "...tiring too easily...pain in my arm and neck..." He is not able to sustain much activity, despite efforts to initiate activity due to pain and ease of fatigue "from nothing".

In a typical 8-hour day he indicates he must spend about 50% of the day reclining/ resting on the sofa with his foot elevated due to pain in the area of the amputation there, and also with his left arm/shoulder propped and supported as well, as a result of his physical limitations and pain. He watches television to pass the time, the Spanish channel. He indicated that he has difficulty concentrating even when watching television and doesn't understand what is on, even on Spanish TV.

In a 5-day work week he indicated that he would have to miss about 2 days per week at any potential job due to pain problems and lack of sleep associated with medical conditions that resulted from his on-the-job injuries.

This would of course greatly exceed the number of days available for personal/sick leave in an average job in South Carolina, about 2-weeks per year.

He returns to bed at about 9-10 PM but gets only about 3-4 hours of non-restorative sleep, often interrupted by pain. He noted no prior history of sleep problems, but now requires prescription pain medication at bedtime to assist in getting off to sleep.

As a direct result of his on-the-job injuries he is now able to participate in far fewer social or leisure activities than was the case prior to his injuries. He indicated that his relationships with friends, family and others have also changed as a result of his medical conditions. He noted he could no longer participate in sports, an activity he enjoyed prior to his on-the-job injuries. He indicated difficulty participating in most activities due to balance problems, ease of fatigue, and foot pain.

He also admits that he has inadequate patience and is easily irritated. He noted he has difficulty concentrating and sustaining attention to complete any task. The overall quality of his life has clearly been greatly diminished by his injuries.

Educational Background: He graduated from high school in his native Mexico. While attending high school he participated on sports teams. He has been in the U.S. for the past 7 years, but has had no formal English training and continues to have severe language deficiencies. He has received no further formal training and has no military experience.

Work History: Mr. Fragoso's work history has been entirely as an unskilled laborer, in the United States. He has worked regularly and has a stable work history. At the time of his on-the-job injuries, he was working as a Construction Laborer for Builders First Source for whom he had worked for about the past 2 years. He earned \$11.00 per hour, working 40-45 hours per week, \$20,000-\$25,000 annually.

Work as a Construction Laborer is defined by The Dictionary of Occupational Titles as unskilled and Heavy in physical demands. Such work is actually Very Heavy as performed, at times, requiring that he lift, bend, reach and stoop on a regular basis as part of his essential job duties. Prior work experience in the U.S. included work as a Carpenter/Helper installing kitchen countertops.

He insisted that in his employment he had no personnel or performance problems. He enjoyed his co-workers, his colleagues and got along well with his supervisors. Clearly it is the on-the-job injury in 2007, which began his medical problems.

Medical Problems: The medical aspects of his injury are documented in other reports, and will not be addressed in great detail herein. However, several more recent medical references have vocational significance and are noted accordingly.

On 11-01-07, an initial MUSC Trauma Center evaluation indicated, "...hit in head with part of crane...LOC at scene...significant blood loss...vomiting x prior to arrival...unable to speak...complex scalp laceration...skull fracture...epidural/subdural hematoma...right

clavicular fracture...multiple right phalangeal fractures...open scalp wound washed and closed...*right frontal contusions*...admit to ICU...vent support..."

On 11-01-07, Dr. Shane Woolf noted, "...hit in the head with a crane...he vomited prior to ED arrival...incurred a *large fracture through his skull*, apparently it is open with subdural and epidural fluid collections...right clavicle fracture, as well as fractures of the proximal phalanges of the right foot, 2-12, with traumatic arthrotomies of the 4th and 5th toes, as well as a non-displaced oblique fracture on the right great toe...not a surgical candidate at the moment per neurosurgery..."

Also on 11-01-07, Dr. Istvan Takacs indicated, "...patient is status post *closed head injury with open skull fracture*...recommend ICU admission, frequent neuro checks..."

An x-ray of the head performed by Dr. Dobrinka Dimitrova on 11-01-07 concluded, "...bilateral apical contusions versus atelectasis...right midshaft clavicular fracture..." An x-ray of the right foot indicated, "...fractures of all five sets of phalanges..."

A CT of the brain performed by Dr. Dobrinka Dimitrova on 11-01-07 concluded, "...*comminuted fracture* with small extra-axial *parietal hematoma* at midline at the vertex, worrisome for a small *epidural hematoma*..."

On 11-02-07, Dr. Woolf performed an irrigation and debridement of open fracture of phalanges, closed reduction and percutaneous pinning of hallux second, third, and fifth toe proximal phalax fractures; and nailed repair fourth and fifth toes.

On 11-07-07, MUSC notes indicated, "...*cranial fractures with head injury*...respiratory failure...right foot crush injury with fractures of all toes...posttraumatic vasospasm..."

On 11-15-07, Dr. Christian Minshall performed a tracheostomy due to the diagnosis of a *closed head injury* with epidural hematoma.

A CT of the chest performed by Dr. Marques Bradshaw on 11-16-07 concluded, "...left lower lobe atelectasis possibly with superimposed pneumonia..." A CT of the chest on 11-18-07 by Dr. Mike Hanley indicated, "...right midshaft clavicular fracture with half shaft displacement...left basilar opacity, likely combination of atelectasis and effusion, but may represent pneumonia..."

An Occupational Therapy Evaluation performed by Josie Craig, OTR on 11-20-07 noted, "...decreased ability to perform ADL's and functional transfers...limited ROM in right shoulder...decreased overall cognitive skills..."

A Physical Therapy Evaluation performed by Paige Thomas, MSRPT on 11-23-07 indicated, "...patient now awaiting possible TMA for right foot gangrene...dizziness with sitting...decreased mobility, decreased ambulation...transfer training, gait training, balance training, therapeutic exercise, wheelchair mobility training..."

An x-ray of the cervical spine performed by Dr. Daniel Zapton on 11-27-07 concluded, "...inferiorly and posteriorly displaced spinous process fractures at C7 and T1..."

On 11-30-07, Dr. Woolf performed a transmetatarsal amputation, toes 2-5, right foot.

On 12-12-07, Dr. Monica Zilkoski noted, "...pain and swelling to the foot...significant wound breakdown and concern for infection at this point...patient is to be admitted to the hospital and plans to revise his amputation with irrigation and debridement, and possible placement of a wound VAC..."

On 12-17-07, Dr. E. Douglas Norcross indicated, "...he complains of some ongoing headaches and some dizziness to changing positions...pain in the right foot...given the severity of his injuries...Lortab prescribed ...continue to follow-up with Neurosurgery and Orthopaedic Surgery..."

On 09-03-08, Dr. George Sandoz noted, "...status *posttraumatic brain injury with associated headache*...headaches appear to be musculoskeletal and status post skull fracture in nature...patient had a skull based fracture with a frontal bone fracture with superimposed subdural and epidural hematomas...he also had frontal lobe contusion ...dizziness appeared to be directly related to an inner ear injury, most likely from his skull based fracture...patient had difficulty concentrating and that appears to be directly related to the injury that he has suffered and after effect typical of this type of injury... shortness of breath could be anxiety attacks or could be damage from the tracheostomy that the patient had...foot pain is from the injury that he has suffered ...difficulty concentrating and performing tasks with irritability is directly after effects from the injury that he suffered...neck pain has never been evaluated and possibility of cervical disc and joint disease and/or spinal stenosis in this patient is present..."

Dr. Sandoz concluded, "...a neuropsychological evaluation in Spanish should be done to see which areas have deficit and what can be done to improve or maximize the recovery and function of this patient...an EMG of the left upper arm and right lower extremity to evaluate the possibility of having a lumbar and cervical radiculopathy should be performed...EEG to evaluate the inner ear and make sure that this paroxysmal event that the patient is having is not associated with seizure, as well for the irritability that the patient has presented to see how the brain is functioning...Robaxin 500mg three times a day for treatment of the headache and the musculoskeletal component that the patient is suffering...Neurontin 300mg three times a day to stabilize mood and control symptoms of paresthesias, headaches and dizziness...Vicodin for pain...pulmonary evaluation to make sure that his trachea and lungs are working properly...I agree with the orthopedic evaluation...vestibular desensitization exercises prescribed...patient has blurred vision that he had presented to me to be evaluated if the treatment and symptomatology of dizziness does not resolve completely..."

An MRI of the brain performed by Dr. Robb Hoehlein on 09-16-08 concluded, "...right mastoiditis..." An MRI of the cervical spine on this same date indicated, "...probable left intraforaminal focal disc protrusion at C4-5 resulting in moderate left neural foraminal stenosis...protrusion is located beneath the exiting left C5 nerve root...CT myelogram could be helpful..."

On 09-16-08, Dr. Sandoz noted, "...he is noted to have a transverse process injury at the level of L3-4 and also a transverse spinous process at the level of C7..."

On 09-17-08, Dr. Kyle Kokko indicated, "...now nine-month followup from surgery complaining of pain in his foot...shooting pain consistent with neuropathic or phantom pain...swelling of the right foot...stressed benefits of having some sort of prosthesis or inserts that he can utilize in his shoes to help him with gait and balance...Neurontin would likely help his phantom pain, increase dose..."

On 10-02-08, Dr. Sandoz noted, "...having dizziness...headache...neck is 8/10, into the left, more significant...associated recently with more low back pain and thoracic pain, but has worsened with activity...*unable to perform any of his ADLs*...presented with headaches and vertigo...inner ear damage we will check electronystagmogram...abnormal mastoid process present on MRI...MRI of the cervical spine shows herniated disc at the level of C5, particularly at the level into the left, which correlates with the clinical findings the patient is having...symptomatology with his back might represent worsening condition of his neck or previous injury...MRI of the lumbar and thoracic spine to be scheduled..." An ENG study on this same date concluded, "...right canal paresis..."

On 10-10-08, Dr. Sandoz indicated, "...dizziness, spells that suggest that the patient is having seizures, low back pain, but by history the patient had an injury on the lumbar spine...from the cervical standpoint, patient has presented with mild disc bulge...from the evidence of the brain, it suggests that there is a right temporal lobe injury..."

On 10-24-08, Dr. George Sandoz noted, "...neck pain, back pain, ear pain and recently noted to have right shoulder pain...the more he does, the more it hurts...the less he performs, the better it is, but it is always there...symptoms significant, persistent, exacerbated by movement, improved somewhat by rest...medication is giving some relief and he continues to rely heavily on it...MRI shows some mild abnormality in the temporal lobe, but no significant lesion...back pain and neck pain...symptomatology of ear pain is significant..."

On 10-30-08, Dr. Mark Wagner noted, "...*postconcussive syndrome*, mild...chronic pain disorder...situational depression...very serious work-related injury result in trauma to his body and skull...skull fracture with acute underlying minor structural change to the brain...*persisting cognitive complaints...exhibiting symptoms of postconcussive syndrome*...abnormal findings largely in the domain of complex attention and concentration...he may have some element of decreased intellectual efficiency...he does have findings positive for situation depression and pain are also contributing to his functional disability...most likely at maximum medical improvement in terms of her neurologic/brain status...the most treatable aspect of the claimant's current syndrome is pain and depression..."

On 11-25-08, Dr. Sandoz indicated, "...he continues to have a headache...foot hurting...symptoms into his neck, 8/10 when turning, difficulty sleeping, unable to ambulate and perform any of his activity...also complaining of low back pain due to worsening and sitting down longtime position...it takes a while for him to keep going...continues to have difficulty hearing on the right ear...he gets short of breath every time that he starts working..."

Dr. Sandoz concluded, "...*traumatic brain injury*...he is tolerating Neurontin well... headache does appear to be related to the *contusive injury* that the patient is having...cervical spinous process fracture continues to bother him...low back pain appears to be associated with a compression fracture and transverse process fracture, fairly stable, but continues to bother him...shortness of breath might be associated with tracheomalacia...vertigo with mastoiditis present...epidural steroid injection of the cervical spine given..."

On 01-05-09, Dr. Woolf noted, "...still having pain about the neck and shoulder...low back has been symptomatic without radicular symptoms...upper extremity pain seems to radiate down into the hand globally...low back pain seems to be worse since starting therapy...left AC joint arthritis...left shoulder posttraumatic stiffness...rotator cuff strain... C7 spinous process nonunion with paracervical pain...low back pain...I would also like to assess cervical disks, particularly C5-C8 nerve roots which may explain his upper extremity symptoms altogether..."

On 01-06-09, Dr. Sandoz indicated, "...headache comes and goes every two to three days...nothing makes it better or worse...recently taking Neurontin and Voltaren without great deal of relief...neck pain is 8-9/10, sharp in nature that is shooting mostly into the left leg...low back pain is 8-9/10 going up into his back... headaches appear to be chronic, posttraumatic in nature...cervical and lumbar disc disease with associated fracture of the spinous process...epidural steroid injection of the cervical spine will be given trying to control the pain..."

On 01-22-09, Melissa Gray, P.T. noted, "...patient continues with complaint of constant pain bilateral cervical area (left greater than right)...headache at the top of head is intermittent...constant paresthesia all digits left hand and left shoulder pain with movement...constant low back pain...turning head to drive is still difficult, as is using left upper extremity to turn the wheel...pain left upper trapezius area with ADL's, carrying light objects near body and reaching away from body..." Mr. Fragoso continued in physical therapy through 04-09-09, at which time PT was placed on hold until he could receive an ESI.

On 01-27-09, Dr. Woolf indicated, "...he continues to have the same pain, which he localizes to the base of the neck on the left side and in the upper portion of the trapezius...radiating symptoms sometimes down the hand and arm...pain on the dorsum on the right foot just proximal to his transmetatarsal amputation...painful right transmetatarsal amputation stump, with metatarsalgia...small partial thickness infraspinatus tear of the left shoulder...possible C4-5 nerve root impingement...I am more concerned about his neck given his symptoms at the base of the neck and trapezius, as well as radiating symptoms in the upper extremity...he may have some neurogenic pain in the foot along the digital nerves..."

On 02-17-09, Dr. Sandoz indicated, "...medication has given some relief, but continues to rely on it for the control of the symptoms...dizziness has continued to be improved with the use of Meclizine...headaches are still persistent... episode of loss of consciousness, and *traumatic brain injury type of picture*..."

On 04-16-09, Dr. Merrell performed the recommended epidural steroid injection at C6-7.

On 06-02-09, Dr. Sandoz indicated, "...headache occurs constantly...entire head... radiation to anterior...debilitating, sharp and worst ever...aggravated by head position and stress...dizziness...*loss of consciousness*...responding to current treatment...having some difficulty with ambulation...needs some assistance with ADLs...intracranial injury of other and unspecified nature...variants of migraine with intractable migraine...dizziness and giddiness...degeneration of lumbar or lumbosacral intervertebrae..."

On 07-07-09, Dr. Sandoz noted, "...*head injury*...location of injury is in the bilateral frontal region and bilateral cervical region...location of pain is facial, head and neck... pain is aching and burning...the mechanical force causing the injury was *contra-coup and coup*...includes fall...aggravating factors include bending over...incoordination, irritability, memory difficulty and speech difficulty...dizziness occurs persistently... imbalance and spinning...aggravated by bending...headache unchanged, entire head with radiation to anterior...blinding...aggravated by head position...not responding to current treatment...difficulty with ambulation...needs some assistance with ADLs... moderate memory loss...late effect of intracranial injury...status *post TBI with complicated migraine, dizziness and cervical and lumbar pain*..."

At the time of this evaluation, he continues to experience bilateral neck and shoulder pain, shortness of breath, numbness in both hands, right foot pain, range of motion difficulties in the neck, as well as obvious symptoms of having suffered a traumatic brain injury. He also continues to experience frequent migraine headaches, at least weekly, which requires that he return to bed in a dark, quiet room. At the time of this evaluation, Mr. Frago is still prescribed Neurontin, but with little effectiveness as to pain management.

References to pain in records exist over an extended period of time. He indicated treatment has included prescription medications, epidural steroid injections, and physical therapy. When asked to describe his pain, he indicated that since his on-the-job injuries he experiences pain at a level 8 on a 10-point scale, at some point of every day, 7-days per week. He noted movement, reaching overhead, and bending exacerbates the pain. His pain is best relieved by prescription medication and resting/reclining. He indicated that he is never without pain and is even unable to sit for 8-hours due to worsening pain symptoms even when being still.

Mental Status Evaluation: He was well oriented to all spheres, and neither demonstrated nor reported any hallucinations or delusional thought processes. He noted no prior mental health history.

He described clinically significant symptoms sufficient to confirm the continued presence of cognitive deficits associated with a brain injury, including a severe level of depression. His cognitive/emotional symptoms include a considerable loss of interest or pleasure which is nearly always present. This includes social withdrawal even from family activities; significant reduction in previous levels of sexual interest or desire; decreased energy, tiredness and fatigue out of proportion to actual activity; impaired ability to concentrate, or make decisions; and is easily distracted with memory difficulties.

These symptoms have clearly resulted in significant distress/ impairment in social, occupational, and other important areas of functioning. These symptoms are not better described by any other general medical condition and there is no evidence of any substance abuse which would cause these same symptoms. In spite of his depression, he denies any suicidal attempts or plans at this time.

He is also continuing to experience classic symptoms associated with anxiety. His anxiety is increased by the fact that he realizes he cannot do what he has done in the past, an anxiety provoking thought.

He does not use illegal drugs and does not consume alcohol. He indicated that he smoked prior to his TBI, but quit following his injuries due to the cigarettes "tasting different". Changes in smell and taste are often symptoms of a traumatic brain injury.

Psychological Test Results: He appeared to cooperate and to give optimal effort during this evaluation. Due to his marked English language deficits, it would have been inappropriate to administer some verbal subtests. Thus, testing consisted of primarily performance subtests and tasks that would not be markedly influenced by language deficits. With those limitations, these results are believed to be valid indicators of his current levels of functioning.

On the Wechsler Adult Intelligence Test - Fourth Edition, using only the performance subtests, he appears to be functioning at no higher than about the "Borderline to Low Average" range of intelligence. Since there is no indication of any developmental delays or other intellectual deficits prior to his graduating from high school in Mexico, it appears, and is reasonable to conclude, that there has apparently been some deterioration in pre-injury levels of functioning.

Again, with his noted lack of English language skills, Reading and Spelling in English would be expected to be markedly limited, of course. On the Wide Range Achievement Test - Revision 4, I was interested in obtaining confirmation as to his limited English language skills. As expected, he has marked Reading limitations. His Reading Standard Score of 27 is only a 2.0 grade level score. However, even his Arithmetic Standard Score of 29 is only a 4.0 grade level score. This would not appear to be consistent with his pre-injury levels of presumed functioning. Regardless of cause, his academic skills are not sufficient for use in work settings in which such skills would be essential.

On the Bender-Gestalt, the quality of his drawings was generally adequate, but did include some errors often associated with cognitive difficulties.

Evidence and Symptoms Associated With An Acquired Physical Brain Injury:
There are multiple medical references over an extended period of time confirming that Mr. Fragoso sustained a (physical) traumatic brain injury. He continues to present classic evidence as to the continuing presence of cognitive deficits that resulted from his brain injury. A variety of behavioral symptoms are evident and have been noted, including attentional problems, irritability, anxiety, depression, apathy, and other similar changes in personality.

He has also developed multiple cognitive deficits of such severity as to have caused impairment in occupational and social functioning which clearly represents a marked decline from his previously higher level of functioning. He demonstrates significant memory impairment which continues to confirm the diagnosis of a brain injury and subsequent cognitive deficits.

He also demonstrated difficulty with remote memory at times and was unable to accurately describe all past material related to the conversation. At times his speech was somewhat vague, and he appeared to struggle to find the right word even in his native language. The interpreter confirmed that Mr. Fragoso was struggling to find the word he was wishing to use.

He also has demonstrated disturbances in executive functioning in his daily activities, a common manifestation of brain injuries. He is unable to plan, initiate, sequence, or monitor complex behaviors. It seems obvious that he would have difficulty in sustaining these activities without the monitoring and direction noted. His decline from likely previous levels of functioning have caused significant impairment in occupational functioning and in handling personal finances.

Cognitive deficits resulting from brain injuries are also often accompanied by multiple disturbances of gait. Mr. Fragoso has experienced such deficits as noted in this report. The multiple cognitive impairments that he has experienced are also associated with depression, anxiety, mood and sleep disturbances. Individuals with brain injuries/cognitive deficits are often especially vulnerable to physical stressors, as well as other psychosocial stressors which tend to exacerbate their deficits and associated problems.

In a publication by the Brain Injury Association of America, some of the common symptoms following brain injuries include, but were not limited to: headaches; sleep problems; lack of patience; short term memory loss; forgets names of friends, colleagues known in past; difficulty with word use/recall; trouble concentrating; slowed ability to process information; organizational problems; major balance problems; depression or mood swings; increased anxiety; easily agitated; changes in vision, appetite, taste, smell, hearing, in balance or muscle coordination; sensitivity to light, sound and temperature. Mr. Fragoso exhibits literally each and every one of these clinically significant indicators.

Utilizing the AMA Guides to the Evaluation of Permanent Impairment-5th Edition, specifically Chapter 13 (The Central and Peripheral Nervous System), Mr. Fragoso is assessed as having impairments based on the Clinical Dementia Rating Scale (CDR). This reflects his apparent lack of awareness of some residual cognitive deficits that continue to be present. He is quite compromised in his attention/concentration, speed of mental processing and multitasking. He avoids most social and recreational activities that previously afforded him pleasure. He still has marked physical limitations and restrictions that clearly prevent him from performing the full range of job duties that his past employment setting required.

Based on the CDR ratings, Mr. Fragoso is assessed as having a "Class 2 Impairment", a level of impairment which requires "direction of some activities", resulting in a 15%-29% impairment of the whole person. Using the midpoint in this range, this equates to about a 22% impairment rating. Specifically, this is based on his memory loss; moderate difficulty in handling some activities; as to community affairs he "appears normal to casual inspection", but has limited his activities; as to home and hobbies, he has abandoned most of his leisure and hobby activities he enjoyed prior to his injuries.

Diagnosis: After observing him during this evaluation, and from careful review of records of past behavior and levels of functioning, he is clearly manifesting signs and symptoms consistent with the requirements to establish and/or maintain several diagnoses. He is continuing to experience major pain episodes and references to pain exist in several medical records over an extended period of time. He is also anxious about his future, especially since he realizes that his past work is no longer an option for him, an anxiety-provoking thought for someone at the age of 30. Finally, his multiple losses, personal, financial, social and leisure, all have led to a level of depression.

Therefore the following diagnoses apply, in keeping with all diagnostic requirements for each:

294.1 Cognitive Disorder, Secondary to (Physical) Traumatic Brain Injury

307.89 Pain Disorder

311 Depressive Disorder NOS

300.02 Generalized Anxiety Disorder

These medical/mental conditions are in addition to his other physical medical problems that are well documented in his files.

Vocational Opinion and Rationale: Several factors must be considered in reaching a vocational opinion. They include his age of 30; still defined as a "younger worker", a positive factor; his educational background in Mexico would have been satisfactory in that environment, but is inadequate in an English speaking work environment and, thus, becomes a negative factor; his profound cognitive impairments have significant vocational implications, a negative factor; his stable, but unskilled work history would be positive; but is offset by his inability to perform any work on a sustained basis and thus becoming a negative factor; due consideration must also be afforded to the pain that he experiences on a daily basis, which requires that he spend 50% of the day "resting or reclining" on the sofa with his foot elevated; and his depression and anxiety also interfere with his ability to maintain sufficient attention and concentration, which becomes a negative factor. The most significant negative factor is, of course, the obvious physical brain injury he sustained due to his on-the-job injuries.

Taking all of these factors into consideration, it is my opinion, to a high degree of professional certainty, based on nearly fifty years of vocational rehabilitation and psychology experience, and nearly a decade of experience as the Executive Director of the Brain Injury Alliance of SC, that he has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain, unable to engage in full-time

gainful, competitive employment as a result of his medical conditions resulting from his on-the-job injuries in November 2007.

The rationale for my opinion is essentially based on the following observations:

Credibility: He appeared credible in his description of his limitations and remaining functional capacities. As a result of the limitations on his neck, shoulder, back, hands, and arms, he cannot complete significant tasks or activities on a regular, sustained basis.

It is noted that the information provided during this interview was highly consistent with information reported in other reports. This provided additional confirmation that the responses and description of events and circumstances was candid, was not feigned or exaggerated, and does not appear to represent any symptom magnification.

Medications: He is still prescribed a pain medication, and is carefully compliant with dosages and times as prescribed, and has been so since his injuries. However, in spite of medication, he continues to experience severe pain on a regular basis, as well as headaches. He also experiences the usual and predicted side-effects of medication, including feelings of fatigue and an inability to function at optimal levels while taking his medications. It is also clear that his medications are directly related to his on-the-job injuries, and therefore should be provided by Workers' Compensation.

Pain/Cognitive Factors and Attendance Implications: Even with pain medication he continues to experience significant pain at such levels as to interfere with his ability to sustain physical activity. His cognitive deficits would also cause difficulty in his ability to pay attention to job tasks and job duties for hours each week, on average. The inability to maintain concentration and persistence interferes with the ability to meet production expectation for even unskilled jobs.

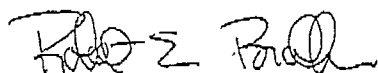
Limitations on Sitting and Standing/Use of Left Arm and Hand: His limitations on sitting and standing, as well as the use of her left arm and hand, are such that vocationally even any sedentary work, which might otherwise have been suggested, is precluded. Vocationally, any work requires some combination of sitting, standing and/or walking, as well as the use of both arms/hands, for a full 8-hour workday, without the need to rest for prolonged periods of time, something he is unable to do in his present condition.

Furthermore, any such jobs would require that he be able to use his neck, shoulder, back, hands and arms repetitively and continuously while meeting minimal production standards. As evidenced during this evaluation, he would not be able to sustain any repetitive activity for an eight-hour basis, day after day, in his present condition.

Summary and Conclusions: Based on all the evidence as described above, consistent with observations during this evaluation and various reports in his file, he would be unable to effectively perform the essential duties in any gainful work activity. It is also clear that the unfortunate combination of factors and characteristics he now faces are directly related to the injuries he sustained while working.

Due to the severity of his symptoms and the wide variety of limitations and descriptions he faces, he remains unable to perform any substantial gainful work activity, which exists in the SC or the national economy. Directly as a result of his on-the-job injuries the only services he could perform are so limited in quality, dependability, or quantity that no reasonably stable market for them exists.

The opinions noted in this report are offered within a reasonable degree of professional certainty, based on more than 45 years of vocational rehabilitation and psychology experience. Thank you for the opportunity to work with you in this matter. If you have any questions, or if I could address additional issues, please do not hesitate to contact me.



Robert E. Brabham, Ph.D.

Licensed Psychologist

Master's in Rehabilitation Counseling

Former Director of the Brain Injury Alliance of South Carolina

Former Director of Brain Injury Division, SC Department of Disabilities & Special Needs



JEFFREY C. CHANDLER, P.C.
FEIN 20-0523540

March 10, 2011

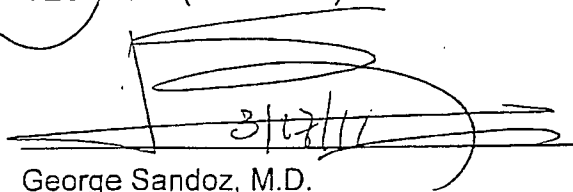
Strand Regional Specialty Associates
Attn: Dr. George Sandoz
8170 Rourke Street
Myrtle Beach, South Carolina 29572

Re: Hector Gomez Fragoso

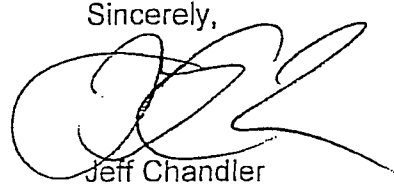
Dear Dr. Sandoz:

As you are aware, I represent a long standing patient of yours, Mr. Hector Fragoso. Enclosed please find CT scan reports from MUSC which were performed shortly after the accident. You have previously determined in your medical reports and at your deposition in this case that Mr. Fragoso has sustained a traumatic brain injury. After reviewing these reports, I need you to answer to a reasonable degree of medical certainty whether Mr. Fragoso has suffered physical brain damage that has rendered him totally and permanently disabled.

☒ YES or NO (Circle One)


George Sandoz, M.D.

Sincerely,


Jeff Chandler

cc: file

Enclosures: (As noted)

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY

Patient Name: GOMEZ, HECTOR

MRN: 002581962

Patcom: 490943644

Admitted: 11/01/2007

Discharged: 12/01/2007

Service: Trauma Surgery

Attending: CHRISTIAN T MINSHALL, MD

Referring:

ADMITTING DIAGNOSES:

1. Status post skull fracture.
2. Open complex scalp wound with epidural and subdural hematoma.
3. Bilateral frontal contusions.

HISTORY OF PRESENT ILLNESS: This is a 27-year-old Hispanic male who was hit in the head with part of a construction crane with positive loss of consciousness at the scene, significant blood loss, positive emesis at scene. He was intubated by EMS. This occurred in Marion County after an elevated crane fell and hit him. The patient was attempted to be intubated by Marion County which was unsuccessful. Then, Carolina Lifecare was able to intubate.

REVIEW OF SYSTEMS: Per HPI.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

SOCIAL HISTORY: Questionable use of ETOH.

DISCHARGE PHYSICAL EXAMINATION: Vital signs: Temperature 99.3, heart rate 114, respiratory rate 19, blood pressure 118/81, saturating 99% on room air. Neurologic: Patient alert and oriented. Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs. Lung sounds clear to auscultation bilaterally. Abdomen: Positive bowel sounds, nontender, nondistended. Trauma: PEG tube in place. Extremities: Right foot in dressing, clean, dry, and intact. Moves knee and ankle joints.

DIAGNOSTIC TESTS: CT of the abdomen on 11/01/2007 showed a right adrenal hemorrhage, bilateral L1 and L2 and right L3 transverse process fractures and multiple posterior rib fractures.

CT pelvis on 11/01 showed a high density structure in the rectum of uncertain significance.

CT of the head on 11/01/2007 showed a comminuted fracture with small extraoccipital hematoma at the midline at the vertex, worrisome for a small epidural hematoma.

CT of the chest with contrast on 11/01/2007 showed bilateral lung contusions and/or aspiration. Right clavicle fracture and C7 and T1 spinous process fractures.

Patient has had multiple CTs of the head and chest x-rays.

CONSULTS SERVICE:

1. Neurosurgery.
2. Orthopedics.

HOSPITAL COURSE: The patient had a protracted hospital stay. Patient was admitted initially through the trauma bay via trauma protocol and then taken to the STICU for medical management.

Neurology: Patient was managed by neurosurgery for his subdural and epidural hematomas. Patient was also managed for multiple spinous process fractures. Patient has subsequently recovered function. He was ambulating without any difficulties, moving all extremities. Patient alert and oriented x3.

Cardiovascular: Patient remained hemodynamically stable. No acute issues.

Pulmonary: Patient initially intubated en route from Marion County by the air medical services. Patient was subsequently transferred to STICU on the ventilator service. Patient had failure to wean off the ventilator and subsequently had a tracheostomy performed while in the hospital. Subsequently, patient had tracheostomy removed.

Gastrointestinal: A PEG tube was placed for nutritional concerns. Patient tolerated tube feeds throughout his stay. Subsequently, after patient was transferred to floor, tube feeds were held and patient was started on p.o. intake. Patient was tolerating p.o. without any problems. PEG tube remained intact at time of discharge to be pulled out at his appointment with trauma surgery.

Musculoskeletal: Patient with multiple fractures that were initially evaluated and treated by orthopedics. The day prior to discharge, the patient was taken to the operating room by orthopedics to have his 2nd through 5th metatarsals amputated. Patient had a full weightbearing status at time of discharge. Subsequently, physical therapy recommendations no further out of hospital physical therapy needed.

DISCHARGE DIAGNOSIS(ES):

1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. C7 and T1 spinous process fractures.
7. Right rib fractures which included 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.
10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes.

DISCHARGE MEDICATIONS: Patient will go home on oxycodone. He will take 1-2 tabs p.o. q.4-6 h. p.r.n. pain.

DISCHARGE PLANS: Patient will follow up with orthopedic clinic at McClennan-Banks on Wednesday in 2 weeks. Patient will also follow up with trauma clinic on Friday in 2 weeks.

DISCHARGE INSTRUCTIONS: Patient is to call for temperature greater than 101.5, pain not controlled with medicine, redness around or drainage from wound. Additionally, patient is to keep wound dry until seen by orthopedics. Activity as tolerated. Diet as tolerated.

Dictated by: Daniel Schwerin, MD

Daniel Schwerin, MD

CHRISTIAN T MINSHALL, MD
Attending

513512 / 30028 /

JOB: 373087

DD: 12/01/07 01:36 PM

DT: 12/04/07 10:26 PM

Additional CC: _____

DOCID: 18233513512

Edited By DANIEL SCHWERIN MD on 12-19-2007 at 08:27:06 AM
Electronically signed by TODD MINSHALL, MD on 01-09-2008 at 03:22:32 PM

Progress Notes

Page: 1

Date Printed: 04/22/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962

SEX: M AGE: 27

12/12/07 : 03:25pm

OUTPATIENT TO INPATIENT TRANSFER FORM
MEDICAL UNIVERSITY OF SOUTH CAROLINA

MUSC



TRANSFER

AMBULATORY CARE SERVICES OUTPATIENT TO INPATIENT TRANSFER FORM REPORT

HECTOR GOMEZ
MRN: 2581962

This is a report of patient condition at time of
transfer and does not represent a complete
patient assessment
(Not to be used for transfers outside MUSC)

DOB: 01/01/51
AGE: 56 year
SEX: male

Clinic: ORTHOPAEDICS - Phone number: 6-8988

PT TO ADMITTING OFFICE TO WAIT FOR AVAILABLE BED WITH FAMILY/FRIENDS PER DR KEITH MERRILL

ADMITTING DIAGNOSIS: RT FOOT INFECTION, S/P AMPUTATION 2ND THRU 5TH TOES

Service: ORTHO

Resident/fellow: ZILKOSKI

Admitting physician: MERRILL

Vital Signs:

Weight: 33.1 kg Isolation: no Allergy band on: YES

ALLERGIES:

PENICILLIN

ADDITIONAL VITAL SIGNS:

TIME	TEMP	PULSE	R	SYS	DIA	INITIALS
	98.8	117		138	83	

Labs drawn/Cultures sent: no

Procedure/Diagnostic tests completed at time of clinic visit: no

Cardiac monitor: no

Respiratory treatment: no

PAIN SCORE TODAY: 4 on 12/12/2007

Location of pain: RT FOOT

Pain intensity on a scale of 0 to 10 (visual analogue scale):

Quality:

What, if any, medication does patient take for pain?

Is pain satisfactorily controlled now? no

INTAKE: none

OUTPUT: none

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Progress Notes

Page: 2

Date Printed: 04/22/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962

SEX: M AGE: 27

Tubes, drains, catheters: none

Dressings: WOUNDS/DRAINS/TUBES/IV SITES:

RN assessment of wound: OPEN WOUND RT FOOT. TISSUE PINK WITH LITTLE DRAINAGE. INTERNAL SUTURES VISIBLE.

Damp to Dry

MEDICATION (given during clinic visit):

Was medication given for pain? no

CURRENT MEDICATIONS: at start of visit:

Rx: OXYCODONE 5 mg 1-2 every 4-6 hours PRN

Medication Reconciliation: reconciled per patient report.

Mental status: alert oriented

Fall Risk: no

Fall risk band on: no

Primary language: Spanish

Valuables:

ID band on: yes

Sensory barriers:

NARRATIVE NOTES/OTHER RELEVANT ISSUES: 11/01/2007 CONSTRUCTION ACCIDENT, HIT IN HEAD BY CRANE. SUBDURAL & EPIDURAL HEMATOMA, SKULL FRACTURE, BILAT FRONTAL CONTUSIONS, RESP FAILURE, MULT RIB FX'S.. ORTHO TO OR 11/30 FOR ISCHEMIC RT FOOT, AMPUTATION 2-5TH TOES.

PATIENT HISTORY:

Active Problems:

ISCHEMIC RIGHT FOOT

Recent Lab Results:

HEMATOCRIT: 37.20 on 12/01/2007

HEMOGLOBIN: 12.0 on 12/01/2007

PLATELET COUNT: 519

TRIGLYCERIDES: 202.0 on 11/16/2007

SODIUM: 137.0 on 12/01/2007

POTASSIUM: 3.30 on 12/01/2007

CO2: 24 on 12/01/2007

BUN: 3.0 on 12/01/2007

CREATININE: 0.7 on 12/01/2007

CALCIUM: 9.4 on 12/01/2007

12/12/07

HGBA1C: 5.5 on 11/02/2007

PT: 15.2 on 11/21/2007

INR: 1.16 on 11/21/2007

Past Medical History -

Social History -

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Progress Notes

Page: 3

Date Printed: 04/22/08

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:27

Family History -

Routine Health Maintenance Status:

REPORT GIVEN TO: Time:
CODE STATUS: Resuscitate

Transfer time: TO ADMITTING OFFICE 1630
Transfer condition at time of admission: STABLE, AMBULATORY
Mode of transport: ambulatory
Accompanied by: Family / friend

RECEIVING NURSE SIGNATURE: _____
Date/Time: _____

RN GIVING REPORT (see Electronic Signature below)

SIGNED BY CHRISTINE M STRANGE, RN (W50) 12/12/2007 04:11PM

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Patcom: 103530309
Admitted: 12/12/2007
Discharged: 12/15/2007
Service: Orthopedic Surgery
Attending: KEITH D MERRILL, MD

Referring:

CHIEF COMPLAINT: Foot pain.

HISTORY OF PRESENT ILLNESS: This is a young gentleman who presents after previously having a TMA secondary to a crush injury who presents with a wound dehiscence. Patient came into clinic today with kind-of foul-smelling open wound. Patient denies any fevers, chills, nausea, vomiting, or diarrhea, however.

PAST MEDICAL HISTORY: Patient had a a subdural hematoma as well as some bilateral frontal contusions with his traumatic injury.

PAST SURGICAL HISTORY: Right 2 through 5 transmetatarsal amputation.

SOCIAL HISTORY: The patient denies smoking.

CURRENT MEDICATIONS: Oxycodone.

MEDICAL ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION: He is alert and oriented in no acute distress. Skin is unremarkable. Lungs are clear. Heart is regular. Abdomen is soft, nondistended, nontender. Foot wound is completely dehisced. It is kind-of foul-smelling. There is fibrinous exudate at this point.

HOSPITAL COURSE: Patient was admitted to MUSC Hospital on 12/12/2007 to the orthopedic surgery service for a diagnosis of wound dehiscence from a previously transmetatarsal amputation. Patient was started on IV antibiotics. On 12/14, patient was consented and taken down to the operating room for an irrigation and debridement of the wound under anesthesia. For full details of this operation, please refer to operative report as dictated. Patient tolerated the procedure quite well. Postoperatively he was taken to the PACU and then to the floor in stable condition. His diet was advanced as tolerated. His pain was controlled on p.o. pain medications. Since the nature of the procedure was relatively minor, the patient did quite well. We felt that he was medically safe for discharge on day of procedure. At time of discharge patient was afebrile. His vital signs were stable. His pain was controlled. His wound was packed and dressed. He was instructed to leave this on until he followed up with Orthopedics in 1 week. Patient's weightbearing status was nonweightbearing to that lower extremity.

DISCHARGE DIAGNOSIS(ES): Wound dehiscence from previous transmetatarsal amputation.

DISCHARGE MEDICATIONS:

1. Oxycodone 5-10 p.o. q.4 hours p.r.n. for pain.
2. Colace 100 mg p.o. b.i.d.
3. Bactrim double strength 160/800 mg p.o. b.i.d.

PATIENT DISPOSITION: Patient is discharged to home in stable

condition. Patient is to follow up with McClennan-Banks Clinic next Wednesday. Patient's weightbearing status is nonweightbearing, right lower extremity. Patient is instructed to do no driving while on pain medications. He may have a regular diet. He is to call for any fevers greater than 101.5, any excessive pain, redness, swelling, bleeding, increased drainage from incision site, any opening or pulling apart of incisions, any other problems, questions, and/or pain medication renewal. Patient may shower if he is able to keep the wound and dressings dry. He is instructed on no soaking wound for 3-4 weeks. Patient is not to change his dressing until followup appointment.

Dictated by: Mark Perna, MD

Mark Perna, MD

KEITH D MERRILL, MD
Attending

747043 / 30028 / 36495
JOB: 375460
DD: 12/14/07 01:51 PM
DT: 12/18/07 09:28 AM

Additional CC: _____

DOCID: 18233747043

Edited By ANN SHULER on 12-20-2007 at 03:50:28 PM
Edited By MARK PERNA on 01-14-2008 at 07:52:13 AM
Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:59 PM

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov



Physician's Statement

Claimant's Name: Hector Gomez-Fragoso Employer's Name: Kade Construction
Physician's Name: Dr. Christopher Morrell Insurance Carrier: Key Risk Insurance Company
Practice/Clinic: MUSC Dept of Orthopaedic Surgery SCWCC File No: 0717524
Preparer's Name: Dr. Christopher Morrell **4MRN: 2581962**
Phone: (843)792-0601

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 11-01-07

Date of first office visit: 2-4-09 Date of last visit: _____

Diagnosis or nature of injury or illness: Cervical radiculitis, Disc protrusion

Body part(s) injured: Cervical Spine Body part(s) affected: Cervical Spine

Date of Maximum Medical Improvement: 12-30-09

Based on the AMA Guidelines, the claimant has sustained a 11 % medical impairment to Whole Person injured body part(s) and a _____ % medical impairment to _____ other affected body part(s).

_____ The claimant is able to return to work without restriction.

☒ The claimant is able to return to work with the following restrictions:

Pain may limit overhead activities with the left arm.

He may perform overhead activities unless symptoms prohibit

_____ The claimant is unable to return to work at his or her current employment.

As of the date I last saw this patient, it is my professional medical opinion the claimant:

_____ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☒ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

Occasional P.T., oral medications, possible injections.

Christopher Morrell M.D.
Treating Physician

2-8-10
Date

Confidential

Page: 1

Date Printed: 02/04/11

Name: GOMEZ-FRAGOSO, HECTOR

ID: 2581962 SEX:M AGE:30

10/30/08 : 00:00am

MUSC NEUROLOGY-INDEPENDENT MEDICAL EVALUATION-RUTLEDGE TOWER
D69

MUSC Department of Neurology
96 Jonathan Lucas Street, Suite 309
PO Box 25060
Charleston, SC 29425

RE: GOMEZ-FRAGOSO, HECTOR

DOB: 10/04/1980

DOS: 10/30/2008

CONFIDENTIAL

IDENTIFYING INFORMATION: Hector Gomez-Fragoso is a 28-year-old single Hispanic male that was involved in a work-related injury who presents for evaluation today. He was referred by Michael Burkett of the law firm Willson Carter Baxley who represent the employer's insurance company in this worker compensation claim. The claimant was accompanied to the evaluation by a translator Gladys Lapietra. The records that I had available for review include handwritten MUSC Trauma Admission notes, the discharge summary from MUSC during the hospitalization from 11/01/2007 through 12/01/2007 and all the associated records. These include notes from Orthopedics, Neurosurgery, Trauma Medicine with doctors, Dr. Hartsock, Dr. Langdon, Dr. Istvan Takacs, Dr. Keith Merrill, Dr. Norcross, and Dr. Minshall. There are serial CT studies. I had a couple of physical therapy notes and a speech evaluation progress note. Outpatient follow-up notes from the same services. I also had notes from George Santos, M.D. from Strand Regional Specialty Associates. The claimant was interviewed with the assistance of the interpreter. The claimant was examined with the assistance of the interpreter. Procedure code 990801. I felt that we had a very good communication between the claimant and myself with the assistance of the interpreter. At the conclusion of the evaluation, the interpreter confirmed my impression. Additionally, the claimant stating that he felt information was understood appropriately by me. He signed an informed consent. The caveat to this entire evaluation is the use of an interpreter and the use of tests that were not in Spanish. Both items can reduce the validity of the findings. In an ideal world, a Mexican born or educated neuropsychologist using urban test norms from Central Mexico City would be ideal. It is possible with the translator and non-standardized procedures that I employed, made the tasks more difficult and artificially lowered the claimants scores, suggesting more impairment than actually exists. Of course, the reverse is also possible. In an effort to reduce the confounding effects of the language barrier, I chose primarily nonverbal tests whenever possible and note the above caveat.

HISTORY: The claimant provided the following history. He stated that he was involved in a work-related accident that occurred on 11/01/2007. We were able to determine that this was a Thursday after the lunch hour. He was working for Kane Construction where he had been employed as a laborer/carpenter helper for approximately one year. He was making about \$11 an hour. He was amnesic for the accident. He said the last thing that he remembered was that he was on top of a garage working on installing the gables for the roof of the one story garage. The next thing he remembers was waking up at MUSC as an inpatient. He said that he was told that a cable broke and he sustained a crush injury to his head and leg. He said that he was also knocked down one story falling to the ground. He stated that he was transported to MUSC via helicopter. He thought that he was in hospital for approximately one month and possibly woke up about midway into the course and estimated about 15 days after the accident. He said that he had injuries to his head and right foot. On his right foot, four toes were amputated. He said that he also injured his neck and left shoulder. He said that his seventh vertebra is "pointing out." He had a trach.

In terms of today's symptoms Mr. Gomez complains that it is hard for him to remember where he puts things. He complained of pain in his neck and left shoulder. He said that he has hearing loss especially on the left. He complains of occasional blurry vision. He described what sounded like phantom pain in his amputated toes. He also described pain in his left arm with occasional paresthesias in his hand. He complained of headaches. He described being anxious with mood swings. He complained of difficulty swallowing. He complained of a change in his gait because of the amputation. He rated his pain on average as an "8" on a VAS. He said that nothing triggers the pain and it seems to come out from nowhere. He gets relief by laying down. He said on some days he might not have pain and other days he might be in extreme pain. There has been no improvement in the pain symptoms over time.

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Confidential

Page: 2

Date Printed: 02/04/11

ID: 2581962 SEX:M AGE:30

Name: GOMEZ-FRAGOSO, HECTOR

In terms of treatment he has been on Neurontin and methocarbamol that he receives from Dr. Santos. He said the medicines help with the pain for a while, but then the pain returns. He said that he has been offered cortisone shots for his shoulder, but has declined.

In terms of the mental confusion, he feels that his condition is getting worse over the time. He complains of forgetfulness. When I asked about the functional impact of his forgetfulness, he said that he has trouble remembering conversations and occasionally has difficulty pronouncing words. I pushed him for other examples, but he had difficulty coming up with any specific complaints. Instead he talked about headache pain, other pains, and feelings of anxiety and depression that are getting worse over the time.

In terms of daily activities Mr. Gomez said that he mostly stays around the house and watches television. He does light housekeeping, socializes with friends and does some cooking. He is living on \$266 a week and shares expenses with his house mates who are his cousins. He has not been back to work and has not made any attempts. He said that he feels that he is not capable of returning to work. When I asked about the barriers, he said that he speculated that he might forget measurements if he were asked and that he might do something wrong. He said his feet and back get tired when he is standing for a long time and this might interfere with his ability to do manual labor. He also said that he feels pain if he stands for too long, especially in his foot. When I asked, he also admitted to having difficulty with balance and dizziness and thought this too might interfere with his ability to work. He did not know if he had any work-related restrictions from his doctor.

The claimant said that all of his followup has been with MUSC doctors and then with Dr. Santos. Now he only sees Dr. Santos perhaps on a monthly basis and is being prescribed the two medicines noted above.

In my review of the medical records, I have handwritten notes from initial Trauma Center evaluation. The above injury is described. Intubation was attempted by EMS, which was unsuccessful and then the aircrew was able to intubate the patient enroute on the helicopter. In the acute ER notes, there is a question of somebody smelling alcohol on his breath. I did not see any blood alcohol levels drawn. There is a reference to loss of consciousness at the scene and no Glasgow scores at admission.

I was unable to get the entire inpatient MUSC chart. The MUSC discharge record indicates an admission from the Trauma Service on 11/01/2007. the patient was hospitalized for one month from 11/01/2007 through 12/01/2007. Loss of consciousness and significant blood loss was noted at the scene. Marion County EMS was unsuccessful at intubation, but he was successfully intubated by Carolina LifeCare Helicopter Transport team. He is admitting diagnosis was skull fracture, open complex scalp wound with epidural and subdural hematoma, and bilateral frontal contusions. Acutely he had a CT scan of the abdomen that showed adrenal hemorrhage, bilateral L1 and L2 as well as right L3 transverse process fractures and multiple posterior rib fractures. A CT of the pelvis on 11/01/2007 showed a high density structure of uncertain significance. The CT of the head on 11/01/2007 showed comminuted fracture with small extra occipitoparietal hematoma at the midline at the vertex, worrisome for small epidural hematoma. CT of the chest showed bilateral lung contusions and/or aspiration. He had a fracture of his right clavicle and C7 and T1 spinal process fractures.

Neurosurgery and Orthopedics followed the patient during his protracted hospital stay. His final discharge diagnosis was subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypertension, scalp laceration status post repair, C7 and T1 spinous process fractures, right rib fractures at 7, 8, 9, and 10, bilateral transverse process fractures at L1 and L2 and right L3, right big toe fracture, right fifth toe fracture, fracture of the skull midline to sagittal through the frontal and parietal, placement of PEG tube, tracheostomy, and status post amputation of two through five toes.

Steve Takacs, M.D. saw him on 11/01/2007 and described him as combative at the scene with vomiting. He was trached at the time and Glasgow Coma Scale was 8/10. He had a number of procedures as noted above during his hospitalization. A CT on 11/07/2007 was indicated because of altered mental status and compared with prior studies. A collection of fluid adjacent to the vertex and extensive left-sided frontotemporal soft tissue swelling was noted. A fracture of the left frontal bone extending to the sagittal suture was noted as unchanged. Ultimately, he was discharged home on 12/01/2007.

Orthopedics had a follow-up on 12/12/2007 and there was significant wound breakdown and concern of infection, so he was readmitted for irrigation and debridement. He had an outpatient follow-up on 12/17/2007 with Trauma/Critical Care

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Name: GOMEZ-FRAGOSO, HECTOR

and was described as having had made "remarkable neurologic recovery." In the exam he was described as awake, alert, and oriented. Because of the severity of his injuries he was told to follow-up with Neurosurgery. The PEG tube had been pulled. He was given Lortab by Dr. Norcross. Orthopedics saw him two days later for the initial follow-up and there was some confusion about changing the dressing. With the interpreter's help he was taught to change his dressing daily.

Mr. Gomez saw Dr. Takacs on 01/16/2008 and he was described as having a skull fracture with a small thin rimmed subdural hematoma in the right frontal parietal region. At this visit, his Glasgow Coma Scale was 15/15 and he was oriented times 3. The latest CT showed a thin rim without mass effect in the right frontal parietal region. Dr. Takacs felt that he had no basic neurologic sequelae and he was released.

The final follow-up visit at MUSC with Orthopedics was on 09/17/2008 and Mr. Gomez was complaining of phantom limb pain, as well as difficulty with gait and balance because of the amputation. Prostheses or inserts were discussed and Neurontin was suggested for the pain.

There is a speech eval from 11/21/2007 as an inpatient. Pertinent information included possible mental confusion as he was only able to follow one step commands and could not adequately hold the pencil in the right or left hand in order to copy name or identify pictures scoring 1/3.

On 08/29/2008 the claimant had a follow-up with Dr. Santos. Complaints at that time had to do with severe and persistent headache, dizziness, neck pain, shortness of breath, difficulty swallowing, difficulty with attention and concentration, difficulty with complex tasks, irritability, and the amnesia that was described above. MMSE was 28/30. His neurologic exam was negative except he lurched forward with his gait. Tests were ordered. His MRI from 10/17/2008 was read as normal suggesting structural resolution of the above acute CT findings. Nerve conduction and EMG studies were negative. Evoked potential was negative. His EEG was within normal limits. Cervical studies were significant for a disk protrusion at C4-5 and 5. A neuropsychological evaluation was ordered.

PAST MEDICAL HISTORY: Per the claimant largely unremarkable. He said that he had kidney stones in 2003. Before the accident he denied any history of a prior head trauma, pains, depression, and anxiety. He denied any significant alcohol or other substance abuse.

MEDICATIONS: Neurontin, methocarbamol.

FAMILY HISTORY: The father and mother were described as alive and well. He had two brothers that were described as alive and well.

SOCIAL HISTORY: The claimant stated he was born and raised in Mexico City. He said that he repeated the second grade. He finished the ninth grade and was unable to tell me if this was the US equivalent of high school. He joked that he did poorly in English, but excelled with typing. He reported that he had been in the US for five years and came to the Myrtle Beach Area because he had cousins that preceded him. In Mexico, he had worked as a clerk in a pharmacy and as a guard for private security. In the US, he worked in a construction industry as a carpenter assistant. His original plan was to come to the US "for a while" and then return to Mexico. His current plans are up in the air with the health and legal situation outstanding. His immediate family lives in Mexico and his extended family in Myrtle Beach and includes a cousin and uncle. Prior to the injury he played soccer. He has had to quit because of gait disturbance and I presume pain.

PHYSICAL EXAMINATION: Weight 191. Blood pressure 140/77. Pulse 77. The patient was ambulatory, spry, and had largely a flat affect. He was cooperative with evaluation and forthcoming with information. He showed me a scar on his forehead that was visible through his hairline. He passed the effort test on the second trial. His MMSE was 28/30, which is in the normal range and consistent with a prior study by Dr. Takacs on 11/01/2007. On all of the nonverbal items from the WAIS-III his scores were impoverished and possibly consistent with his educational/vocational background. His estimated an overall index score was 68. On an arithmetic subtest from the WRAT, he had a similar score and did not know how to approach some of the more complicated arithmetic problems reflecting his academic achievement. He had psychomotor slowing on Trails A and C, but scored in weak-normal range for the more cognitively difficult Trails B test. On a visual memory test, he actually scored in the normal range. For simple vigilance he passed the test with a perfect score, but failed the more difficult task of distractibility. He endorsed moderate-to-severe pain in areas described in the history that included his head, neck, shoulder, and left foot. He reported that the pain is generally extreme, causing functional limitations, and reported that the pain adversely affects his mood. He was unable to understand the Likert

Confidential

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Date Printed: 02/04/11

ID: 2581962 SEX:M AGE:30

Name: GOMEZ-FRAGOSO, HECTOR

Scale and was given a true-false mood inventory to assess his mood. He scored in the extreme range with 27/30 positive and his is consistent with severe depression. He denied any suicidal ideation or attempt.

IMPRESSION:

1. Postconcussive syndrome, mild.
2. Chronic pain disorder.
3. Situational depression.

DISCUSSION: Mr. Gomez had a very serious work-related injury resulting in trauma to his body and skull. He had a skull fracture with acute underlying minor structural change to the the brain. Follow-up structural and functional studies (i.e. EEG, CT and MRI) have been read as unremarkable demonstrating structural resolution of the work-related injury. He has persisting cognitive complaints. While he has had excellent neurologic recovery, it is probably that he is exhibiting symptoms of postconcussive syndrome. The cognitive findings while mostly normal, do contain abnormal findings largely in the domain of complex attention and concentration. In addition, he may have some element of decreased intellectual efficiency, although this was not measured. I do not think that the severity of his cognitive deficits represents a major barrier for return to work, especially manual labor. Additionally, he does have findings positive for situational depression and pain are also contributing to his functional disability.

In terms of recovery, Mr. Gomez is most likely at maximum medical improvement in terms of his neurologic/brain status. Fortunately, his cognitive deficits are relatively mild. Pain, dizziness, and balance will probably be the major limiting factor for his capacity to return to manual labor, but I would defer to his neurologist about work-related restrictions in this domain.

The most treatable aspect of the claimant's current syndrome is pain and depression, but unfortunately he has been variably noncompliant with his medications. Something like Cymbalta or another SSRI might double for treatment of both mood and pain related problems. Compliance with this type of treatment may reduce some of his functional disability.

Mark Wagner, PhD
Clinical Neuropsychologist
Associate Professor of Neurology

MW/am1251
dd: 10/31/2008
dt: 11/01/2008
JobID: 760927

cc:Mr. Michael Burkett, Willson Jones Carter Baxley LLC, 501 Wando Park Boulevard, Mount Pleasant, SC 29464

THIS NOTE IS CONFIDENTIAL

SIGNED BY MARK WAGNER, Ph. D. (ATTENDING) (D69) 11/04/2008 11:47AM

SUMMARY SHEET	Test Date: 10/30/2008	
Name:	Hector Gomez-Fragoso	
MRN:	2581962	
Age:	28	
Education	9	
Handedness	Right	
WAIS-III		
	IQ Score	%ile
VIQ		
PIQ	68	2
FSIQ		
Subtests	Scaled Score	%ile
Vocabulary		
Similarities		
Arithmetic		
Digit Span		
Information		
Comprehension		
Letter Number Sequence		
Picture Completion	5	5
Digit Symbol	6	9
Block Design	4	2
Matrix Reasoning	5	5
Picture Arrangement		
Symbol Search	8	25
Object Assembly	5	5
WMS-III	SS	%ile
Spatial Span	6	9th
CERAD		
MMSE	28/30	
Gordon CPT	Raw	%ile

Vigilance Correct	30	72
Vigilance Commission	0	68
Distractability Correct	14	0
Distractability Commission	2	50
TOMM	Raw	
Trial 1	42	fail
Trial 2	47	pass
WRAT Arithmetic	Raw	Standard Score
Total Correct	31	73 (5th grade)
Trail Making Test	Raw	T
Part A	49	31
Part B	100	41
Part C	42	36
Geriatric Mood	Total Score	
	27	/30

Brief Visuospatial Memory Test	Raw	T	%ile
Trial 1	8	55	69%
Trial 2	10	52	58%
Trial 3	11	52	58%
Total Recall	29	53	62%
Learning	3	46	34%
Delayed Recall	11	56	66%
Percent Retained	100%		<16th%
Recognition Hits	6		>16th%
Recognition False Alarms	6		<1st%
Recognition Discrimination Index	0		<1st%
Recognition Response Bias	0.93		<1st%

Pain Questionnaire	Raw	Label	
Total Pain-Related Impairment Score	44	Moderately severe impairment	

Patient: Gomez-Fragoso, Hector
DOB: 10/4/1980 Age: 28.0
Height: Weight:

ID: A81323-1
Gender: Male
BMI: —

Physician: Dr George Sandoz
Referring Physician: Dr George Sandoz

Technician: K

Recording Date: 10/2/2008 Time: 4:32 PM
Recorded Time: 2481.6 min. (41.4 hrs.)

Report Date: 10/5/2008

:
Syncope/paresthesia/vertigo

:
THIS IS A 24 HOUR AMBULATORY EEG RECORDING. A baseline EEG was performed prior to the patient leaving the office. Photoc stimulation and hyperventilation were done. There were no reported episodes.

EEG REPORT

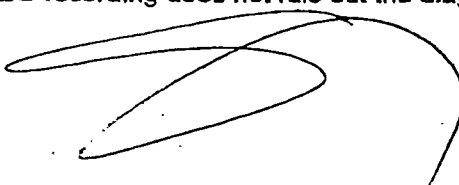
GENERAL DISCRIPTION: This was a 19 channel awake and sleep sleep extended EEG recording with international 10/20 electrode placements. The background activity consisted of symmetrical, posterior dominant, medium amplitude 9-12 Hz Alpha. These activities were symmetrical. No significant slow wave activity was noted. No significant fast activity was noted.

ACTIVATION & SLEEP: Symmetrical attenuation of the background activity with eye opening was noted. Hyperventilation produced no significant changes to the background activity. Photoc stimulation produced no significant changes to the background activity. Deep sleep (stage III & IV) was noted by a decrease in sleep spindle activity and an increase in amplitude of theta and delta activity.

OTHER DATA: No event presses noted, no seizure, no ictal activity, no slowing present in this study.

CLINICAL IMPRESSION:

This EEG is within a wide range of normal limits. No focal abnormality or seizure discharges were noted. The above mentioned EEG Variants have unknown clinical significance. The absence of epileptiform discharges during the EEG recording does not rule out the diagnosis of a seizure disorder.



Dr George Sandoz

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5141659

MRN: 002581962
Date Exam Completed: 01/16/2008 09:59
Last Update: 01/17/2008

EXAMINATION: CT of the Brain 01/16/08 09:59:00

ACCESSION NUMBER: 5141659

INDICATION: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS, FRONTAL CONTUSION, SKULL FRACTURES, ASSESS STABILITY

COMPARISON: Head CT 11/7/07

TECHNIQUE: Multiple contiguous axial CT images of the head were performed without IV contrast.

FINDINGS: There is no evidence of new hemorrhage or extra-axial fluid collection. There are no signs of acute infarct. There has been interval resolution of previously visualized left parietal and right temporoparietal soft tissue swelling. Again seen are skull fractures with extension into the sutures as described on prior CT. The fracture do appear to have some healing, but the fracture lines are still present. There's been interval on clearing of the paranasal sinuses with no significant mucosal thickening or fluid levels identified. The orbits are unremarkable.

IMPRESSION:

1. No evidence of acute intracranial process.
2. Healing skull fractures.

DICTATED BY: Dr. CHRISTOPHER MOSES
I have reviewed the images and agree with the findings in this report.

History: 27 Y/O MALE WITH S/P TRAUMA/HEMATOMAS,FRONTAL CONTUSION,SKULL FRACTURES

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Page: 1

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5141659

MRN: 002581962
Date Exam Completed: 01/16/2008 09:59
Last Update: 01/17/2008

Technologist: VALARIE RADCLIFF
Interpreter 1: ZORAN RUMBOLDT
Interpreter 2: CHRISTOPHER MOSES
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: ZORAN RUMBOLDT
Date Authenticated: 1/17/2008

Transcribed by: Tech IntTalk

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Physician's Statement

Claimant's Name Hector Gomez-Frausto

Employer's Name: Kade Construction

Physician's Name: Dr. Kyle Shane Wolfe

Insurance Carrier: Key Risk Insurance Company

Practice/Clinic: MUSC Dept of Orthopaedic Surgery

SCWCC File No: 0717624

Preparer's Name: Dr. Shane Wolfe

Phone: (843) 792-1168

MRN: 2581962

The undersigned physician has been authorized by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to §§42-15-60, 42-1-172 or 42-11-10.

Date of Injury or Illness: 11-01-07

Date of first office visit: _____

Date of last visit: 6/29/9

Diagnosis or nature of injury or illness: Transmetatarsal (R) amputation

Body part(s) injured: (R) foot Body part(s) affected: (R) LE

Date of Maximum Medical Improvement: 6/29/9

Based on the AMA Guidelines, the claimant has sustained a 40 % medical impairment to 1 (RLE) injured body part(s) and a 1 % medical impairment to Left Shoulder other affected body part(s).

☐ The claimant is able to return to work without restriction.

16% wt + 1% wt = 17%

☒ The claimant is able to return to work with the following restrictions:

No Climbing > 6 steps; use safety equipment.

☐ The claimant is unable to return to work at his or her current employment.

17% = combined value
Rating for foot!

As of the date I last saw this patient, it is my professional medical opinion the claimant:

☒ will not need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ will need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

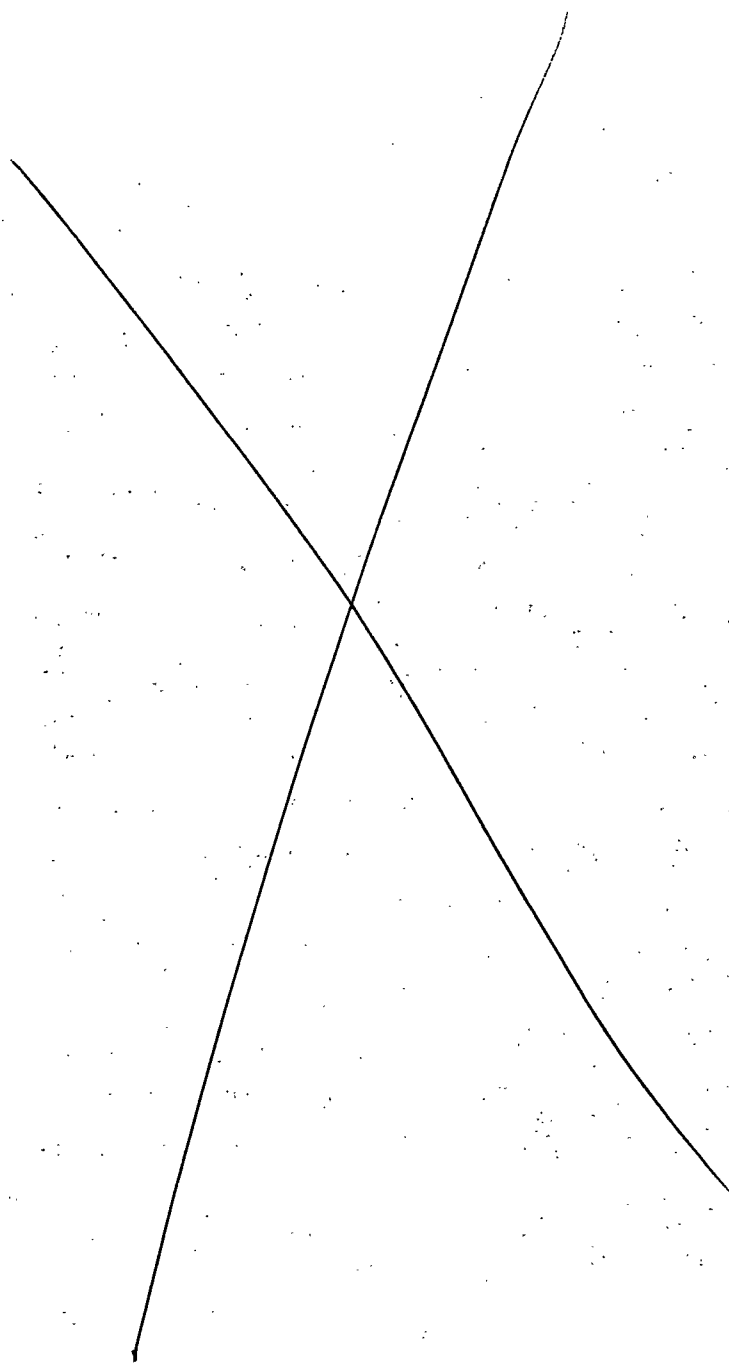
Shoulder based on whole person %age for each + use of combined value table.

Treating Physician

Date

[Signature]

4/8/10





Southern Reporting, Inc.

Transcript of the
Deposition of

George M. Sandoz, M.D.

8/6/2010

Fragosa vs. Kade Construction, LLC, et al.
0717624

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SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. File No. 0717624.

Hector G. Fragosa, :
Claimant, :
vs. :
Kade Construction, LLC, :
Employer, :
AND :
Key Risk Management Services, :
Inc., :
Carrier/Defendants. :
:

Deposition of GEORGE M. SANDOZ, M.D., taken before
Michele E. Starkey, Court Reporter and Notary Public in
and for the State of South Carolina, commencing at
the hour of 1:29 p.m., Friday, August 6, 2010, at
Strand Regional Specialty Associates, 8170 Rourk
Street, Myrtle Beach, South Carolina.

Reported by
Michele E. Starkey

8/6/2010

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APPEARANCES

For the Claimant:

Jeffrey C. Chandler, Esq.
Chandler Law Firm
2501 Oak Street
P.O. Drawer 1889
Myrtle Beach, SC 29578

For the Employer/Carrier:

Michael W. Burkett, Esq.
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, SC 29209

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EXHIBITS

There were no exhibits marked during this deposition.

STIPULATIONS

It is stipulated by and between counsel for the respective parties that all objections are reserved until the time of trial, except as to the form of the questions.

This deposition is being taken pursuant to the South Carolina Workers' Compensation Act and all applicable rules.

- - - -

The reading and signing of this deposition is waived by the deponent and counsel for the respective parties.

Whereupon,

GEORGE M. SANDOZ, M.D., being duly sworn and cautioned to speak the truth, the whole truth, and nothing but the truth, testified as follows:

EXAMINATION

BY MR. BURKETT:

Q Dr. Sandoz, my name is Michael Burkett and I represent the employer and its insurance carrier in this workers' compensation matter.

A You got it.

Q Have you had your deposition taken before?

A Yes, I have.

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1 Q And you understand the testimony you're going to
2 give today is sworn testimony just as if you were
3 testifying at a hearing for this matter?

4 A Yes, I'm aware.

5 Q And in fact, in workers' compensation, this
6 testimony will actually be your hearing testimony.
7 Are you aware of that?

8 A No, I wasn't, but okay.

9 Q Now you are. Okay, good. Just briefly, you're a
10 board certified neurologist?

11 A Yes, and ophthalmologist.

12 Q And ophthalmologist, okay. And how long have you
13 been in private practice here in Columbia -- I mean,
14 in Myrtle Beach?

15 A Myrtle Beach have been twelve years.

16 Q Twelve years? And how long have you been private
17 practice in general?

18 A Twelve years.

19 Q Twelve years, okay.

20 A I finished out my training in June of '98 and have
21 been in practice July '98 here in this practice.

22 Q All right. And just to make sure we establish this
23 for the record, it's my understanding you are fluent
24 in Spanish; is that correct?

25 A That's correct.

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George M. Sandoz, M.D.

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1 Q And that's probably, sounds like your native
2 language. Is that right?

3 A Yes, that's --

4 Q So did you have any trouble communicating with Mr.
5 Fragosa in this claim?

6 A No.

7 Q Okay. Basically want to talk to you a little bit
8 about the condition. You have diagnosed him with a
9 traumatic brain injury; is that correct?

10 A That's correct.

11 Q And it's my understanding that traumatic brain
12 injury is as a result of the blow he received to the
13 head which actually included a skull fracture; is
14 that correct?

15 A That's correct.

16 Q And the skull fracture itself is basically just a
17 break in the skull bone. Like if I were to break my
18 arm, I'd break the bone in my arm; you have a skull
19 fracture, you break your skull bone. Correct?

20 A Yes, it's a little bit more harder because the bone
21 is called -- it's protected a little bit more vital
22 organ, in this case the brain, so the force that it
23 need to go and inflict is much higher than let's say
24 for your hip.

25 Q Right.

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1 A Or your arm.

2 Q Okay. And but in this case, the records do not
3 indicate that it was a -- that there was no
4 indication of a depressed skull fracture; is that
5 correct?

6 A No. Basically appear to have just cracked open.

7 Q Just cracked open, all right. And just so we all
8 understand, the depressed skull fracture would
9 actually be where the -- some of that bone fragment
10 actually pressed into the brain itself?

11 A Well, or the architect of the bone is depressed.

12 Q Okay. All right. But no surgical intervention
13 required to repair the skull fracture in this case?

14 A That's correct.

15 Q All right. And the last note that I believe we all
16 have from you, as far as treatment dates for Mr.
17 Fragosa, is August of 2009. Does that sound
18 accurate to you, according to your records?

19 A 2009. Give me one second, I tell you. 12th of
20 August of '09, that's correct.

21 Q Okay. And you haven't seen him since then?

22 A No, he has not been seen since then.

23 Q Okay. And your -- if we look at -- do you have that
24 report in front of you, Doctor, or do you need my
25 copy?

1 A No, I do have -- sorry. I have everything is
2 electronic. We have electronic medical records and
3 I have, while I'm looking at the computer, it's --
4 I'm look at the notes.

5 Q All right, that's fine. I just want to make sure.
6 If you look at the August 12, 2009 note, where in
7 the section for physical exam.

8 A Yes.

9 Q And the subsection of neurological?

10 A Uh-huh.

11 Q You note "the level of consciousness is normal,
12 orientation is alert and oriented, memory is intact,
13 cranial nerves are intact. Motor reflexes, normal;
14 facial, normal." Looks like his hearing was normal.
15 For the most part, a normal neurological exam; is
16 that correct?

17 A Except that he has -- the test is where we testing
18 his inner ear function is lateralized into the left.

19 Q Okay.

20 A That's the damage -- that suggests that the inner
21 ear, the -- you have two inner ears. The one on the
22 right is damaged so he doesn't hear from that, and
23 that's the area that is damaged, so when you place a
24 tuning fork and give you a pitch sound, he's only
25 hearing on the left and not on the right; meaning

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1 that the right inner ear is damaged.

2 Q Okay. Is that from the accident or from something
3 else?

4 A That is from the accident.

5 Q From the accident. All right.

6 A Or directly related to the accident.

7 Q And just by way of explanation, how is that related
8 to the accident, the damage to that inner ear?

9 A At the time the concussive injury that the patient
10 had suffered had created an inner ear damage.

11 Q Okay. I was looking, for example, if you can just
12 look at the May 19, 2009 note, and tell me when you
13 have that in front of you and I will ask you the
14 questions.

15 A May 19. You got it.

16 Q Okay. I was looking, unless I'm missing it here,
17 under the neurological -- in the physical exam and
18 neurological, I don't see acoustic listed there. Am
19 I missing it?

20 A Got it. No, it wasn't --

21 Q Is it something you test every time or just --

22 A Not all the time.

23 Q Okay.

24 A I mean, I know that the guy had an inner ear damage,
25 and I test if he complains, or like in this case,

1 the September was just to give him an impairment
2 rating, or a more significant --

3 Q Right. Now, one of his other complaints that
4 appears to be fairly consistent, and correct me if
5 I'm wrong, throughout the claim or throughout your
6 treatment with him has been some dizziness; is that
7 correct?

8 A That's the dizziness, exactly.

9 Q And some headaches that come -- that sometimes are
10 more consistent than other times; is that right?

11 A Exactly, that's correct.

12 Q Even though in your August 12th -- I'm just curious
13 about this. In your August 12th, 2009 note that we
14 looked at a minute ago, you've noted memory was
15 intact, and in your clinical assessment, you note
16 mild or moderate memory loss.

17 A Exactly. When I said, you know, he's alert and
18 oriented times three and intact, is like you ask him
19 what day is it, the place, and the name. Those are
20 the three things, but for anything more complex, you
21 know, no, I don't ask him all the time so that's why
22 I said it's alert and oriented times three.

23 Q Okay, now --

24 A And those are the three things that I ask him,
25 what's your name, what's your date of birth, what --

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1 sorry. What day is today, and what's the place that
2 we are.

3 Q All right. Now, when we talk about the clinical
4 assessment things he reports to you when he sees
5 you, the dizziness and the headaches, when you put
6 those in your report, those are things we can't test
7 for; is that right? We're relying on the subjective
8 complaints of the patient?

9 A Yeah, the suggestive complaint of the patient and
10 the history that he had presented with.

11 Q And that would be -- those complaints would be
12 consistent with the post concussive --

13 A After the effects of the trauma that he suffer in
14 his head, yes, that's correct.

15 Q All right. Same thing with memory loss? Do you
16 rely on his subjective information or do you
17 actually test for that memory loss?

18 A Well, I tested some of that, you know, I give it
19 where and ask him and what he does. One of the
20 things that has always been asked about this one was
21 to do a neuropsych evaluation, a neuropsychological
22 evaluation, but to determine, you know, if this is
23 something that is really directly related or not.

24 Q Right. Okay. But as far as your concern that
25 headaches and dizziness and that moderate memory

1 loss, those are the results of that -- do I call it
2 post concussive symptoms?

3 A Traumatic brain injury.

4 Q Okay. All right. Now, let's look at -- you wrote
5 two notes; one was August 20, 2009, and one is June
6 3, 2009.

7 A Sorry, one is --

8 Q We'll do August 20th first.

9 A September, give me one second. August 20th, 2009,
10 yes.

11 Q All right. And I'm going to start with this one
12 first only because I was looking at all of this and
13 my interpretation is there might be a little error
14 here but I just want you to tell me if I'm right or
15 wrong.

16 A Okay.

17 Q You reference the fifth edition and table 13-5 --
18 the fifth edition of the AMA Guidelines in table
19 13-5.

20 A Yes.

21 Q Now, 13-5 is the table for dementia.

22 A Well, that's the only thing that I have available
23 for him to go and do the injury.

24 Q Okay. Well, and the reason I ask, because in the
25 June 3rd, 2009 note, you've got one on the screen,

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1 you reference the sixth edition of the guidelines
2 and table 13-8, which measures the mental status,
3 cognition, highest integrative function.

4 A Exactly.

5 Q Is there -- I know there's a difference because the
6 books are different.

7 A That's correct.

8 Q This one on the June 2009 report, you basically put
9 him in class two which is, you know, a moderate
10 category basically.

11 A Uh-huh.

12 Q Is that still accurate? Was there a reason you went
13 to the fifth edition? I'm trying to distinguish
14 between the two of them.

15 A Just because, you know, when I get like in June, I
16 have now that one, in August, I had this one only.

17 Q Okay.

18 A So that's the only reason.

19 Q Is the -- since the June -- since the sixth edition
20 actually gives you a bigger range where you can test
21 alteration of mental status, cognition, highest
22 integrative function, is the June one probably the
23 more accurate assessment since it gave you better
24 guidelines to go by, or what would you say?

25 A Doesn't really matter, it's just by the edition.

1 Q Okay. All right.

2 A You know, this year we're going to go and do this
3 part, I go do the assessment, and when I do the
4 assessment at one time, it's -- this was available.

5 Q All right.

6 A And when I do the other one, it's the other one
7 available.

8 Q I got you. Now, would you agree that -- do you
9 still stand by the two reports, even though you're
10 using two different books? You still agree with
11 both of those reports?

12 A Yes.

13 Q Okay. And just for the record, for the sixth
14 edition, we can submit this later, it says
15 alteration in mental status, cognition, highest
16 integrative function that interferes with the
17 ability to assume some normal roles or perform
18 activities of daily living. Is that --

19 A That's correct.

20 Q -- a fair assessment of Mr. Fragosa? All right.
21 Now, we've arrived at this because of what you
22 called traumatic brain injury, correct?

23 A That's correct.

24 Q As far as physical findings on his brain, if you
25 were to look at scans, is it fair to say there is no

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1 physical damage to the brain that we can see; is
2 that right?

3 A There's no evidence of any damage on the brain that
4 we can go and see, that's correct.

5 Q Okay. So what we're dealing with here are these --
6 the traumatic brain injury, and sometimes I like to
7 call it because I don't know what else to call it,
8 but I see it often, is the post concussive
9 syndrome --

10 A Got it.

11 Q -- which is the same thing.

12 A This is not a concussion, this is an injury suffered
13 to the brain.

14 Q Injury suffered to the brain.

15 A That's why traumatic brain injury is the preferred
16 term.

17 Q What's the difference between the jar that a brain
18 takes in a concussion and what he may have had?

19 A The concussion should resolve.

20 Q Okay. So we're looking at -- so we call it
21 traumatic brain injury because it's a longer period
22 of time?

23 A Because there's been some damage and injury to the
24 function of the brain.

25 Q And we're aware of that because of --

1 A The history that he gives, the findings that he had
2 initially, and the clinical presentation that he
3 has.

4 Q Right, and that clinical presentation today is still
5 the moderate memory loss, the dizziness, the
6 headaches?

7 A The headaches.

8 Q All right. But just to clarify again, as far as the
9 physical damage to the brain, physical, something we
10 can physically see on a scan, CT, MRI or anything
11 else, we're not going to see anything; is that
12 correct?

13 A Not in this case.

14 Q Okay. All right. As far as ongoing, you haven't
15 seen him since August, was he on any medications
16 when you released him or can you tell?

17 A Initially had placed him on medications but he has
18 been for loss to follow up. Some of the medications
19 that he has were used for the treatment of pain,
20 and -- and that is going into the cervical spine
21 therapy, and I've been giving him for the treatment
22 of the headaches that he has, so I haven't seen him
23 since then.

24 Q All right.

25 A I don't know why, and I don't know why he has not

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1 presented.

2 Q Okay. Can you tell from your notes whether he's
3 called in for any refills or anything? I don't
4 think he has and I think he told me that, I'm just
5 checking with you.

6 A The last, you know, contact that I have with any of
7 them is the case nurse manager in 8/24.

8 MR. BURKETT: Okay. I don't have anything
9 else.

10 EXAMINATION

11 BY MR. CHANDLER:

12 Q Just want to ask you about the MRI findings, Dr.
13 Sandoz.

14 A Right.

15 Q You did one and it was -- you ordered one and it was
16 conducted on September 16, 2008. What is
17 significant at all about findings of severe
18 mastoiditis?

19 A Well, that's the part of the injury that he has
20 suffer and that's why he's dizzy.

21 Q Okay. So when the radiologist notes that he has
22 severe right mastoiditis, that's telling us what
23 about the injury to the brain?

24 A That suggests that he had an injury to his head, and
25 if you look, you know, there's also within the

1 dictation or within the body of the findings, in the
2 last paragraph, and it says sensitivity of the
3 artifact of the subcutaneous tissue of the left
4 skull could be from prior trauma.

5 Q What is artifact telling us?

6 A That there is some -- that there is things that
7 shouldn't be there because motion, metal, movement,
8 and it said that there is non-seen that will suggest
9 intracranial hemorrhage, but it doesn't mention
10 anything of sheer injury or what they call basically
11 damage to the brain in the more diffuse manner.

12 MR. CHANDLER: Okay. Do you --

13 MR. BURKETT: I don't have -- well, I
14 probably do but it's easier for me to look over your
15 shoulder. Do you have --

16 MR. CHANDLER: I don't have any other --
17 well, you know what, I do have a few.

18 Q I just wanted to clarify the one point about the MRI
19 studies because I thought there was an acute
20 finding.

21 A Exactly. This is after the, what do you call it,
22 this is here. Then he had done other testing at
23 MUSC.

24 Q Let me ask you some questions, Dr. Sandoz, about Mr.
25 Gomez Fragosa's cognitive deficits.

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1 A Uh-huh.

2 Q You believe that the traumatic brain injury has
3 affected Mr. Fragosa's ability to return to
4 employment?

5 A To gainful employment, yes.

6 Q Okay. I believe the history that this guy gave you
7 was that he was a construction worker and he was
8 injured in the construction-related accident. Is
9 that your understanding?

10 A That's correct.

11 Q Based on the condition that he has now and the
12 limitations that he has, do you believe that he can
13 return to any kind of former construction-related
14 employment?

15 A No, I don't think he will be able to.

16 Q Okay. Would --

17 A The reason being is because -- not only because of
18 the traumatic injury, I don't think he's able to
19 follow any type of commands, but the most
20 significant change is the inner ear injury that he
21 suffer which is making him unsteady, so any type of
22 high work or ladder or scaffold is out of the
23 question.

24 Q Okay. Is it your opinion to a reasonable degree of
25 medical certainty that he will need to take

1 medications for life to control his condition?

2 A With a certain degree of medical certainty, I
3 believe that the patient will require to take
4 medications on a permanent basis to control the
5 symptoms that he has.

6 Q Okay. Will he need to have periodic neurological
7 office visits and/or diagnostic studies to kind of
8 monitor his condition?

9 A That's correct.

10 Q Okay. Periodic blood work to see how the
11 medications are affecting his body overall?

12 A Yes. That's correct. Sorry.

13 MR. CHANDLER: I don't have any other
14 questions.

15 RE-EXAMINATION

16 BY MR. BURKETT:

17 Q Doctor, I'm looking back at this September 16, 2008
18 MRI study. Explain again, mastoiditis indicates
19 that there -- you could tell -- is that the
20 radiologist picking up on the actual old skull
21 fracture or is that something else?

22 A No, this is new. The old skull fracture was on the
23 left side. All the -- you know, the brunt of his
24 trauma was in the left side so this injury to the
25 brain, because it's kind of like a solid mass, can

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1 transmit the energy on the -- of the impact of the
2 bang to the opposite side. So said you hit here,
3 sometimes the injury that you suffer is in the
4 opposite side.

5 Q Okay. So that's my question. What exactly is the
6 mastoiditis?

7 A The mastoid is, if you imagine the skull, it will be
8 too heavy if you make it solid bone, so there is the
9 mastoid process like the one that is behind the ear
10 that is full of caverns so it make it lighter, the
11 mastoid.

12 Q The skull itself?

13 A It's part of the skull.

14 Q Part of the skull?

15 A The temporal bone -- sorry to technical -- the
16 temporal bone has a, you know, has like a con --
17 like a wave. It has the mastoid process and the
18 temporal bone itself. There are three bones that
19 are stuck together. And one is just to make it,
20 first of all, the head lighter, protect it more, and
21 allow the inner ear to tolerate a change in
22 pressures. Like a sponge there, that in case you go
23 too high or too low, it absorbs the pressure there
24 instead of popping the ear or breaking the ear like
25 sometimes it happens when the pressure goes too high

1 too quickly. And that's been damaged from the
2 injury that he suffer.

3 Q Okay. So the mastoid isn't part of the brain, it's
4 part of the --

5 A Skull.

6 Q -- skull. Okay. So all right. And --

7 A Which is the part of the skull that the right inner
8 ear is located, which when we do the testing, the
9 right inner ear is the one that appears to be
10 damaged. So the complaint that the patient is
11 having, the clinical signs, clinical symptoms, the
12 complaint that he has, and the findings that we do
13 on the studies, they're all correlate.

14 Q All right. The inner ear problem correlates with
15 that mastoiditis?

16 A Exactly.

17 Q Which is, I guess, sounds like an inflammation of
18 that area. Is that --

19 A Well, it's like fluid of the inflammation from the
20 response to the injury that he suffer.

21 Q Okay. All right. And as far as the cognitive
22 deficits, are you talking academic ability or
23 just -- what kind of things are you talking about
24 with cognitive deficits?

25 A When I ask him, I mean, I'm asking simple stuff,

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1 like can you -- how many bricks are -- can you lay
2 in a day, and how many are in a foot, so stuff that
3 he's able to relate, how many feets are there to
4 this, and he's not able to figure that stuff out.

5 Q All right. And you didn't know him before this
6 accident, did you?

7 A No, this is the first time I've ever seen him.

8 Q All right. So is it fair to say he may not have
9 known that stuff before the accident, we just don't
10 know?

11 A Exactly, I don't know. He's a construction worker.
12 I expected him to know, you know, that stuff.

13 MR. BURKETT: All right. I don't have
14 anything else.

15 MR. CHANDLER: I don't have anything. Thank
16 you.

17 (Deposition was concluded 1:52 p.m.)

18 (*This transcript may contain quoted
19 material. Such material is reproduced as read or
20 quoted by the speaker.)

21 (**Certificate accompanies sealed original
22 only.)

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

WCC File No. 0717624

Hector G. Fragosa, Employee/Claimant, ... Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier
..... Respondents.

CERTIFICATE OF COUNSEL

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

Respectfully Submitted,



Stephen B. Samuels
SAMUELS LAW FIRM, LLC
Post Office Box 50349
Columbia, SC 29250
(803) 779-4000
Attorney for Appellant

Columbia, South Carolina
March 21, 2013

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

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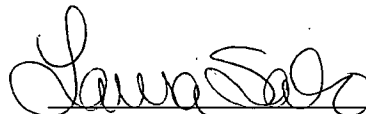
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PROOF OF SERVICE

I certify that I am the paralegal to Stephen B. Samuels and I have served the **Brief of Appellant, Reply Brief of Appellant, and Record on Appeal** upon the Respondents by mailing copies of the same in the United States mail, with sufficient postage affixed thereto and return address clearly marked on **March 27, 2013**, addressed as follows:

Michael W. Burkett, Esquire
J. Gabriel Coggiola, Esquire
Attorneys for Respondents
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, South Carolina 29209


Laura Sabo, Paralegal

March 27, 2013

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