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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Commons Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No.: 2012-213175

Gilbert Chavis,Employee, ... Employee,

v.

AVX Corporation, Employer, and Liberty Mutual Insurance, ... Carrier,

In Re: AVX Corporation and Liberty Mutual Insurance Company, ... Respondents,

v.

South Carolina Second Injury Fund,...Appellant.

RECORD ON APPEAL

Latonya Dilligard Edwards, Esquire
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Columbia, South Carolina 29210
(803) 750-2214
ATTORNEY FOR APPELLANT

AND

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Sugar Log Sheets

Date Dec 3. 2004

Name Gilbert Chavis

Please call to 293 8400 or fax to 293 9440 on:- 347-5748

Current diabetic medicines (include name of pill or insulin, dose and frequency)

1) Glucophage 500 mg. 2 BID
2) Glipizide 10 mg. Bid
3) Humulin N. 16 QD
4)

Date	Pre-Breakfast	Pre-Lunch	Pre-Supper	Comments
11-29	347	232	232	
11-30	271		274	
12-1	253		212	
12-2	262		218	
	271			

For Doctor's use only

— ↑ to 26 u qd
— call on wed am

Date of review

Signature

Date of phone call 12-3-04 JM

Pt. notified

2/7/07 Patient cancelled appointment due to insurance issues. Was told he needed to continue care if not with us with someone.

Sugar Log Sheets

Date

Name Gilbert Chavis

Please call to 293 8400 or fax to 293 9440 on:- Monday 347.5748

Current diabetic medicines (include name of pill or insulin, dose and frequency)

1)------16u NPH at Supper.

2)------

3)------

4)------

+has lost 6½ since Tue.

Date	Pre-Breakfast	Pre-Lunch	Pre-Supper	Comments
11/24	248		309	16
11/25	312		308	16
11/26	280	477	327	16
11/27	373		383	16
11/28	351	AL 456	425	10 At Lunch 26
11/29	347			

10:00 362

Patient stopped pills & was on insulin only. Will resume pills & drop back to 16u qd & call sugars to us on Friday.

For Doctor's use only

~~↑ NPH to 36 u every morning.~~

~~Call Sugars Thursday~~

Date of review

Signature.......

Date of phone call 11.29.04 JN

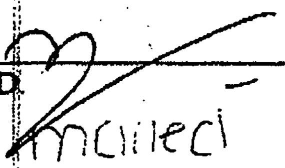
THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, S.C. 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 11/23/04
CURRENT MEDICAL HISTORY: He comes in for follow up. His A1c is up form 7.5 to 9.1. We took him off Avandia because of the weight issue. He remains on Glipizide 10 mg. twice a day and Metformin 1000 mg. twice a day. Cholest. 161, Trigl. 292 and LDL 74. He is off Lopid and off Lipitor. He said that he couldn't handle the cost. Sugars are running in the 200's in the morning and 180 to 200 pre-supper. He noticed that using his TENS machine helps his neuropathy pain. His weight is down another 5 pounds for a total of 14 pounds. He has had no ankle swelling since he stopped Avandia.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 84 per minute BP: 160/90 Weight: 212
HEART: Sounds are normal.
LUNGS: Clear.
EXTREMITIES: The legs show no edema.
IMPRESSION: We need to get him stated on insulin. He doesn't want to go back on Avandia even though it was working quite nicely. We will begin NPH using a pen starting at 16 units a day. He will call sugars to me in a week. His blood pressure is up. I am going to have him begin HCTZ 12.5 mg. a day and then follow up in a couple of weeks. He will go back on the Lopid which he should be able to afford.

Philip R. Nicol, M.D.

THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, S.C. 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 7/13/04
CURRENT MEDICAL HISTORY: He comes in for follow up. His sugars continue to run in the 180 to 200 range. He stopped his Avandia and lost weight down to 208 pounds initially although now he has gained back to 217. He is on Glipizide 10 mg. twice a day and Metformin 1000 mg. a day. He is unable to do much exercise although is doing a little bit of yard work.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 80 per minute BP: 140/75 Weight: 217
HEART: Sounds are normal.
LUNGS: Clear.
EXTREMITIES: The legs show no edema.
IMPRESSION: We have only two options. We need to either add a TZD back in or some supplemental insulin. He is not keen on either of those options and wants to try improved diet and exercise. Will do that and see him back in September.



Philip R. Nicol, M.D.

Nov 16, 2004 - mailed records to SC Vocational

11/16/04 rp lipid, alt, ast, a1c

Needs refill
Glucophage
Nyles
248-5015

Sugar Log Sheets

Date 7/7/04

Name Gilbert Chavis

Please call to 293 8400 or fax to 293 9440 on:- 347-5748

Current diabetic medicines (include name of pill or insulin, dose and frequency)

1) Glucophage 500 mg 2 Tablets Bid

2) Glipizide 5 mg 1-Am - 2 pm

3)

4) Took him off Avandia 8 mg.

Lost weight went from 224 to 204

Date	Pre-Breakfast	Pre-Lunch	Pre-Supper	Comments
7-5	356	347	406	
7-6	334	~~3~~	369	
7-7	320			
				Having mini headaches,
				Slight Nausea when he wakes up.

For Doctor's use only

— ↑ Glipizide to 10 mg bid

— OV ~~in~~ ~~[illegible]~~ Mon or Tues – sugars are way too high

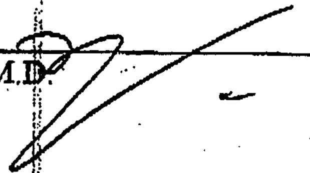
Date of review

Date of phone call pt notified 7/7/04 1:35pm

Signature [signature]

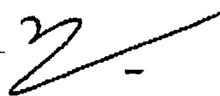
THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, SC 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 06/22/04
CURRENT MEDICAL HISTORY: He comes in for follow up. His A1c is 7.5 on triple therapy. Cholest. 144, Trigl. 143 and LDL 79 on Lipitor and Lopid. Sugars are running from 150 to 190 in the morning and 160 to 170 pre-supper. He says that he has tried hard watching his diet. He hasn't done too much exercise. His weight is up another 4 pounds. He is very disturbed about the weight gain. He said that it makes him short of breath. On looking back through his records he has gained a total of 29 pounds since we began Avandia. He has had no chest pain, shortness of breath or ankle swelling.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 72 per minute BP: 120/90 Weight: 224
HEART: Sounds are normal.
LUNGS: Clear.
EXTREMITIES: The legs show no edema.
IMPRESSION: I am going to go ahead and stop the Avandia. It is pretty clear-cut that he has gained 30 pounds or so since he started it. Will see how he does over the next 3 months without it. I have asked him to call me sugars in about 2 weeks to just see how he is doing. His blood pressure is excellent and his cholesterol is excellent. I will see him back in 3 months.



Philip R. Nicol, M.D.

7/12/04 Pt. called & cancelled appt.
Feels better.
Sugars 8AM 100 - 280
wt 211 16.

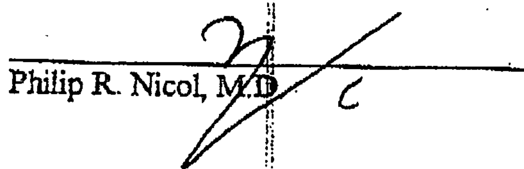


THE DIABETES CENTER
5046 HIGHWAY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

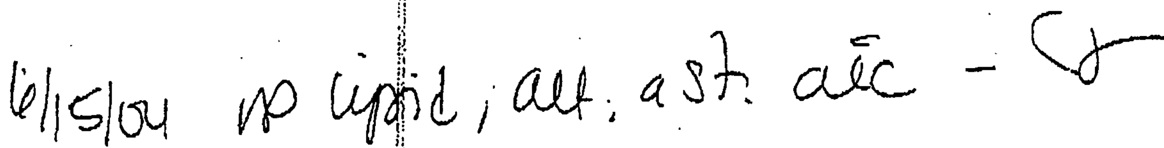
PATIENT'S NAME: Gilbert Chavis
DATE OF EXAM: 03/16/04

CURRENT MEDICAL HISTORY: He comes in for follow up. His Alc is down from 8 to 7.3 on Triple therapy. Cholest 151, Trigl 120, and LDL 92 on Lipitor and Lopid. He said Dr. Bonn is giving him some kind of testosterone cream which is helping improve his strength. He had a sleep study last night. He doesn't know the results. His weight is up 8 pounds. There is no chest pain or shortness of breath. His ankle swelling with PRN Diuretics. He has on going back pain.

PHYSICAL EXAM:
VITAL SIGNS: Pulse: 76 per min BP: 140/80 Weight: 220.
HEART: Normal.
LUNGS: Clear.
EXTREMITIES: The legs show no edema.
IMPRESSION: His Alc has improved. Cholest is excellent and Trigl are excellent. He needs to work on his weight. He's going to try and loose 10 pounds by the time I see him next time. I'll see him back in three months.



Philip R. Nicol, M.D.



THE DIABETES CENTER
5046 HIGHWAY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT'S NAME: Gilbert Chavis
DATE OF EXAM: 12/16/03

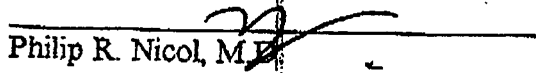
CURRENT MEDICAL HISTORY: He comes in for follow up. His Alc is up from 7 to 8 on Triple therapy. Cholest 183 up from 140 and Trigl 390 up from 246. His AST 25 and his ALT 43. He is not quit sure whether he is on Lipitor or Lopid but is pretty sure he is not on the combination. Sugars have been running between 190 and 250 in the morning and 225 to 240 pre-supper. He's been less active because of his back. He said he is involved with the Workmen Comp. people and he just lays around the house all day in pain. His weight is down 3 pounds. There is no chest pain or shortness of breath. He has occasional ankle swelling.

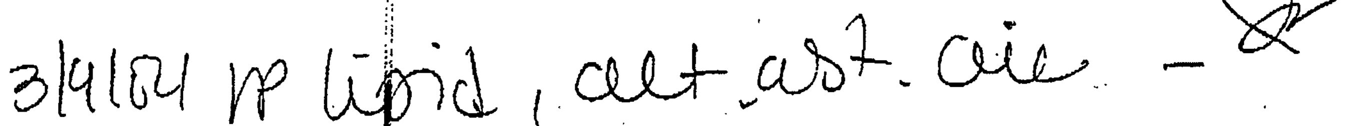
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 76 per min BP: 140/80 Weight: 212.
HEART: Normal.
LUNGS: Clear.
EXTREMITIES: The legs show no edema.

IMPRESSION: I need to know what his lipid agents are. He will call us when he gets home. His Alc has slipped primarily because of inactivity I think. Blood pressure is acceptable. I'll see him back in three months.

Philip R. Nicol, M.D.

PRN/tr

3/9/04 

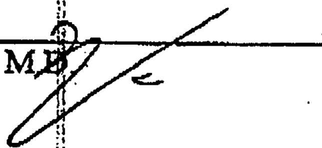

3/4/04 rp lipid, alt ast. alc

3/9/04 Head congestion / yellow mucus.

THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, S.C. 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 10/21/03
CURRENT MEDICAL HISTORY: He comes in for his lab work today. While he was here he mentioned some upper respiratory symptoms. They have been going on for about 10 days. He has had no fever or chills. He has had a dry cough. His chest feels tight. He had a sore throat early on in things.

PHYSICAL EXAM:
VITAL SIGNS: Temp: 97.8 Pulse: 68 per minute BP: 136/90 Weight: 215
HEENT: There is no lymphadenopathy in the neck.
HEART: Sounds are normal.
LUNGS: Clear.
IMPRESSION: He has an upper respiratory infection. I gave him some Biaxin and he will let me know if things don't settle down.



Philip R. Nicol, M.D.

10/23/03 Called & said not better — [illegible]

12/9/03 [illegible]

THE DIABETES CENTER
5046 HIGHWAY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT'S NAME: Gilbert Chavis
DATE OF EXAM: 09/04/03
CURRENT MEDICAL HISTORY: He comes in for follow up. Morning and evening sugars have been running in the 160 or so range. He is on Triple therapy. He has gained 9 pounds. He said he is trying very hard on his diet. He's noticed some ankle swelling recently. It occurs mostly during the day and goes down over night. We seem to have resolved the issue of his low blood sugars. He's been less active the past week and they have been running a bit higher. He said he is feeling weak again despite getting his testosterone shots every couple of weeks.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 80 per min BP: 140/80 Weight: 214.
HEART: Normal.
LUNGS: Clear.
EXTREMITIES: He has no edema today.

IMPRESSION: I gave him some Dyazide for PRN use for his edema. There is none apparent today. We will see what his Alc is when we follow him up later in the month before deciding whether the increase dose of Avandia has helped.

Philip R. Nicol, M.D.

PRN/tr

9/15/03 w/lipid, alt, ast, a1c — [illegible]

9/24/03 Shave :—

Good response to 2/month Testosterone shots & Viagra 100 mg.

Will not proceed [illegible]

9/2/03 am 100 – 150
pm 60 – 170 No Δ
C/O ankle swelling – likely Avandia related
Come in if doesn't settle down.

9/2/03 pt notified sugars ok – No Δ doses –
Call if continues pre supper lows – swelling
likely caused by avandia – Come in if it doesn't settle
down per Dr. Nicol. [illegible] –

Gilbert Chavis

7/30/03- sugars Better he ↓ meds because he was afraid sugar was going to drop
Am 115-190 } asked to take meds as directed
pm. 84-131 } call sugars mon or sooner if sugars 60 or less. SKH

7/30/03 1:49 pt. notified. [initials]

8/6/03- sugars Am 125-222 } on max agents. may
pm 78-193 } need insulin if diet & exercise doesn't ↓ sugar.
SKH

8/6/03 pt notified sugars too high if he can't bring these down with diet & exercise on current meds - insulin is the only other option. call sugars 1 wk per S Herrington PA-C. Pt. agreed — [initials]

8/14/03 am 100-200
pm 80-230
falling. Call 1/52 again
[initials]

8/22/03 am 80-150
pm 56-180 — pre supper lows

Δ to 5mg am

THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, S.C. 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 06/23/03
CURRENT MEDICAL HISTORY: He comes in for follow up. He is off Wellbutrin and Dr. Kang has him on some type of sleeping medication. He is not sure what it is. His sugars have been about 260. He says that the lowest they have been has been 180. The Nexium that Dr. Nicol gave him for his indigestion did help. He is currently not exercising. His appetite is good. His weight is up 4 pounds. He denies chest pain or shortness of breath. He says that his feet bother him every since he had his stroke.

CURRENT MEDICATIONS:
Roxicodone 15 mg. qd 6 hours PRN for pain
Glucotrol XL 10 mg. bid
Glucophage 500 mg. 1 in the morning, 2 in the evening
Avandia 4 mg. qd
Neurontin 400 mg. bid
Lopid 600 mg. qd

PHYSICAL EXAM:
VITAL SIGNS: Pulse: 72 BP: 140/90 recheck 122/70 Weight: 205
HEART: Regular rate and rhythm.
LUNGS: Clear to auscultation bilaterally.
ABDOMEN: Soft, non-tender. Bowel sounds present.
EXTREMITIES: There is no peripheral edema.
LAB DATA: AST 31, ALT 53, Cholest. 198, LDL 120, Trigl. 241 down from 289, Hemoglobin A1c 7.4 up from 6.4.

IMPRESSION:
1. Hyperlipidemia with elevated triglycerides. I am going to increase his Lopid to 600 mg. twice a day.
2. Diabetes. I am going to increase his Avandia to 8 mg. a day. He will check his sugars twice a day and he will call these to the office on a weekly basis to see if we have any other room for improvement in an attempt to get his A1c back down.
3. His blood pressure is good and we will plan on seeing him back for follow up in 3 months.

Susan Herrington PAC
Susan Herrington, P.A.-C

7/18/03- Sugars - Am - 134 - 207
pm - 100 - 220 - } Same call sugars ↑ wm Glucophage 500mg ii BID

THE DIABETES CENTER
5046 HWY. 17 SOUTH
MYRTLE BEACH, S.C. 29588

PATIENT: Gilbert Chavis
DATE OF EXAM: 5/15/03
CURRENT MEDICAL HISTORY: Cholest. 222, Trigl. 289 and LDL 129. I had given him 30 days of Lopid when this blood work was drawn 2 weeks after her finished the Lopid. He forgot his initial appointment. His testosterone level was 252. He is seeing Dr. Shore for that.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 72 per minute BP: 130/80. Weight: 201
HEART: Sounds are normal.
LUNGS: Clear.
IMPRESSION: I will leave Dr. Shore to deal with his Testosterone issue. He will resume Lopid and we have follow up blood work set for June. He mentioned some reflux, which is no longer responding to Zantac. I gave him some Nexium to try.

Philip R. Nicol, M.D.

6/16/03 Lipid, ALT, 987, AC →

7/3/03- sugars- Am. 171 - 229 } same meds
pm - 154 - 243 } call 1 wk
SKH

7/3/03 PHONED PATIENT AND TOLD HIM TO STAY ON SAME DIABETIC MEDS AND CALL SUGARS IN 1 WEEK. — [illegible]

THE DIABETES CENTER
5046 HIGHWAY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT'S NAME: Gilbert Chavis
DATE OF EXAM: 03/24/03

CURRENT MEDICAL HISTORY: He comes in for follow up. His Alc is stable at 6.4 on 10 mg twice a day, plus Avandia 4 mg a day. Cholest is 211. The Trigl's have jumped from 287 to 585. He is on nothing for his lipids. Sugars have been running 120 to 160 in the morning and 175 to 185 pre-supper. His main complaint is fatigue and lack of libido. He said the Viagra hasn't helped him. Dr. King apparently has tried an anti depressant but he had some side effects and is being switched to another one. His weight is up 5 pounds. There is no chest pain, shortness of breath, or ankle swelling.

PHYSICAL EXAM:

VITAL SIGNS: Pulse: 76 per min BP: 140/80 Weight: 203.
HEART: Normal.
LUNGS: Clear.
ABDOMEN: Normal.
EXTREMITIES: The legs are normal.
IMPRESSION: I'm going to try him on a month of Lopid and see whether I can get his Trigl's looking better. The lack of libido is his main complaint. I'm wonder whether perhaps he is depressed. He'll let me know what Dr. King has him on. I'll set him up for a three month follow up.

Philip R. Nicol, M.D.

PRN/tr

Wellbutrin by Dr Kang

5-3-03 Alt Ast lipid, Testosterone drawn. — LM
6-19-03 COPY OF LAB TESTS 5/08/03 FAXED TO DR SHARE'S [illegible]

1/24/03 am 95 - 127

pm 188 - 192 No Δ.

1.24.03 pt. notified try to ↑ exercise in p̄ noon to lower pm readings - doesn't need to call anymore sugars until March visit per Dr Nicol → [illegible]

THE DIABETES CENTER
5046 HWY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT NAME: Gilbert Chavis
DATE OF EXAM: 12/18/02
CURRENT MEDICAL HISTORY: He comes in for follow up. His A1c has dropped from 7.8 to 6.3. Cholest. 190, Trigl 287 and LDL 105. He is on Glucotrol 10 mg. twice a day, Avandia 4 mg. a day and Glucophage 1500 mg. a day. He is not experiencing any side affects so far. Morning sugars run 104 to 180 and afternoon ones 110 to 180. In general he is feeling better. He continues to have problems with his left arm and shoulder. He has had a rotator cuff problem.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 76 per minute BP: 140/90 Weight: 198
HEART: Sounds are normal.
LUNGS: Clear.
EXTREMITIES: Legs are normal.
IMPRESSION: His A1c is excellent. Lipids are good and blood pressure is reasonable. He is very pleased with the results. I am gong to back his testing down to 3 days a week, keep him on his current medications and he will call me sugars in a couple of weeks.

Philip R. Nicol, M.D.

1/3/03 am 90 – 140
pm 100 – 190 No Δ.

1/3/03 pt notified No Δ in meds til next visit per Dr. Nicol. Pt agreed –

1/20/03 am 110 – 161
pm [illegible] Same till next.

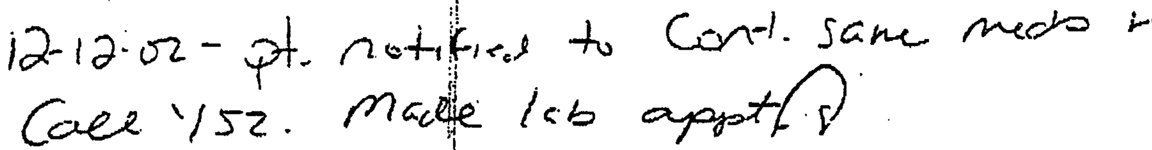
THE DIABETES CENTER
5046 HWY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT NAME: Gilbert Chavis
DATE OF EXAM: 12/05/02
CURRENT MEDICAL HISTORY: He comes in for follow up. His recent afternoon sugars have been unsatisfactory ranging from 150 to 240.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 84 per minute BP: 140/80 Weight: 195
IMPRESSION: I want to add Avandia 4 mg. a day. I gave him some samples. He is not happy about this. He is very worried about the cost of his medicines even though he has a pretty good prescription plan. I told him that he just had to try and find a way to do this to prevent the long-term damage that uncontrolled diabetes can cause. He will send me his sugars in a week.

Philip Nicol, M.D.
PRN/tr

12/11/02 No show labs. ve

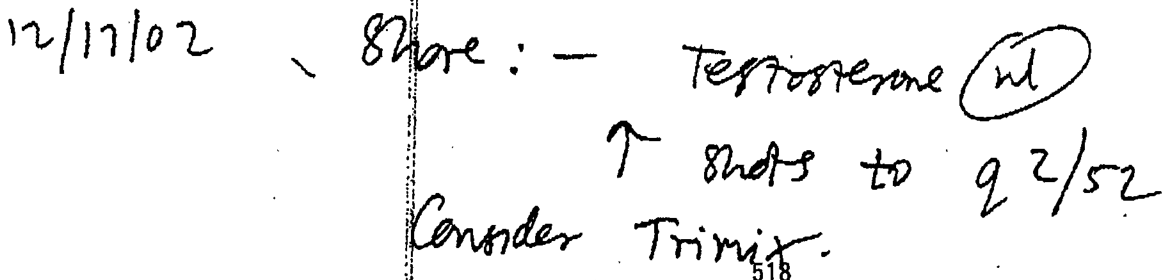
12/12/02 am 113 – 180
pm 150 – 260 Same 1/52



12-12-02 – pt. notified to Cont. same meds + Call 1/52. Made lab appt.

12-16-02 – Lipid, A1C

12/17/02 – Note: – Testosterone (nl)
↑ shots to q 2/52.
Consider Trimix.



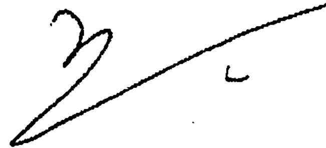
11-27-02- pt. notified sugars looking better. Cont. Same meds call 1 5f ♡

12/2/02 Royal :-

Mild BDR

Min. Cataracts

2/4/02



am 100 - 140

pm 150 - 240 Come in for T2D

11/14/02 Shone :-
For w/u
Testosterone given.

11/15/02 am 130 - 200
pm 150 - 240 Same - call wed

11/15/02 pt notified - looks like better readings - past few day - stay on same doses + call on wed per Dr. Nicol. Pt agreed -

11/20/02 am 80 - 170
pm 130 - 190 on 10 bid Glucotrol
500 bid Glucophage
Δ to 1500 glucophage
call 1/52

11/22/02 pt notified ↑ glucophage to 500mg am + 1000mg pm + call sugars 1/52 per Dr. Nicol. Pt agreed -

11/27/02 am 100 - 140

THE DIABETES CENTER
5046 HWY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

PATIENT NAME: Gilbert Chavis
DATE OF EXAM: 10/16/02
CURRENT MEDICAL HISTORY: He comes in for follow up. His insulin level was 9.0 with a C-pep 2.2. Thyroid tests were normal Testosterone was 209. Sugars are running 170 to 300 in the morning and 230 to 310 pre-supper.
PHYSICAL EXAM:
VITAL SIGNS: Pulse: 72 per min. BP: 144/90. Weight: 193.
IMPRESSION: I am going to switch him to Glucotrol 5mg. bid. He will call his sugars to me after the weekend. He said his libido is bad and he wants Testosterone replacement. Will refer him to one of the Urologists to pick up that issue.

Philip R. Nicol, M.D.
PRN/tr

10/30/02

am 150 – 200
pm 150 – 280 — Taking Glucovance — Can't afford Glucotrol

10-30-02 Called pt. to tell him Glucotrol is $$ than Glucovance. He states he will buy Glucotrol as soon as workmens comp check gets to him. Gave him 2 wks worth of samples + a written Rx. with instructions take One BID + call sugar in wk. He agreed

11/02 – sugars – am – 176 – 210
pm – 177 – 337 } – Add Glucophage 500 at supper x 5d if tolerates ↑ to BID call sugars Wed.

-2 pt notified – sugars too high – continue
01 – need to add Glucophage ...

THE DIABETES CENTER
5046 HWY 17 SOUTH BY-PASS
MYRTLE BEACH, S.C. 29588

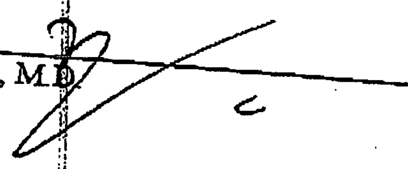
PATIENT NAME: Gilbert Chavis
DATE OF EXAM: 10/01/02
CURRENT MEDICAL HISTORY:
He is a new patient. He was diagnosed 14 years ago with polyuria and Polydipsia. He was seeing Dr. Eagerton but didn't get on with him. He sees Dr.Kang for some musculoskeletal problems. After his diagnosis he was on diet control for 1 year and then was on Glipizide and then Metformin, now Glucovance 5/500 one twice a day. He has been checking sugars in the morning and they have been running around 180. He hasn't been checking them later on a regular basis. He has breakfast at 9:30, lunch at 1:00 and dinner at 6:30. Sometimes he snacks. He has an occasional low reading. He complains of fatigue. He doesn't exercise. His foot feels numb particularly on the left. He had an eye check up by an optometrist. He has some background retinopathy and a trace of macula edema. His appetite has been good. Weight has been steady. He is a non-smoker, non-drinker. His bowels and urinary tract are asymptomatic. He has no chest pain, shortness of breath or ankle swelling. There is no palpitations, no syncope and no dizziness. He has no skin problems or arthralgias. He has had low back pain since 1996.
PREVIOUS MEDICAL HISTORY:
Positive for a stroke affecting his left side in 2000. Most of his neurologic function returned. He has had right rotator cuff surgery. He had a tracheotomy at the age of 10 after swallowing something. He had a growth removed from his perineum.
SOCIAL HISTORY:
He is married with 2 children. He worked at AVX but is off on disability.
FAMILY HISTORY:
Positive for his father with diabetes.
CURRENT MEDICATIONS:
Roxicodone
Glucovance
Testosterone shots.
ALLERGIES: Intolerant of Codeine.
PHYSICAL EXAM: Reveals a healthy white male.
VITAL SIGNS: Pulse: 68 per min BP: 140/78. Height: 5'5"
Weight: 193. BMI: 32
HEENT: Carotids are equal with no bruits. Thyroid is not enlarged. There is no lymphadenopathy.
HEART: Normal.
LUNGS: Clear.
ABDOMEN: Normal.

Page Two
Gilbert Chavis
10/01/02

EXTREMITIES: Legs are normal. Peripheral pulses are present. Reflexes are symmetrical. There are no sensory levels. There is no onychomycosis.

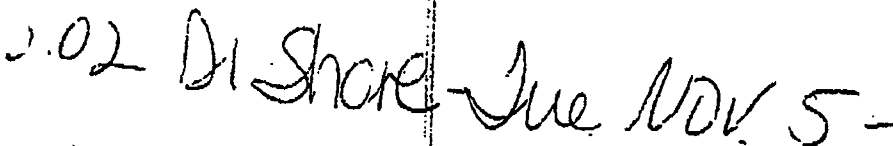
LAB DATA: Renal normal. Urine negative. Liver normal. Cholest 160, LDL 92, HDL 31, Trigl 183, A1c 7.8, fasting sugar 214.

IMPRESSION: I will get an insulin and c-peptide to help me decide what the best agents are for him. He will check twice a day sugars for me. Will get him fixed up with Dr. Royal in view of the abnormalities detected by the optometrist. He says that he knows that he has bilateral carpal tunnel syndrome. He is due to have surgery to relieve an ulnar nerve entrapment sometime in the near future. He requested a testosterone level in addition to his diabetic lab work. I will see him back when we have these values back.



Philip R. Nicol, M.D.
PRN/tr

10/11/02 T4 7.2
TSH 1.4
Test 209
Insulin 9.0
C pep 2.2



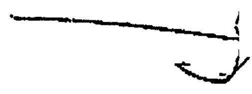
.02 Di Shore - Tue Nov 5 -

25/02 am 150 – 220
pm 130 – 250 ↑ to 10 bid

Call

Gilbert R. Chavis

10.1.02 Dr Royal - Wed Oct. 30 - 9:45



10/9/02 C Peptide Insulin, TSH, T4, Testosterone

— [illegible]

NAME: Gilbert R. Chavis

ALLERGIES: Codeine

MEDICATION	10/16/02	12/5/02	12/18/02	3/24/03	5-15-03	6-23-03	9/4/03	9/23/03
Roxicodone 15mg ÷ q6° prn pain	✓	✓						
Glucovance 5/500 ÷ BID	✓	stopped	✓	✓	✓	✓		
Testosterone Shots	ran out ✓						✓	✓
Glucotrol XL 10mg BID		—	✓	✓	Ø	Ø		
Glucophage 500mg ii am ii pm		—	✓	✓	✓		✓	✓
Baby ASA ii QD		✓	✓		✓	✓	5mg am 10mg pm	
Avandia 4mg ÷ qd		✓	÷ qd ✓	✓	✓	✓	ii BID	✓
MVI			✓	✓	stopped			✓
Oral Ca+				✓	✓	✓	8mg	✓
Neurontin 400mg tid				✓	stopped			
...od 600mg ÷ QD				✓	stopped			
...xium 40mg ÷ qd prn				✓	BID ✓	✓	✓	BID ✓
...ox 25mg ÷ q6						✓	÷ BID	✓
...andia ÷ qd								✓
								✓
								✓
								✓

DISC IMAGING

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

D I A G N O S I S • I N S I G H T • S E R V I C E • C A R E

May 10, 2000

Received a call from Mr. Gilbert Chavis saying that his orthopedic doctor was out of town and he was almost out of pain medication. I agreed to write him a prescription, which I did, and mailed it to him, although I explained to him that I would prefer in the future that he get his prescriptions from the doctors more closely involved in his care. I feel that I have a close enough relationship to him and am familiar enough with his current clinical problem that it is reasonable for me to go ahead and do this.

David D. Goltra, Jr., M.D.

19591

1136 Bowman Road, Mount Pleasant, SC 29464 • (800) 933-DISC • (843) 884-4MRI • FAX (843) 8

DISC
IMAGING

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

DIAGNOSIS • INSIGHT • SERVICE • CARE

April 13, 2000

Mr. Chavis presented today for follow up MRI study, requested by Dr. Groblowski. I spoke with Mr. Chavis and he states he is feeling considerably better, is walking without difficulty, has no more dizziness and has essentially recovered from his left cerebellar infarction. He states that he called and left a message here to that effect a few days ago, which unfortunately was not conveyed to me. I filled out some paper work regarding his work status and disability. He is between orthopedic doctors at this time and requested that I give him a prescription for Tylox, which he has been taking on a regular basis for pain, since he is unable to get in to see his orthopedic physician in the next few days. I wrote him a prescription for #30 Tylox and filled out his paper work and suggested that he call me if he has any other needs or problems.

David D. Goltra, Jr., M.D.

19591

1136 Bowman Road, Mount Pleasant, SC 29464 • (800) 933-DISC • (843) 884-4MRI • FAX (843) [illegible]

DISC IMAGING

FINDINGS

OVERVIEW:

(CONTINUED)

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PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 04/13/00
REFERRED BY: DANIEL B. GROBLEWSKI, M.D.
TYPE OF EXAM: MRI BRAIN,W/O AND W/CONTRAST
PT #: 01-95-91

(CONTINUED - PAGE 2)

SUPRATENTORIAL COMPARTMENT: Evaluation of the supratentorial compartment shows normal size lateral ventricles and cortical sulci. The nuclear structures are normal in their appearance. There are no areas of abnormal signal intensity, no evidence of abnormal enhancement and no evidence of mass lesion.

OPINION: The area of signal abnormality in the right cerebellar hemisphere, presumably representing a cerebellar infarction, has diminished considerably in size since the prior study and is only seen with certainty on one slice of the T2 weighted sequence. There is no abnormal enhancement or restrained diffusion in this region.

DAVID D. GOLTRA, JR, M.D.

DDG/NL

DISC IMAGING

D I A G N O S I S • I N S I G H T • S E R V I C E • C A R E

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/25/00
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: LATERAL SELECTIVE EPIDURAL BLOCK, CERV
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 45-year-old male with right shoulder pain.

TECHNIQUE: After informed consent was obtained, the patient was placed on the fluoroscopy table in the supine position. The skin over the right neck was prepped and draped in a sterile fashion. Using fluoroscopic guidance, a 22 gauge Chiba needle was advanced toward the right C5-6 neural foramen. When the patient's radicular pain was reproduced, the stylet was removed from the needle. No blood return was obtained. Following this, a neurogram was performed, using a small amount of Omnipaque 240 documenting opacification of the nerve root sheath. 1 cc xylocaine and 80 mg Depo-Medrol were injected into the perineural space.

Upon removing the needle, a small amount of blood returned was obtained and direct compression was applied to the lateral neck. At approximately the time when the needle was removed, the patient had an episode of syncope, which lasted for approximately one minute. When he awakened, he was nauseated and mildly disoriented. When he recovered from this, he stated that his right shoulder pain was gone.

OPINION:

1. Selective right C6 nerve root block with alleviation of right shoulder pain.

2. Syncopal episode during procedure.

[signature]

DAVID D. GOLTRA, JR, M.D.

DDG/smt-60

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PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/25/00
REFERRED BY: A. JAY PRESLAR,III, M.D.
TYPE OF EXAM: CT BRAIN
PT #: 01-95-91

CLINICAL INFORMATION: The patient has had syncopal episode.

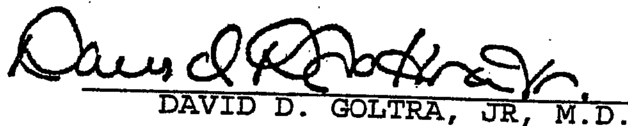
TECHNIQUE: The patient is examined in the GE Highlight Advantage CT System. **SERIES:** 1) Lateral scout view; 2) AX 3 x 3 mm posterior fossa; 3) AX 5 x 5 mm brain; 4) AX 3 x 3 mm posterior fossa; 5) AX 5 x 5 mm brain.

CONTRAST: The last two series were carried out during and following an injection of 100 cc of Omnipaque 300.

SEDATION: None.

FINDINGS: Axial images through the brain demonstrate no evidence of intracranial mass, hemorrhage, edema or other abnormality. Bony structures are normal in appearance.

OPINION: CT of the brain is within normal limits.



DAVID D. GOLTRA, JR, M.D.

DDG/smt-12

DISC IMAGING

Richard C. Holgate, M.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

D I A G N O S I S • I N S I G H T • S E R V I C E • C A R E

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/08/00
REFERRED BY: A. JAY PRESLAR,III, M.D.
TYPE OF EXAM: MRI CERVICAL SPINE
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 45-year-old male with right-sided neck and shoulder pain; prior rotator cuff surgery.

TECHNIQUE: The patient is examined on the High Field GE Horizon LX Echo Speed MR System which functions at 1.5 Tesla. A dedicated spine coil is used to obtain high resolution images of the cervical spine. SERIES: 1) COR, T1, SE, 7 mm; 2) SAG, T2, FSE, 3 mm; 3) AX, T2*, GRE, 3 mm. Additional series: 1) AX, T1, SE, 5 mm.

CONTRAST: None. SEDATION: None.

FINDINGS:

OVERVIEW: Coronal T1 weighted images demonstrate normal appearance of the lung apices, paraspinous musculature and brachial plexus regions.

CERVICAL SPINE OVERVIEW: There is normal alignment of the cervical vertebral bodies. Craniocervical junction is normal in appearance and no abnormal signal is present within the cervical spinal cord.

C3-4. Mild annular osteophytes are present, resulting in mild neural foraminal stenosis.

C4-5. Bilateral annular osteophytes are present, left greater than right, with moderate left and mild right neural foraminal stenosis. A very small, shallow central disc protrusion is present.

C5-6. There is a right parasagittal disc protrusion which contacts and flattens the spinal cord. This is superimposed upon a diffuse disc bulge which narrows both neural foramina, slightly more so on the right than left, where there is moderate right neural foraminal stenosis.

C6-7, C7-T1. Axial images taken at these levels show normal disc space height and signal with no evidence of bulge or herniation of disc material, and no evidence of protrusion of disc material beyond its normal confines. The spinal cord and exit foramina are normal in their appearance.

OPINION:

(CONTINUED)

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PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 01/08/00
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: MRI CERVICAL SPINE
PT #: 01-95-91

(CONTINUED - PAGE 2)

1. C3-4. Mild bilateral neural foraminal stenosis secondary to annular osteophytes.

2. C4-5. Moderate left and mild right neural foraminal stenosis secondary to annular osteophytes; shallow central disc protrusion.

3. C5-6. Right parasagittal disc protrusion superimposed upon a diffuse disc osteophyte protrusion with moderate right and mild to moderate left neural foraminal stenosis. Protruding disc contacts and flattens the spinal cord at this level.

DAVID D. GOLTRA, JR, M.D.

DDG/smt-60

DISC IMAGING

Richard C. Holgate, M.D., F.R.C.P.C.
Beverly M. Genez, M.D., Ph.D.
David D. Goltra, Jr., M.D.
Tara C. Noone, M.D.

DIAGNOSIS • INSIGHT • SERVICE • CARE

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 10/23/99
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 44-year-old, 190-pound, 5'5" male with chronic right shoulder pain.

TECHNIQUE: The patient is examined on the High Field GE Horizon LX Echo Speed MR System which functions at 1.5 Tesla. A dedicated shoulder coil is used to obtain high resolution images of the shoulder. **SERIES:** 1) COR, T1, SE, 7 mm; 2) AX, T2*, GRE, 4 mm; 3) SAG, Oblique, FSE, Proton/Fat Sat, 4 mm; 4) SAG, Oblique, T2/Proton, SE, 4 mm.

CONTRAST: None. **SEDATION:** None.

FINDINGS:

The patient had a prior examination performed at Health South. If this examination becomes available for comparison, an addendum comparing the two will be issued to this report.

OVERVIEW: Views include the pulmonary apices and proximal brachial plexus, and no abnormality is seen in these structures. A survey view of the opposite shoulder shows no abnormality. There are multiple foci of magnetic susceptibility artifact within the soft tissues, resulting from surgical clip placement.

GLENOHUMERAL JOINT: The head of the humerus is well-seated within the glenohumeral joint. The glenoid labrum is intact showing normal signal and the biceps tendon is within its groove. There is no evidence of a Hill-Sachs deformity to indicate previous anterior dislocation. There is no evidence of a joint effusion.

ACROMIOCLAVICULAR JOINT: There is heterogeneous fluid signal intensity within the subacromial space; this fluid is contiguous with the acromioclavicular joint space and most likely is post-operative in nature. There is no evidence of rotator cuff impingement following decompression.

ROTATOR CUFF: The proximal muscle bellies of the elements of the rotator cuff demonstrate normal substance. There is abnormally-increased signal intensity within the distal supraspinatus tendon, which is slightly attenuated. Slightly higher signal intensity is noted along the articular surface; however, a full thickness tear is not identified.

(CONTINUED)

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10-21
SKC

GRAND STRAND REGIONAL MEDICAL CENTER
Myrtle Beach, SC

PT: CHAVIS, GILBERT
MR#: F000375088

OPERATIVE REPORT

PT: CHAVIS, GILBERT
DICT PHY: STEVEN K. WHITE, MD

DATE OF PROC: 10/21/2002

SURGEON: Steven K. White, MD

PRE-OP DX: Left cubital tunnel syndrome.

POST-OP DX: Left cubital tunnel syndrome.

ANES: General endotracheal.

PROC PERFORMED: Ulnar nerve transposition.

INDIC: This patient was referred to our office by Dr. Kang. He has positive nerve conduction studies for a cubital tunnel syndrome. He had a previous stroke from have a cervical epidural, and he has had problems since then. He is also a diabetic, and he has a several-month history of having Tinel sign and pain in the left forearm, and he was found to have isolated cubital tunnel syndrome at that point by Dr. Kang. He has complained of pain in the left shoulder, arm, forearm, hand. Ring and little fingers tend to go numb, also.

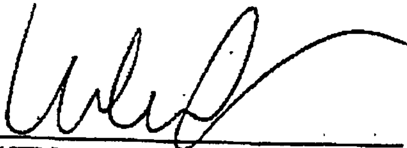
DESC OF SURG: The patient was taken to the operating room and was put to sleep under general anesthesia. A tourniquet was put high up on his left arm. He was sterilely prepped with Betadine solution, and he was draped off sterilely. The left and arm were exsanguinated of blood. The tourniquet was inflated to 275 mmHg. An incision to be made along the ulnar grove. It was marked off with a marking pen, and then an incision was made down through the skin into the subcutaneous tissue. A 2.5 loop magnification was used. Dissection was carried down to the fibrofatty tissue where posterior cutaneous nerve to the forearm was seen, and this was isolated off and not injured. Further dissection was carried down into the ulnar grove where the septum was opened, and the ulnar nerve was seen. It was carefully dissected out both distally and proximally. Careful attention was done to avoid any nerve injury leaving the ulnar nerve to enervate the flexor carpi ulnaris muscle. The nerve was isolated off both distally and proximally with a vessel loop, and then attention was then turned more medial past the medial epicondyle along the fascia of the pronator flexor group. The subcutaneous tissue was dissected off this. Minor bleeders were cauterized as necessary. Then a marking pen was used to mark out a large Z, and then used the needle tip cautery, then a large Z was cut in order to make a groove for the new ulnar nerve transposition. The ulnar nerve was then easily placed into the new bed of muscle over the brachialis muscle without tension on the nerve. It was then closed with 3-0 Ethibond suture over the nerve, and a hemostat was used to easily insert between the muscle closure and the nerve so that there was no pressure on the nerve, itself. The patient was noted to

have a large intermuscular septum, and a lot of this was resected and sent to Pathology for specimen. This was resected so that there would be no pressure on the nerve as the nerve transversed over this. The tourniquet was let down. Bleeders were cauterized, and the wound was closed with buried 3-0 PDS suture and a subcuticular PDS suture. The patient was then put into a long-arm splint. The elbow flexed at 90 degrees, and the splint went along the ulnar border of the wrist to the MCP joint. The ____________ was well padded prior to that with Xeroform fluffs, cling, and web roll. He tolerated the procedure well.

EBL: Negligible.

cc: GREGORY KANG, MD, FAX # 293-8869

D 10/21/2002 12:58:37
T 10/22/2002 08:37:47/108 Job #: 1251244/Doc #: 797186



STEVEN K. WHITE, MD

Doctor's Care CONWAY
1400 Main St.
CONWAY SC 29526
(803) 248-6269

DATE: 01/28/00
NAME FIRST GILBERT LAST CHAVIS
CHART # Encounter#: 23490
PAT # 195386.0
TIME: Fri Jan 28 10:57
SEX: M
AGE: 45
BIRTH DATE: 12/07/54
HOME ADDRESS: 616 MCKINLEY WAY CONWAY SC 29526
HOME PHONE: (843) 347-5748
EMPLOYER: AVX
REG. M.D.
LEGALLY RESPONSIBLE PARTY if pt. a minor/Relationship: Non-Smoker
BUSINESS PHONE: (000) 000-0000
SS# 248-04-2224
BCBS COLUMBIA SERVIC

STATEMENT OF PROBLEM OR INJURY: problems balancing; had nerve block Tuesday & hasn't been
LAST TETANUS:
MED. ALLERGIES: NKA
WGT 191 BP 116/84 P 102 R 20 T 98.0

HISTORY: the same since - couldn't talk or walk Tuesday; (R) arm shoulder & neck pain; wants BS ✓
OV
MEDICATIONS (pt. now on): Glipizide 5mg II QAM & QPM
Dr. Roman left - [illegible]

PHYSICAL:
See Notes from East Cooper Medical Center. 1/25-26/00.
Pt [illegible] "I'm slow" - double vision when watching TV; & (R) shoulder pain that is worse than before nerve block. No other [illegible].
PE. WD WN [illegible] A&O NCAT Appears Comfortable PERRL EOMI No Nystagmus
(+) conjugate gaze.
[illegible] mouse on & off [illegible]
Neck supple [illegible] Non-tender
Lungs clear [illegible] Abd soft Non-tender
(-) Romberg, finger to nose [illegible] gait normal - pt walked down Hallway & back [illegible] when he turned [illegible] Room he grabbed door edge & bumped into it.

Unremarkable / Problem: MENTAL, EYES, EARS, NOSE, THROAT, [illegible], LUNGS, HEART, ABDOMEN, PERINEUM, ARMS, LEGS, NEURO, SKIN, INJURY, OTHER

Services Rendered: BLOOD WORK, INJECTIONS, URINALYSIS, X-RAY, OTHER
FSBS - 280
Hgb [illegible]
CMP 250.00
Results: See additional Note.
Notes:
82947 - 10.00
86677 - 39.00
80054 - 43.00
99215 - 135.00
$ 227.00

719.41 532.9 250.00

DIAGNOSIS: (1) Hx NIDDM (2) Persistent (R) Shoulder Pain (3) Hx Duodenal Ulcer

INSTRUCTIONS & PRESCRIPTIONS & TREATMENT:
Dr Grabiewski 11 Am 347 4196
Cont. Glipizide 15mg qam 10mg qpm
Glucometer #100 strips
Discussed [illegible]
Dr Grablewski [illegible]
Pt [illegible] Dr [illegible] Tuesday.
1-31-00 @ 11:15am

STAFF: [illegible] PA-C
M.D.

RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS
[...]IZE THE RELEASE OF MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO DOCTOR'S CARE PHYSICIANS OR THEIR DESIGNEE FOR SERVICES DESCRIBED ABOVE

DATE
Gilbert R Chavis
PATIENT OR AUTHORIZED PERSON'S SIGN.

Fi-Fi Jubran, M.A., CRC, CCM, CDMS
Rehabilitation Consultant

P. O. Box 290609
Columbia, SC 29229-0609

Telephone: (803) 699-9930
Fax: (803) 699-1920

VOCATIONAL ASSESSMENT

PERSONAL DATA:

Name: Gilbert Chavis
Date of Birth: December 7, 19545
Dates of Injury: December 1, 1998 and December 27, 1999
Date of Interview: August 21, 1954 and October 20, 2003
Sources of Information and Evaluation: Review of medical and file records, behavioral observations and interview with the injured worker.
Analysis of vocational and occupational factors, and review of medical and/or psychological limitations.
Reason for Referral: Vocational Assessment to determine employability

INJURY/MEDICAL STATUS:

Gilbert Chavis is a 48-year old male who sustained two work-related incidents, one on December 1, 1998 and the other on December 27, 1999. On December 1, 1998, Mr. Davis was working on machinery at AVS. He related that he was lifting a heavy pot. He tried to get the pot back on the wheel when he injured his back. He recalls immediately felt a "burning" pain in his right shoulder. He was referred to Dr. Jeffrey Wilkins of Coastal Orthopedics who initially tried conservative treatment such as physical therapy and cortisone injections. When this type of treatment failed to relieve the severe pain Mr. Chavis was experiencing, Dr. Jay Preslar III, orthopedic surgeon, performed arthroscopic rotator cuff debridement for a partial thickness tear and also subracromial decompression around August of 1999. He began having popping in his shoulder and still experienced ongoing pain.

Mr. Chavis was then referred to Dr. Robert Elvington of Pee Dee Orthopaedic Associates who, after ordering an MRI, told the claimant he had impingement of the right shoulder with AC joint arthritis. Further surgery was discussed with Mr. Chavis. He was referred to a Dr. David LD. Goltra, Jr., for an epidural injection at East Cooper Hospital in Mt. Pleasant, SC. On January 25, 2000, Mr. Chavis related he had a stroke or a cerebral vascular accident. The stroke affected his memory, his speech, his right hand, and his ability to walk.

Dr. Wilkins referred Mr. Chavis to Dr. Daniel Growblewski, a neurologist. Dr. Groblewski's notes reflect that his impression was that the claimant had sustained brain damage as a result of his stroke. Mr. Chavis continued to experience right upper extremity pain in forearm and hand. The claimant continued to experience right upper extremity pain in his forearm and hand. He underwent nerve conduction studies, which showed no evidence of radiculopathy or carpal tunnel syndrome. Additionally, Mr. Chavis was diagnosed with cervical spondylosis.

Dr. James R. Merikangas, Director, Neuropsychiatry Program at Georgetown University Hospital, saw Mr. Chavis for complaints of imbalance, neck and shoulder pain, and headaches and depression. Dr. Merikangas completed a report, which read, "A review of systems, physical examination and his history are all consistent with a cerebellar and brain stem stroke occurring from interference with the vertebral arterial system in the course of a cervical injection for pain relief as described in the previous reports." Dr. Merikangas' report clearly explained how a misplaced needle could cause the type of stroke that Mr. Chavis had.

The claimant was referred to the Pain Management Program at Palmetto Health Facility and evaluated by Dr. Clay Drummond, a clinical psychologist and the Director of the Center for Pain Management on September 18, 2001. Dr. Drummond noted the significant negative impact the work injury has had on the claimant's family. His relationship with his wife and daughter has been strained due to financial problems and his inability to perform the activities he had prior to his injury. The claimant reinjured his back on December 27, 1999.

Dr. Drummond diagnosed Mr. Chavis with "moderate depression" based on the Beck Depression Inventory. The psychologist's report reads, "Compared to other patients with chronic pain he is experiencing more pain severity and interference with his life. Household chores and outdoor work have been negatively affected by his pain symptoms. Dr. Drummond's diagnosis was "307.89 (DSM-IV) Pain disorder associated with both psychological factors and a general medical condition."

Kimberly Shull-Massey, physical therapist, with Palmetto Health on September 28, 2001, performed a physical therapy initial evaluation. She noted in her report that since his stroke, Mr. Chavis had "significant decreased sex drive and this definitely bothers him." At that time, he was taking 4-6 tablets of prescription, Roxicodone, for severe pain. It was reported that a TENS unit did not provide much relief. Ms. Shull-Massey's report indicated Mr. Chavis appeared to have a neurological deficit.

Gilbert Chavis 3
Vocational Assessment

Dr. Drummond, Director of the Pain Management Program, referred Mr. Chavis to Dr. L. Randolph Waid, a licensed clinical psychologist, for a neuropsychological evaluation. Dr. Waid evaluated the claimant on May 2nd, 15th, and June 12, 2002. The objective of this evaluation was to determine the effects the cerebellar stroke Mr. Chavis, which he sustained while undergoing an epidural nerve injection for back pain.

Dr. Waid's report reads, "Neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected a considering the location of the stroke. Attention/concentration appears to be intact, though there was notable variability in his performance on memory/learning tasks. Indeed, there is compelling evidence of reduced capacity for immediate learning/memory, but no evidence of rapid forgetting or amnestic syndrome. There is no compelling evidence for impairment of for impairment affecting visual spatial skills, receptive or expressive language functions, or sensory perceptual functions. Mr. Chavis was generally efficient and commensurate with his intellectual/educational level in his performance on tasks assessing executive/higher reasoning skills." Dr. Waid continues, "Assessment of emotional functioning reveals an individual who continues to suffer from chronic pain and comorbid depressive and anxious difficulties. This has been a highly stressful period for Mr. Chavis and his wife, and it certainly has affected the quality (of) their life. In summary, there is neuroradiographic evidence of the sustainment of a cerebellar stroke as well as some residual impairments affecting Mr. Chavis' capacity for learning/memory/memory functioning. A great obstacle for Mr. Chavis' return to life pursuits is continuing pain and physical limitations. I would agree with previous diagnoses of Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89) as well as Depressive Disorder, NOS (311). Mr. Chavis likely experiences a mild reduction in overall neurocognitive functioning consistent with the location of stroke. There is not extreme interference in his overall cognitive processing. Mr. Chavis remains in need of care directed toward his chronic pain syndrome and comorbid psychological problems. Clearly, pain and physical limitations psychological problems. Clearly, pain and physical limitations serve as the primary obstacle with regard to his successful return to vocational and social pursuits. These difficulties also serve as an obstacle to efficient neurocognitive functioning."

Dr. Gregory Knag, a physiatrist who continues to treat Mr. Chavis, wrote a note that read, "Mr. Gilbert Chavis has been a patient of mine. He is permanently disabled due to the injuries that he suffered. He is unable to work. He has been disabled from January 25, 2000 until the present. I do not see his condition changing in the future."

Gilbert Chavis 4
Vocational Assessment

Dr. Neal Shore treated Mr. Chavis. Dr. Snow's November 5, 2002 note reads, "The pt. Is a pleasant 47 YO male who has had a several year history of decreased sexual function and drive." Dr. Shore's diagnosis was "Hypogonadism. Sexual dysfunction." Dr. Shore completed a questionnaire, indicating Mr. Chavis' diagnosis was "Erectile Dysfunction".

He was asked whether he felt, in his medical opinion, this condition was most likely caused either directly or indirectly as a result of his patient's (Mr. Chavis) work injuries and if he felt this was pre-existing condition, did he fell it most aggravated or precipitated in any way by his injures and their "sequellae (various medical procedures and treatment, medications to treat work related conditions, stress, depression, pain, and inability to work, resulting from his injuries, etc.)? Dr. Snow checked "Yes". When asked what further treatment would be necessary, he wrote, "Genital Prosthetic..."

Dr. Kang referred Mr. Chavis to Dr. Michael McCaffrey at Strand Regional Specialty Associates. The initial evaluation by Dr. McCaffrey took place on March 25, 2003. In the ***"Initial Evaluation"***, the report reads, "Patient is a middle age right hand dominant male who was injured lifting 95 pound pot at AVX. He subsequently had a right shoulder arthroscopy with rotator cuff debridement by Dr. Preslar. He has had a C5-6 HNP and has an epidural steroid injection where he apparently sustained some sort of neurological complication. He describes it as a stroke. It affected his left side but has resolved for the most part. He has had pain in his left shoulder ever since. He has night pain. He has paresthesias down the dorsum of the forearm. He has pain with driving. He had an MRI a year ago. My evaluation is now requested by Dr. Kang."

On November 6, 2003, Dr. McCaffrey's notes read, "He has been concerned lately because he has lost all of his libido. He has been receiving testosterone injections twice a month by Dr. Shore but that did not improve. He is on multiple medications now and did not have nay problems prior to this stroke. He is not even having any success with Viagra." The ***"PLAN"*** section reads, "We had a lengthy discussion concerning his problems. Counseling time exceeded 10 minutes of his 15 minutes plus examination. I have recommended that he discuss this with Dr. Nicol and Dr. Kang and perhaps Remeron or the Roxicodone are to blame. This is certainly outside my area of expertise."

"As far as his shoulder is concerned, I believe that he is at maximum medical improvement. His impairment, suing the range of motion model is 10%. He merits a 10% impairment for his Mumford procedure or resection arthroplasty of his AC joint. "He" merits a 6% impairment for his flexion deficit. This combines to 24% impairment for his flexion deficit. This combines to 24% left upper extremity impairment."

CURRENT MEDICATIONS:

As of last meeting on October 20, 2003, Mr. Chavis was on the following medications:

1. Roxicodone, 30 milligrams for pain. Claimant reported taking 6 tablets a day.
2. Vioxx, 25 milligrams, an anti-inflammatory medication.
3. Neurontin, 400 milligrams, for severe headaches.
4. Nortriptyline, 25 milligrams, to help him sleep.
5. Metformin, 500 milligrams, for diabetes.
6. Glucotrol, 10 milligrams, for diabetes.
7. Avandia, 8 milligrams, for Type II diabetes.
8. Lipitor, 10 milligrams, for high levels of cholesterol.
9. Mirtazapine, 15 milligrams, an anti-depressant.
10. Testosterone, prescribed for increasing sexual drive according to claimant.
11. Viagra, an anti-impotence agent, prescribed for erectile dysfunction

Additionally, Mr. Chavis takes other over-the-counter medications. When asked about side effects, claimant reported experiencing numerous side effects, which is not unusually given the numerous prescriptions he is taking. Drowsiness, decrease in sexual drive, decreased concentration and memory, fatigue, and irritability are some of the effects he could remember.

PREVIOUS MEDICAL HISTORY:

Mr. Chavis denied sustaining any on-the-job injuries prior to December 7, 1998. He stated that other than having non-insulin-dependent diabetes and history of bleeding ulcers, his other conditions and symptoms began after his work injury and stroke.

ACTIVITIES OF DAILY LIVING:

The claimant reported he awakens frequently throughout the night and estimates he averages 3½ hours of sleep at night. He is often awake prior to 7am. He does very limited housework and at his pace. He washes a few dishes and tries to vacuum to help his wife. However, even that simple task fatigues him. The claimant related

Mr. Chavis stated he used to love to play golf and softball and ride motorcycles. He also used to do yardwork but is no longer able to do those activities due to his severe level of pain and physical limitations. What appeared to bother him the most, based on his statements, was he no is no longer able to play with his grandson, 3 years of age, like he did prior to his work injuries.

The claimant related he spends most of his time at home. He and his wife have a very strained relationship and that bothers him greatly. He appeared both embarrassed and angry about the impact the injury has had on his sexual abilities. Mr. Chavis stated, "I'm always depressed." He also admitted he had crying spells.

Mr. Chavis reported he has noticed that he has a very difficult time remembering things since his injury. He used to pride himself on his memory for details. He stated the one thing that keeps him "going" is his teenage daughter.

EDUCATIONAL BACKGROUND:

Claimant completed the 10th grade at Dillon High School. Around September 2000, he took night classes and earned a GED. He has not had any further schooling nor has he had any formal training other than on-the-job training.

OBSERVATIONS:

Mr. Chavis was very casually but neatly dressed in shorts and a shirt. He was polite and cooperative but Consultant became acutely aware that the claimant was someone who was quite sensitive about his condition and became irritated quickly when having to recall traumatic events related to his injuries. Consultant noticed that he never appeared to be in comfort, which could have been due to his level of pain. He stood and sat intermittently throughout the interview. At the second interview, one of his feet was swollen, which he was unsure if that was due to his medications or diabetes.

The claimant frequently talked about his physical abilities prior to his injury in a sad nostalgic manner. It was apparent that he has always perceived himself as being very masculine and his injuries have really disturbed that perception.

At times, Mr. Chavis was very candid and disclosed more information than necessary, as though he were trying to convince himself that his life had really changed. Other times, his mind appeared to wander and he would pause and ask this Consultant what her questions was. He related that it was quite frustrating to not be able to keep himself focused and forget dates and "things" so frequently.

Despite Mr. Chavis' efforts to smile, he indeed exhibited a flat and depressed affect and mood during both interviews. He seemed quite obsessed about his marital and financial problems.

WORK HISTORY:

At the time of December 7, 1998 work injury; Mr. Chavis was working at AVX in Myrtle Beach, SC as a paste processor. The Dictionary of Occupational Titles Code, which is published by the Department of Labor, is 550.585-034. It is classified and described by Mr. Chavis as a medium job, involving lifting up to 50 pounds. This job has a SVP, or specific vocational preparation, the time it takes to perform the duties of the job, of a 3. This classifies the job as being semi-skilled. However, the skills gained are very unique and specific to this industry and would not directly transferable to other jobs of lighter exertion.

The claimant worked as a laborer for 2 years, installing aluminum. This was manual labor requiring repetitive bending, stooping, and kneeling. It also required prolonged standing and walking and lifting over 45 pounds. This is a job that was unskilled, containing no transferable skills.

Mr. Chavis work history also includes work as a sandblaster. This required him to lift over 150 pounds of metal and stand for prolonged periods. This is another job that contains skills that are specific to that job and not directly transferable to other jobs of lighter exertion. He worked for nearly 2 years the textile industry. He placed yarn on pallets. He worked for another 2 years as a spray painter and had to lift bags of sand, which he stated weighed up to 100 pounds.

TESTING RESULTS:

Mr. Chavis was administrated the **Wide Range Achievement Test-Revision 3** by this Consultant. His reading was equivalent to an 8th grade level; his spelling was equivalent to a 5th grade level, and his arithmetic was at the 7th grade level. The scores are nearly identical to the scores reported by Dr. Waid in his report after the licensed clinical psychologist administered the same test. Therefore, it is the opinion of this Consultant that these scores are a fair representation of the claimant's academic abilities.

VOCATIONAL IMPRESSIONS AND CONCLUSIONS:

Transferability of skills applies to work skills, which a person has demonstrated in vocationally relevant past jobs that can be used to meet the requirements of other jobs. Transferability of skills is most likely among those jobs that require similar skills, when similar tools and machines are utilized, and when similar processes or services are involved. As indicated previously in this report, the jobs that Mr. Chavis performed either have no skills or have specific skills that would not transfer to jobs of lighter exertion.

His performance on the WRAT3 reflects Mr. Chavis would not be suited for clerical work because he performed arithmetic, spelling, and reading at below a high school level.

Taking into consideration vocational factors such as Mr. Chavis' age, educational background, history of unskilled strenuous work, lack of transferable skills, inability to use both arms and hands for repetitive production type motions, his severe level of pain, the effects of the pain medications he need to take, his lack of concentration and poor memory, irritability and anger he has, his lack of self-esteem and depression; it is the professional opinion of this Consultant that Mr. Chavis could not compete for employment at this time. In addition, based on statements made by his specialists who have treated him in the past, he has sustained marked limitations, which are not only physical but also psychological.

RECOMMENDATIONS:

Consultant recommends Mr. Chavis be provided psychological services in order to assist him in coping with the traumatic events, particularly the stroke. The claimant is rightfully angry at the impact this injury and the stroke have had on his mental status and his family.

Fi-fi Jubran, M.A., CRC, CCM, CDMS
Rehabilitation Consultant

12/20/03
Date

FI-FI JUBRAN, M.A., CRC, CCM, CDMS
REHABILITATION CONSULTANT
P.O. BOX 29609
COLUMBIA, SC 29229 - 0609
COLUMBIA, SC 29229
PHONE: 803-699-9930
FAX: 803-699-1920

EDUCATIONAL BACKGROUND:

M.A.
Vocational Rehabilitation Counseling
South Carolina State University
May 1991
GPA 4.0

B.S.
Business Administration
South Carolina State University
May 1985

CERTIFICATIONS:

Certified Rehabilitation Counselor (CRC) #26208
Certified Case Manager (CCM) #06886
Certified Disability Management Specialist (CDMS) #08957
Rehabilitation Counselor Certifications from U.S. Department of Labor #06-340
Rehabilitation Supplier, State of Georgia #1380
Qualified Rehabilitation Counselor, State of North Carolina
Vocational Expert, Social Security Administration

EMPLOYMENT HISTORY:

March 1995 – present
Rehabilitation/Vocational Consultant
Self-Employed, Columbia, SC

Perform vocational evaluations, transferable skills analysis, labor market survey,

and job placement services for insurance carriers, long-term disability providers, attorneys, U.S. Department of Labor, rehabilitation companies, insurance carriers, and other parties. Coordinate medical treatment for injured workers. Modify job site based on medical limitations. Conduct vocational testing to identify aptitudes and interests. Meet with businesses and other potential employers to advocate for the employment of individuals with limitations. Coordinate and justify training programs. Meet with specialists to obtain information regarding a client's condition and their prognosis for vocational planning purposes. Conduct Job Analysis to determine essential functions and physical demands of a particular job.

Perform medical case management with the objective of returning the injured worker, if feasible, back to their preinjury job or a modified job as soon as medically possible.

October 1992 – January 1995
Senior Rehabilitation Consultant
American International Health and Rehabilitation Services, Columbia, SC

Performed vocational assessments to determine the vocational potential of a client taking into consideration their age, education, training, work experience, medical condition, and limitations. Conducted Labor Market Survey in order to determine the availability of jobs within a client's medical or psychological restrictions, and their earning potential. Performed on-site Job Analysis to determine whether accommodations could be made to the workstation to accommodate injured workers with limitations. Provide job seeking skills counseling and support. Coordinated medical evaluations and discussed a client's condition with the specialists to determine options of treatment, work status, and to assist with vocational planning.

March 1991 – June 1992
Vocational Rehabilitation Counselor
S.C. Department of Vocational Rehabilitation, Orangeburg, SC

Duties involved providing services to clients with physical, mental, and developmental disabilities. Determined whether an individual was eligibility for services. Secured employment for clients with limitations. Coordinated training programs. Conducted job placement services. After placement, provided follow-up services to assist clients in maintaining employment. Arranged for on-the-job training programs Worked with other community agencies in serving needs of clients. Consistently exceeded placement goals established by the agency.

ORGANIZATIONS/AWARDS:

Case of the Year (1992) Awarded by the S.C. Department of Vocational Rehabilitation

Customer Service Award (1992) National award presented by American International Health and Rehabilitation Services. This award was based on input from customers and clients.

Member, International Association of Rehabilitation Professionals in the Private Sector (IARPPS)

SECTION A: TO BE COMPLETED BY THE SUPERVISOR

EMPLOYEE NAME: Gilbert Chavis SSN: 248-04-2224 TITLE: Paste Processor

DEPT-SEC-SHIFT: 79-29-01 DATE OF HIRE: 12-3-87 TIME ON THIS JOB:

DATE/TIME OF ACCIDENT: 12-27/99 LOCATION OF ACCIDENT: Production floor

SECTION B: TO BE COMPLETED BY THE EMPLOYEE

Time 8:00-8:30

DESCRIBE THE ACCIDENT: Moving pot of work on a set of bad wheels. Pot came halfway off wheels. When I tried to keep the pot on the wheels my back began to burn. Now at 2:30 P.M. back is not burning but hurts when I pick up something

LIST ANY WITNESSES: Toni

EMPLOYEE SIGNATURE: Gilbert R. Chavis DATE: 12-27-99

SECTION C: TO BE COMPLETED BY THE SUPERVISOR

DESCRIBE THE ACCIDENT:

CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN:

COMPLETION DATE OR EXPECTED COMPLETION DATE:

SAFETY RULES VIOLATED? : YES/ NO DISCIPLINARY ACTION TAKEN: YES/NO

NAME : (PRINT) (SIGNATURE) DATE:

SECTION D: TO BE COMPLETED BY THE INFIRMARY

NEAR MISS: RECORDABLE: INJURED BODY PART(S) :

CODE(S):

MINOR TREATMENT: LOST WORKDAY: TYPE OF INJURY/ILLNES:

CODE(S):

SECTION E: TO BE COMPLETED BY THE SAFETY DEPARTMENT

REMARKS:

ACCIDENT CAUSE: (CODES)

NAME : (PRINT) (SIGNATURE) DATE:

NOTE: THE SAFETY DEPARTMENT WILL COPY COMPLETED REPORT TO AREA MANAGEMENT AND SUPERVISOR

Form **W-2** **1999**

Copy C For EMPLOYEE'S RECORDS (See Notice to Employee on back of Copy B.) This information is being furnished to the Internal Revenue Service. If you are required to file a tax return, a negligence penalty or other sanction may be imposed on you if this income is taxable and you fail to report it.

Wage and Tax Statement OMB No. 1545-0008 Department of the Treasury-Internal Revenue Service

a Control number	1 Wages, tips, other compensation	2 Federal income tax withheld
1187	22729.50	275.41
7 Social security tips	3 Social security wages	4 Social security tax withheld
	23432.46	1452.81
8 Allocated tips	5 Medicare wages and tips	6 Medicare tax withheld
	23432.46	339.77

c Employer's name, address, and ZIP code

AVX CORPORATION
P. O. BOX 867
801 17TH AVENUE SOUTH
MYRTLE BEACH SC 29577

b Employer identification number	9 Advance EIC payment	10 Dependent care benefits
33-0379007		
d Employee's social security number	11 Nonqualified plans	12 Benefits included in box 1
248-04-2224		

13 See instrs. for box 13	14 Other
D 1020.50	
10 243349	

e Employee's name, address, and ZIP code

0248042224

GILBERT A CHAVIS
616 MCKINLEY WAY
CONWAY SC 29526

15 [ ] Statutory employee [ ] Deceased [X] Pension plan [ ] Legal rep. [X] Deferred compensation

16 State	Employer's state I.D. no.	17 State wages, tips, etc.
SC	25274545-4	22729.50
18 State income tax		19 Locality name
293.92		
20 Local wages, tips, etc.		21 Local income tax

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

WCC File # 9927964
Carrier File # WC550-448871
Carrier Code # ______
Employer FEIN ______

Claimant's Name: Gilbert Chavis	SSN: 248-04-2224
Address: 6160 McKinley Way	City State Zip: Conway, SC 29526
Home Phone: unknown	Work Phone: unknown
Employer's Name: AVX Corporation	
Address: P.O. Box 867	City State Zip: Myrtle Beach, SC 29578-0867
Insurance Carrier: Liberty Mutual Insurance Co.	
Preparer's Name: Roy A. Howell, III	Phone #: (843) 881-4228

A. Total Wages Paid

Date of injury: December 27, 1999 (month day year)

1. Check Applicable Method:
   - [x] Report of earnings of injured employee based on four completed quarters.
   - [ ] Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - [ ] Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: 12-3-87.
   - [ ] Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)
2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	3-21-99	$6028.61
2nd	6-20-99	$7177.20
3rd	9-19-99	$3502.18
4th	12-26-99	$6724.47

Total Paid 2. $23432.46

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. —
4. Add lines 2 and 3 TOTAL WAGES PAID: 4. 23432.46
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 49

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).
AVERAGE WEEKLY WAGE: 6. $478.21

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $318.82
8. The compensation rate is as follows (choose one):
   - [ ] When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - [ ] When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - [ ] When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - [ ] Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8: ______.
   - [x] The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $318.82

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803) 737-5723.

South Carolina Wor[illegible] Compensation Commission
P.O. Box 1715 • 161[illegible] [illegible]rion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 9826170/2-04
Carrier File # WC550-441515
Carrier Code #
Employer FEIN

GILBERT R CHAVIS — Claimant's Name
248-04-2224 — SSN
616 MCKINLEY WAY — Address; CONWAY — City; SC — State; 29526 — Zip
(843) 347-0812 — Home Phone #
Work Phone #
T. BROWN — Preparer's Name

AVX CORPORATION — Employer's Name
PO BOX 867 — Address; MYRTLE BEAC — City; SC — State; 2957[illegible] — Zip
Liberty Mutual Group — Insurance Carrier
(800) 532-7706 — Phone #

Date of Injury: December 1, 1998 (month day year)

Date of Notice to Employer of Injury: December 16, 1998 (month day year)

Payment of Temporary Compensation (choose A, B, or C) Check one: ☐ Initial period ☑ Additional period ☐ Corrected compensation rate

A. Temporary Total at the compensation rate of $ 263.69 per week. For this period of disability, disability began on 2/21/2000 and the date of first payment was 3/7/2000.

B. Temporary Partial at the compensation rate of $ ______ per week. Note: When Temporary Partial compensation rate will vary, report first payment here. Supplement throughout the period of Temporary Partial compensation by filing Form 15S with the Form 18, which shall be filed six months after the date of injury and eac[h] six months thereafter until the file is closed. For this period of disability, disability began on ______ and the date of first payment was ______

Calculation of Temporary Partial rate:

Average weekly wage before injury		$
- Current weekly wage	-	$ ______
Difference in wages before injury and now	x	$ .6667
x .6667		$
Temporary Partial Compensation Rate		

C. Salary in lieu of temporary total / temporary partial (circle one) compensation in the amount of $ ______ per week. For this period of disability, disabilit[y] began on ______ and the date of first payment of salary in lieu of temporary compensation was ______.

THIS SECTION MAY BE USED ONLY WITHIN 150 DAYS AFTER NOTICE TO EMPLOYER OF THE INJURY. ATTACH DOCUMENTATION AS TO THE REASON FOR THE TERMINATION.

II. Termination of Temporary Compensation — Temporary compensation payments were stopped on ______ for the following reason:

- ☐ Claimant has returned to work at least 15 days and no temporary partial compensation is due.
- ☐ Claimant agrees he/she is able to return to work and has signed a Form 17.
- ☐ Based on a good faith investigation, the claim is denied. Reason for denial: ______
- ☐ Claimant has been released to return to work without restrictions and employment has been offered.
- ☐ Claimant has been released to return to work at limited duty and employer has provided limited duty work consistent with the terms upon which the Employee has bee[n] released.
- ☐ Claimant has refused medical treatment, examination, or evaluation. Note: Benefits must be resumed if claimant accepts the treatment, examination, or evaluation. Additional report must be filed if compensation is resumed.

I certify that this form has been served on the claimant per R.67-211.

Signature of Claims Administrator — Date

III. Notice to Injured Worker or Legal Representative when Temporary Compensation Has Been Stopped:

The employer's representative may stop temporary compensation within 150 days of the date of notice of injury for the above reasons. However, if you believe that temporary compensation shou[ld not] have been stopped, you may request a hearing by signing below and returning this form to the SCWCC Judicial Department at the address at the top of the form. A hearing will be held within 60 [days of] receipt of your request to determine if temporary compensation has been properly terminated.

MY SIGNATURE BELOW INDICATES THAT I DO NOT AGREE WITH THE TERMINATION OF TEMPORARY COMPENSATION. I REQUEST A HEARING TO DETERMINE WHETHER I AM ENTITLED TO FURTHER TEMPORARY COMPENSATION PAYMENTS.

Check one: Form 15(II) ☐ has ☐ has not been received.

Signature of claimant or legal representative — Date

Employer's representative must complete and file Form 15 with Claims Department within ten days after compensation begins or is terminated. Employer's representative must serve the Form-15 on the cl[aimant] when compensation begins per R.67-211. Employer's representative must prepare and serve Form 20 within thirty days of beginning compensation per R.67-1603. Employer's representative must ser[ve per] R.67-211 two copies of the Form 15 on claimant immediately on termination of compensation with documentation attached as to the reason for the termination. Injured worker may contest termina[tion of] compensation by completing section III of the Form 15 and filing it with Judicial Department.

Employer FEIN

Gilbert Chavis
Claimant's Name

248-04-2224
SSN

6160 McKinley Way
Address

Conway
City

SC
State

29526
Zip

Home Phone #

Work Phone #

Wanda Kelley
Preparer's Name

AVX Corporation
Employer's Name

PO Box 867
Address

Myrtle Beach
City

SC
State

29

LIBERTY MUTUAL GROUP
Insurance Carrier

(000) 731-0830
Phone #

Date of injury: December 1, 1998
month day ye

1. Temporary Compensation Paid:

Number of Weeks	From	To	Amount
9	8-16-1999	9-26-99	$ 2373.21
	2-1-2000	2-21-2000	$
			$
			$
			$

2. The claimant returned to work on ______
month day year

☐ With restrictions but at a salary not less than before the injur
☐ Without restrictions.

3. The claimant agrees he or she was able to return to work on February 22, 2000
month day year

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT, OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

Claimant's Signature

Employer's Representative Signature

(Check one) ☐ Witness ☐ Claimant's Attorney

Date Agreement Signed

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 day period, obtain a Form 17 to document that claimant agrees he or she is able to return to work.

WCC FORM # 17 REV. DATE 3/97
39-CSF-8 R4

17

RECEIPT OF COMPENSATIO

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

WCC File # 9826170
Carrier File # 510-192314 550-441515
Carrier Code # 55-4
Employer FEIN

Gilbert Chavis — Claimant's Name
248-04-2224 — SSN
AVX Corporation — Employer's Name

6160 McKinley Way, Conway, SC 29526 — Address / City / State / Zip
PO Box 867, Myrtle Beach, SC 29578 — Address / City / State / Zip

Home Phone # — Work Phone #
LIBERTY MUTUAL GROUP — Insurance Carrier

Wanda Kelley — Preparer's Name
(000) 731-0830 — Phone #

Date of injury: December 1, 1998 (month day year)

1. Temporary Compensation Paid:

Number of Weeks	From	To	Amount
9	8-16-1999	9-28-99	$ 2373.21
	2-1-2000	2-21-2000	$
			$
			$
			$

2. The claimant returned to work on ______ (month day year)

☐ With restrictions but at a salary not less than before the injury.
☐ Without restrictions.

3. The claimant agrees he or she was able to return to work on February 22, 2000 (month day year)

I agree that I was disabled for the period(s) indicated and I was paid compensation as shown above. **I UNDERSTAND THAT MY WEEKLY TEMPORARY COMPENSATION CHECKS WILL STOP; HOWEVER, I GIVE UP NO RIGHTS TO COMPENSATION FOR FUTURE DISABILITY, FOR PERMANENT DISABILITY, DISFIGUREMENT, OR MEDICAL CARE.** The effect of this form has been fully explained to me, and I have received a copy of it. I understand that I should not sign this form until 15 days after I have returned to work or agree I was able to return to work.

Claimant's Signature ______

Employer's Representative Signature: Tony Deschamps/W 2/24

(Check one) ☐ Witness ☐ Claimant's Attorney

Date Agreement Signed ______

File this form with the Claims Department no later than 31 days from the date the claimant returned to work to terminate temporary compensation after the first 150 days after employer's notice of the injury according to R.67-505. Within the 150 day period, obtain a Form 17 to document that claimant agrees he or she is able to return to work.

WCC FORM # 17 REV. DATE 3/97
39-CSF-8 R4

17

RECEIPT OF COMPENSAT

PRIMARY MEDICAL ASSOCIATES

Asbury H. Williams, MD
Board Certified · Family Practice

Suite 6 - Ocean Lakes Plaza
Post Office Box 14340
Surfside Beach, S.C. 29587
(803) 238-5654

James M. Vest, MD
Board Certified · Family Practice

Gilbert Chavis

Gilbert Chavis was seen in our office on 6/7/96.

CHIEF COMPLAINT: Back pain

DIAGNOSIS: LS strain

X-RAYS:

LABORATORY:

TREATMENT: Flexeril, Ultram, Cont Rx

RESTRICTIONS:

REFERRAL:

FOLLOW UP:

RETURN TO WORK: 6/7/96 - [illegible]

SIGNED: [signature]

510-157760
312

RECEIVED
AUG 12 1996
COLUMBIA

ASBURY H. WILLIAMS, M.D., P.A.
OCEAN LAKES PLAZA, # 8, P.O. BOX 14340
SURFSIDE BEACH, SC 29577
DEA # AW 0337524
(803) 238-5854

NAME Gilbert Chavis AGE

ADDRESS DATE 6 B 96

℞

Continue PT
for 3 weeks

[signature]

Refill ______ times
☐ Label

DISPENSE AS WRITTEN SUBSTITUTION PERMITTED
FP0303525

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
1400 Hwy. 544
Conway, South Carolina 29526-8485
(803) 347-7222 FAX: (803) 347-3305

James W. Yates, Jr., M.D.
J. Stewart Haskin, Jr., M.D.
A. Jay Preslar III, M.D.
William L. Mills, M.D.

ORTHOPAEDIC EVALUATION

Gilbert R. Chavis
616 McKinley Way
Conway, SC 29526

Date:	June 12, 1996
Case No:	20347
Age Race Sex:	41 M
Referred By:	Dr. Asbury Williams

COMPLAINT: Right-sided lower back pain.

HISTORY: This 41-year-old white male presents today complaining of an injury to his lower back at work on 4-8-96. He states he was lifting a pot away from his body which weighed approximately 25 pounds and he felt sudden sharp pain in the right side of his lower back. He was working at AVX at the time. His pain is increased with sitting and laying on his side, decreased with stretching exercises. He denies any bowel or bladder dysfunction.

PAST MEDICAL HISTORY: Significant for diabetes. Negative for stroke, cancer, weight loss, kidney, liver, lung or heart disease, or hypertension.
SURGICAL HISTORY: Tracheotomy as an infant. Excision of a rectal mass which was benign at age 13.
SOCIAL HISTORY: The patient is married with two children. Tobacco use: None. Alcohol use: Occasional. Employment: He is now working at Precision Southeast.
MEDICATIONS: Flexeril, Ultram and Glipizide.
ALLERGIES: No known drug allergies.

PHYSICAL EXAM: General appearance: Reveals a pleasant cooperative male who is not overweight and in no acute distress. Lumbar spine: No visible deformity, tender to palpation in the right paraspinous muscles. Good range of motion with fingertips to the distal tibias in forward flexion. Increased pain with extension. No pain with range of motion of the hips bilaterally. Good pedal pulses bilaterally. Neurologic exam: Motor strength of the lower extremities is 5/5 bilaterally. Deep tendon reflexes are normoactive and symmetric bilaterally. Sciatic tension signs are negative.

X-RAYS / LAB:

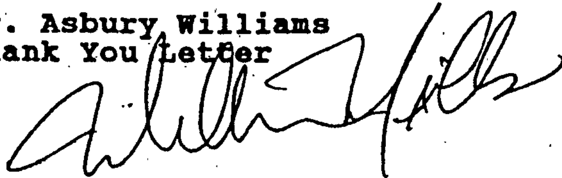
IMPRESSION: Nonradicular lumbar pain.

RECOMMENDATION: Physical therapy for Williams flexion protocol for four weeks. The patient was instructed to bring his lumbar x-rays which were done previously with him. He is able to work full-duty. He will return for follow up in six weeks. (K. White, PA-C)

William L. Mills, M.D. **dsh**

CC: Dr. Asbury Williams
Thank You Letter

CC: NWWI



July 23, 1996 Gilbert Chavis
illiam L. Mills, M.D. /cfr Case No.: 20347

Mr. Chavis returns. He is working but continues to have ongoing lower back pain. Lumbar x-rays are reviewed and show no evidence of spondylolysis or spondylolisthesis.
PLAN: 6-week work conditioning program. He is able to work full duty and we will see him back after that.

CC: Dr. Asbury Williams CC: NWWI

September 23, 1996 Gilbert Chavis
William L. Mills, M.D. /vlr Case No.: 20347

Mr. Chavis returns for followup if his back pain symptoms. He is in the work conditioning program and feels that his strength has increased. However, he does have some ongoing symptoms of non-radiating lower back pain. He is now working full duty. I had a long discussion with him today regarding that fact that I really don't feel that surgery is indicated. Hopefully, his symptoms will continue to improve with time. I went over proper lifting techiniques from a biomechanical standpoint. He is now at maximum medical improvement with a 5% permanent impairment to his lumbar spine. This is equivilent with a 5% whole person impairment. We will see him back as needed. He is able to work full duty.

CC: Dr. Asbury Williams CC: NWWI

ATE: 10/24/96

Patient missed appointment. Card Sent.

October 31, 1996 Gilbert Chavis
William L. Mills, M.D. /dsh Case No.: 20347

Mr. Chavis is back today and overall much improved with what he describes as improvement of his symptoms. He is currently working two jobs. I have emphasized the importance of continuing with stabilization type exercises and I again went over proper lifting techniques with him. We will see him back as needed.

CC: Dr. Asbury Williams CC: NWWI

November 21, 1996 Gilbert Chavis
William L. Mills, M.D. /cfr Case No.: 20347

He states that his lower back pain is getting worse. He has been doing his home exercises. He is still working full duty at two different jobs. He frequently lifts up to 40 pounds at work but does not have any pain while he is working. He has pain in the evenings when he is resting. We have recommended a lumbar MRI scan and a SED rate. This has been schduled for 2-2-96 at Conway Hospital. He will return for follow-up after his scan has been completed. (Kristina K. White, PA-C)

CC: Dr. Asbury Williams

December 4, 1996 Gilbert Chavis
William L. Mills, M.D. /vlr Case No.: 20347

.e is here today for followup of his lumbar MRI. The MRI is reviewed and by my interpretation there is no abnormality seen. There is no evidence of a focal disk herniation. There is no nerve root compression seen. Sed rate is normal at 15. I don't feel that he has a surgical problem. He is at maximum medical improvement. He is able to continue working. He has a 5% residual impairment due to his ongoing subjective symptoms. We will see him back on an as needed basis.

CC: Dr. Asbury Williams CC: NWWI

March 12, 1997 Gilbert Chavis
William L. Mills, M.D. /dsh Case No.: 20347

Mr. Chavis is back today with continued symptoms of non-radiating lumbar pain. I again discussed with him the fact that without a component of leg pain I really don't think I can help him with a surgical procedure. I really don't think there is anything further that I can offer him at this point. This may certainly be something that he is just going to have to learn to live with. Will refer him to Dr. Wilkins to see if there is anything further that he can offer him from a treatment and therapy standpoint. I do think that Dr. Wilkins' evaluation would be helpful as it may certainly diminish Mr. Chavis' disability and give him some relief of pain.

CC: Dr. Asbury Williams CC: NWWI

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

S COPY IS FOR THE INSURANCE CARRIER.

March 5, 2001 Gilbert Chavis
William L. Mills, M.D. /vlr Case No.: 20347

Mr. Chavis is here today for evaluation of his neck. He reports neck pain associated with radicular symptoms in his right arm since 1998. He also has symptoms in his left arm, but these are not as significant as that on the right. He states he had a "stroke" after a selective nerve root block. On exam today, he has a negative Hoffman sign. Deep tendon reflexes are normoactive and symmetric. There is normal strength.

IMPRESSION: Chronic cervical pain with radicular symptoms.

PLAN: I have reviewed MRI today, which was performed on 2-28-2001 and by my interpretation there is foraminal stenosis on the left at C4-5 which does not entirely explain his symptoms, particularly since he has predominantly right arm pain. I would recommend at this time EMGs and nerve conduction studies of both extremities as well as cervical CT myelogram, as I feel that I would need more anatomical detail prior to making any definite decisions regarding whether or not surgical intervention would help with is pain syndrome.

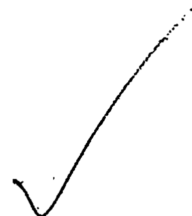
CC: WC

:HIS COPY IS FOR THE INSURANCE CARRIER.

, :h 22, 2001 Gilbert Chavis
William L. Mills, M.D. /dsh Case No.: 20347

Mr. Chavis returns with a CT myelogram of the cervical spine. It was reviewed with Dr. Mills today and there is a diffuse disc bulge at C4-5 and C5-6, however, no spinal stenosis or focal disc herniation is noted. On exam today that I completed, the patient described pain into an ulnar nerve distribution. Tinel's sign was positive bilaterally, right greater than left. Spurling sign of the neck was negative. I feel that the patient's bilateral arm pain is coming from ulnar neuritis and not from the cervical spine. We will go ahead and begin treating him for ulnar neuritis. I will set him up for EMGs and nerve conduction studies with Dr. Wilkins. In the meantime, I placed him one EC Naprosyn around the clock, 500 mg b.i.d. We made night splints for him to wear to keep his arms extended at night as he describes the worst pain in the morning when he wakes up and states he sleeps with his arms flexed. Hopefully, these measures will help resolve the pain. We will also have him followup with Dr. Haskin for further evaluation and treatment of the ulnar neuritis. As Mr. Chavis has such pain, he may need ulnar nerve decompression. (Maureen M. Sevilla, PA-C)

CC: WC



Strand Orthopaedic Consultants

C- 157760
312

GILBERT CHAVIS 12/27/96

Is seen with a history of developing pain in his R. arm and shoulder and low back when he lifted a heavy object at work in May of 1996. He subsequently was later seen by Dr. Asbury Williams and treated with medications and therapy. He was referred to Dr. Mills who treated him with conservative measures and had an MRI done of the lumbar spine and hips which are neg. The pain has worsened in the last month or so and the pain in his neck, which originally quit, has returned. It is worse with activity. Feels a burning pain with abduction. Pain in his back he feels when he does heavy lifting motions but is worse after having done all these motions during the day. He is working 70-80 hrs. at 2 different jobs, AVX and Precision Engineering. Both of these jobs involve moderate lifting 25 lb. or so.

His pain in the low back is non-radiating and is primarily to the L. side in the paravertebral but does, at times, extend all the way across. The pain in his neck is in the R. base of neck, particularly when the shoulder is painful. His shoulder pain is over the lateral aspect of the shoulder and is worse when he lies on it and with activities. No weakness. No paresthesias, etc.

PAST HISTORY: Patient's a nonsmoker. He denies alcohol intake. His mother died of cancer and his father died suddenly of unknown causes. Only hospitalizations were for removal of a peroneal mass and for a tracheostomy as a child. He has some occasional gastric upset, otherwise ROS is neg.

P.E.: He has good symmetrical strength in all the upper extremity muscle groups. Reflexes of both the upper and lower extremities are 2+ and symmetrical. He has full ROM of the C spine. Complains of some pain in the R. paravertebral musculature at low base posteriorly on the R. with extremes of motion. He is slightly tender over the lateral aspect of the shoulder. He has no AC tenderness or prominence. He has full ROM but complains of mild pain on wide abduction. He is slightly tender laterally over the interval between the humeral head and the acromion. He stands with a level pelvis. He flexes hands to mid calves. He is able to walk on heels and toes. L. side bending causes some paravertebral discomfort on the R. which is the side of pain. He has good pedal pulses. Claims slightly diminished sensation in his L. leg which is general. NO radicular pattern noted. SLR is neg. Abdominal exam is neg. He has some mild lower lumbar tenderness. No paravertebral tenderness.

I think he may have an impingement syndrome of his R. shoulder robably overuse and strain of the lumbar spine. I might try an anti-inflammatory drug and some stretching exercises for his low back. Want to see him one additional time in 3 weeks.

THOMAS P. HARDEN, M.D. /pc

510-1577760
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GILBERT CHAVIS 1/23/97

Mr. Chavis has had a good bit of improvement and wants to return to full activity. He may do so, return here PRN.

THOMAS P. HARDEN, M.D. /pc

GILBERT CHAVIS 01/30/97

Returns stating he has had increase in pain in his R. shoulder. He as had continued back pain as well but this is tolerable. His shoulder pain is primarily lateral and than over the scapular area. He is injected with 2 and 2 with relief of symptoms. Return PRN.

THOMAS P. HARDEN, M.D. /pc

2-6-97
Pt called c/o pain in his shoulder running down his shoulder blades into his back. SMC suggested him to see TPH on 2-7-97. TPH was consulted and perscribed Darvocet & Flexeril called in to his pharmacy. Pt was notified & med called in.
SMC-TPH/

GILBERT CHAVIS 02/07/97

Returns saying he has had a good bit of pain in his shoulder with radiation down the arm posteriorly. Extension of his neck causes some R. basilar neck pain. Deviation and extension to the L. cause pain in the L. scapula area similar to the feeling he has in the R. scapular area. He has minimal tenderness now over the anterolateral aspect of the shoulder. I think we have improved that. Will get MRI of the shoulder and C spine.

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THOMAS P. HARDEN, M.D. /pc

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
J. Stewart Haskin, Jr., M.D.
A. Jay Preslar III, M.D.
William L. Mills, M.D.
Jeffrey C. Wilkins, M.D.

MUSCULOSKELETAL EVALUATION

Gilbert R. Chavis

Date:	**March 18, 1997**
Case No:	**20347**
Age Race Sex:	**42 WM**
Referred By:	**Dr. William L. Mills**

COMPLAINT: Low back and right shoulder pain.

HISTORY: This is a 42-year-old white male with the chief complaint of low back and right shoulder pain since 4-8-96 from a work injury, treated by Dr. Mills including a normal sed rate, work hardening, MRI of his lumbar spine done at Conway Hospital which was read as normal. He is working at two jobs and having some difficulty. No numbness or tingling. No bowel or bladder dysfunction. Sleeping improvement to how he was before.

PAST MEDICAL HISTORY: Pertinent for non-insulin dependent diabetes and on Glipizide. Throat surgery at 10 years old.
SOCIAL HISTORY: He works for AVX and also for Precision Southeast in materiel handling. He notes the Precision Southeast job is significantly more difficult on his back.

PHYSICAL EXAM: White male who appears his stated age, well-nourished, well developed, answers all questions clearly and appropriately. NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted. NEUROLOGIC/UPPER: Strength, sensory, reflex exam of upper extremity including biceps, triceps, brachioradialis and pronator reflex within normal limits. Negative Hoffman's or Spurling's signs. Negative scapulohumeral reflex. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted. VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency. HIPS: Patrick's sign negative. Passive range of motion with internal and external rotation without pain. Log rolling negative. No signiricant trochanteric tenderness. KNEES: No effusion, erythema or increased warmth noted. Lachman normal. Varus and valgus stress at 0 and 30 degrees without abnormal

Attn: Sophia

1400 Highway 544, Conway, SC 29526-848 • (803) 347-7222 • FAX (803) 347-3305

laxity or instability. Joint line without tenderness. Patellar movement symmetric without tenderness of patellar facets. Apprehension sign negative. Anterior and posteiror drawer within normal limits. SHOULDERS: Active and passive range of motion within normal limits without pain. No tenderness to palpation of AC joint, subdeltoid bursa or biceps tendon. Negative impingement or apprehension sign. No instability noted.

LUMBAR SPINE: Tender and trigger points in the quadratus lumborum and lumbar paraspinals and also in the parascapular muscles on the right recreating his pain.

X-RAYS / LAB:

IMPRESSION: Myofascial pain.

RECOMMENDATION: Trigger point injections. Physical therapy. Voltaren. Followup in three weeks.

INJECTION NOTE: I injected the quadratus lumborum on two sides with divided 3 cc of 1% Lidocaine with no improvement in the patient's pain. Injected infraspinatus in two different sites with divided 3 cc of 1% Lidocaine with numerous jump signs and improvement in the patient's pain.

Jeffrey C. Wilkins, M.D.

dsh

CC: Dr. William L. Mills
Thank You Letter

CC: NWWI

ɔril 9, 1997 Gilbert Chavis
-ffrey C. Wilkins, M.D. /dsh Case No.: 20347

File C-157700 312

- presents today noting improvement in his shoulder following shots and also articularly being off work at his second job. No particular improvement in his low back pain. I have a note from physical therapy and they feel he is ot going to make any further progress. He does note occasional sporadic umbness in his right lower extremity with squatting. He is having concerns about whether or not the MRI was sufficient because he is having tailbone pain.

HYSICAL EXAM White male who appears his stated age, well-nourished, well-developed, answers all questions clearly and appropriate.
EUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity

including patellar, achilles, medial hamstring reflexes within normal limits. lantar responses downgoing. No ankle clonus or increased tone/cogwheeling oted. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted. VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency. No particular tenderness over the coccyx region although there is some mild sacroiliac tenderness. There is an epilateral fabere's test positive. Contralaterals negative. SHOULDER: Reveals good range of motion. Decreased tenderness to palpation in the myofascial tissues of the right shoulder. IMPRESSION: Probable sacroiliitis.

PLAN: Discontinue the Voltaren and begin Naprosyn. Follow-up in ten days. If not better, we will give him sacroiliac joint injection, hold physical erapy, hold him off his second job until next appointment.

April 18, 1997 Gilbert Chavis
ffrey C. Wilkins, M.D. /dsh Case No.: 20347

Returns today saying his back is a lot better particularly likes the aprosyn, stating his back is a lot better and his shoulder is a little etter and he is asking about returning back to is second job. hysical examination reveals decreased tenderness to palpation in the scapulothoracic region. White male who appears his stated age.
EUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity ncluding patellar, achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling oted. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted. VASCULAR: istal pulses intact. No skin changes consistent with vascular insufficiency.

IPRESSION: Sacroiliitis, improved.
Shoulder myofascial pain improved.

AN: We discussed with him the fact that only significant strengthening improvement of indurance of strength would allow him to do both jobs. However, we do feel it is appropriate to have a trial back at the second job. ontinue Naprosyn. Will follow-up in one month, release him if he is able lerate the other job without problems.

May 6, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /dsh 510.157760 312 | Case No.: 20347

He returns today noting he has returned to his second job and has had increase in shoulder pain. Some increase in back pain but back is still tolerable with the Naprosyn. Physical examination does reveals negative impingement sign, negative Jobe's test. Negative apprehension sign. No instability. Some tenderness to palpation in the myofascial region.

IMPRESSION: Chronic shoulder pain. PLAN: Course of myofascial release, continue current medications, off the second time for two weeks until follow-up. We will give some consideration to serotonergic medications in light of his rather flat affect.

May 23, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /cfr | Case No.: 20347

Returns today. No progress since the last visit. He did have a thorough work site analysis by Chris Floyd and Jeff Lee. It was recommended assistance with lifting 50 pound pots. Physical examination is unchanged.
IMPRESSION: Chronic shoulder pain.
PLAN: To improve pain tolerance and muscle function, we have added Zoloft. Referred him to Dr. Gawith for urologic complaints. Hold him off work at Precision Southeast for six weeks. Naprosyn. We will see him back in approximately one month.

FORMS COMPLETED: 6/6/97
OFFICE MAILED: Faxed (See form) NM

June 20, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /dsh | Case No.: 20347

Returns today making good progress with the Zoloft. He does have the complaint on 100 mg dose of decreased libido and nausea. Physical examination reveals marked decrease and tenderness to palpation in the right scapulothoracic region.

IMPRESSION: Chronic shoulder pain improving.

PLAN: Will have him cut back to 50 mg. He is to continue to follow with Dr. Gawith for related complaints. We will rate him at 5% whole person permanent impairment rating. That is DRE category II for the cervical spine. I have given him no impairment rating for the lumbar spine and he is released from our care.

Gilbert Chavis
Case No.: 20347

July 10, 1997
Jeffrey C. Wilkins, M.D. /dsh

He returns today having been doing quite well but the pain has returned. He is quite frustrated. Physical exam today reveals tender and trigger points. Flat affect. Negative impingement sign. Good range of motion in the shoulder and lumbar spine.

IMPRESSION: Chronic shoulder pain.

PLAN: We will put him on Prozac 20 mg, Naprosyn. Hold him off his night time job for three weeks and see him back at that that.

Gilbert Chavis
Case No.: 20347

July 30, 1997
Jeffrey C. Wilkins, M.D. /cfr

Returns today having some good days but all-in-all, unchanged from previous. Still taking Zoloft. Did not switch to Prozac. Physical examination is unchanged.
IMPRESSION: Chronic pain.
PLAN: Continue his full duty job. He has been dismissed from his night time job. We have added Duract when he calls in for a refill of his anti-inflammatories. He is to switch to Prozac immediately.

Gilbert Chavis
Case No.: 20347

August 18, 1997
Jeffrey C. Wilkins, M.D. /cfr

Returns today. Fills something was missed on the MRI. His back is still having pain. Physical examination reveals tenderness to palpation, most noted on the right side. Some increased pain in extension greater than flexion.
IMPRESSION: Chronic pain.
PLAN: CT myelogram, Conway Hospital. Switch him to Effexor, titrating dose. Back to Naprosyn and we will see him back.

Gilbert Chavis
Case No.: 20347

August 29, 1997
Jeffrey C. Wilkins, M.D. /vlr

Returns today after CT myelogram. Frustrated and depressed. Physical examination reveals flat affect. NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted.
VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency. Negative impingement sign. IMPRESSION: Chronic pain.

PLAN: We will try a low dose of Yohimbine. We will switch him to nocturnal Serzone for sleep ½ - 1 p.o. q. h.s. Increase his Effexor to 225 a day. See him back in followup for 3 weeks. Note, CT myelogram of Conway Hospital today reveals no evidence of central or lateral recessed stenosis. No significant herniated disc. No fracture or dislocations. No significant facet degeneration.

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COLUMBIA, SC

September 22, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /vlr | Case No.: 20347

Returns today doing well with the Effexor-Serzone combination. Improvement in his neck, shoulder and low back pain with no particular side effects. No worse than his other symptomatology. NEUROLOGIC/UPPER: Strength, sensory, reflex exam of upper extremity including biceps, triceps, brachioradialis and pronator reflex within normal limits. Negative Hoffman's or Spurling's signs. Negative scapulohumeral reflex. NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted. Shoulder examination normal except for myofascial dysfunction.

IMPRESSION: Chronic pain.

PLAN: Continue on his current medications. He is not going to try Yohimbine due to cost. He is to call us if any side effects once this is started. We will continue on his current dose because he has essentially maxed out both medications in combination.

FORMS COMPLETED: 9/29/97
OFFICE MAILED: m

October 13, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /dsh | Case No.: 20347

He returns today possibly some better, no worse. Occasional sharp pain between his shoulder blade in his back. Physical exam does reveal some tightness in the latissimus and quadratus lumborum. Shoulder examination normal including negative impingement. Negative instability sign. Negative sulcus and negative drawer sign. There is no winging with wall pushups.

IMPRESSION: Chronic pain. PLAN: Discontinue Serzone and begin Remeron, titrating up to 30 mg and he will call with follow-up.

510-157760
file 312

November 7, 1997 | Gilbert Chavis
Jeffrey C. Wilkins, M.D. /cfr | Case No.: 20347

Returns today. Was unable to tolerate the Remeron. Anti-inflammatories helping. Otherwise no change.
IMPRESSION: Chronic pain.
PLAN: Little else to offer in the care of Mr. Chavis. He has failed physical therapy. He has had sufficient imaging and he has also failed numerous medications. I will continue him on his symptomatic treatment at this point and we will see him back as needed.

FEB 23 1998

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
1400 Hwy. 544
Conway, South Carolina 29526
(803) 347-7222 • FAX: (803) 347-3305

December 2, 1997

Sandria S. Bagwell
Liberty Mutual
P. O. Box 100154
Columbia, SC 29202-3154

File

RE: Gilbert Chavis
Your File No: 510-157760
Our Chart No: 20347

Dear Ms. Bagwell:

This is in regards to your letter dated December 1, 1997 regarding Gilbert Chavis. I do feel that Mr. Chavis has reached maximum medical improvement as of November 7, 1997. I do feel that he still requires continued treatment to keep him at this level of function. As stated on June 20, 1997, I would rate him as a DRE category II injury to the cervical spine with a five percent (5%) whole person impairment rating. No permanent impairment from lumbar spine complaints.

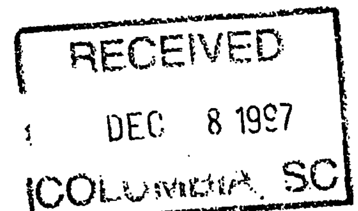
If I can be of any further assistance, please let me know.

Sincerely yours,

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

Jeffrey C. Wilkins, M.D.
Physical Medicine and Rehabilitation

JCW/vlr



James W. Yates, Jr., M.D. — Orthopaedic Surgery, Sports Medicine
J. Stewart Haskin, Jr., M.D. — Orthopaedic Surgery, Surgery of the Hand
A. Jay Preslar III, M.D. — Orthopaedic Surgery
William L. Mills, M.D. — Orthopaedic Surgery, Spinal Surgery
Jeffrey C. Wilkins, M.D.

Administrator: Bruce W. Thompson, M.A., M.B.A.

February 27, 1998
Jeffrey C. Wilkins, M.D. /cfr

Gilbert Chavis
Case No.: 20347

Returns today. He is still having discomfort. He says he has been off his medication for quite some time. Is still having problems with impotency. Physical exam reveals full range of motion except in extension. Some diffuse tenderness to palpation. NEUROLOGIC/LOWER: Strength, sensory, reflex exam of lower extremity including patellar, achilles, medial hamstring reflexes within normal limits. Plantar responses downgoing. No ankle clonus or increased tone/cogwheeling noted. DERMATOLOGIC: Skin warm and dry. No vesicular rash noted.
VASCULAR: Distal pulses intact. No skin changes consistent with vascular insufficiency.
IMPRESSION: Chronic back pain.

PLAN: Return him to the Zoloft per his request. Try Duract. He wants to get a second job. We told him he would probably be much more comfortable with a nonphysical job. He is concerned regarding the pay for this. He notes he saw Dr. Western, who sounds like a neurologist in Columbia who, per the patient, agreed with our opinion and offered no particular new treatments.

CC: Dr. Asbury Williams

CC: NWWI

File
510-157760
312

RECEIVED
MAY 26 1998
COLUMBIA SC

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

November 16, 1998 Gilbert Chavis
Jeffrey C. Wilkins, M.D. /dsh Case No.: 20347

returns today still having the pain in his arm, otherwise doing. He has een laid off once and now working at AVX. He saw Dr. Hayes who prescribed some medications, says it didn't help. But apparently per Dr. Hayes' notes, he was poorly compliant with it. He had an MRI ordered by Dr. Stengal. Neurologic, dermatologic and vascular normal. Restriction in extension greater than flexion. MRI essentially normal for patient's age. Disc architecture appears to be within normal limits. Some mild degenerative changes again appropriate for Gilbert's age, body habitus and occupational load.
IMPRESSION: Chronic back pain.
Will get a muscle stimulator, place him on some Remeron q.h.s. No estrictions with work.

CC: Dr. Asbury Williams CC: NWWI

December 23, 1998 Gilbert Chavis
Jeffrey C. Wilkins, M.D. /vlr Case No.: 20347

Getting improvement in his back pain with the muscle stimulator. He has particular pains in a forward flexed position. He has some increased pain on xtension greater than flexion.

IMPRESSION: Chronic back pain. Question facet syndrome.

PLAN: Send him down to Dr. Holgate for an L5-S1 facet block on the right. If he does have a facet hypertrophy on that side, this would fit with his symptoms. We will have him continue the muscle stimulator.

CC: Dr. Asbury Williams
CC: NWWI

January 11, 1999 Gilbert Chavis
Jeffrey C. Wilkins, M.D. /dsh Case No.: 20347

He returns today stating he does not whether to hug us or hit us due to the fact his facet has helped so much that he wishes he had it sooner. Neurologic, dermatologic and vascular normal. Marked improvement in extension.

IMPRESSION: Facet pain.

I discussed with him the fact that if it recurs we would repeat the block one more time and if the pain recurs after that, we will give consideration to facet rhizotomy. Note: Must be careful the numbering has he has a transitional vertebra.

CC: Dr. Asbury Williams CC: NWWI

OCT 14 1999
COLUMBI

March 24, 1999 Gilbert Chavis
ffrey C. Wilkins, M.D. /ajf Case No.: 20347

file

Gilbert Chavis returns today. Back still doing very well. Now complaining of elbow pain. He points to the tricep tendon region. He says this begin 12/01/98. He was lowering an item at work. He still continues to work but he is having to restrict his weight somewhat. Physical exam reveals tenderness of the triceps with some myofascial dysfunction. He has full strength. Neurologic, dermatologic and vascular exams are normal.

IMPRESSION: Myofascial pain. PLAN: Tender trigger injection. Follow-up with Louise. Continue current work.

INJECTION NOTE: Three cc of celestone/lidocaine was injected into four separate injection sites using a clean technique, no significant grittiness. Some improvement in pain. No jump signs.

510-192314
312

April 21, 1999 Gilbert Chavis
Jeffrey C. Wilkins, M.D. /vlr Case No.: 20347

Returns today without particular improvement. We examined him today in length with Louise from Physical Therapy. He has good strength. Negative impingement sign. Does have pain with resisted stretch to the triceps. Focal tenderness over the triceps tendon, as before.

IMPRESSION: Tricep pain.

PLAN: We expected better response. We will have the patient undergo a BTE evaluation to look for any muscle strength asymmetries. We would expect no permanent impairment from this condition. Give consideration to shoulder MRI. This would be the only diagnosis that could tie in all current complaints.

May 13, 1999 Gilbert Chavis
Jeffrey C. Wilkins, M.D. /vlr Case No.: 20347

Returns today says when he lifts his arm over his head he gets pain in the sub deltoid region as well as the triceps. Note, with the same maneuver, he has no firing of the triceps. Neurologic, dermatologic, and vascular exams are normal. Impingement sign laterally. Negative flexion.

IMPRESSION: Impingement syndrome.

PLAN: We will inject him today. Send him for an MRI of the shoulder, with treatment based on the results. 8 cc of Lidocaine and 2 cc of Celestone injected into the patient's right subacromial space with immediate improvement in some of the patient's symptoms.

OCT 14 1999
COL

THIS COPY IS FOR THE INSURANCE CARRIER.

:e 10, 1999
.ffrey C. Wilkins, M.D. /dsh

Gilbert Chavis
Case No.: 20347

ne returns today for followup of his MRI. Physical examination reveals impingement sign, intermittently reproducible pain with abduction internal otation. Neurologic, dermatologic and vascular normal. MRI does reveal artial rotator cuff tear. Also, opinion of Dr. Genez.

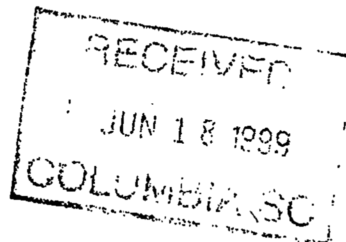
IMPRESSION: Impingement syndrome. Partial rotator cuff tear.

ggressive physical therapy program for strengthening. Limitation with no overhead activity vocationally or recreationally. Patient will return in 3-4 eeks.

510-192314

312

CC: WC



COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

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...e 30, 1999 Gilbert R. Chavis
...frey C. Wilkins, M.D. /dsh Case No.: 20347

[e returns today unimproved. Neurologic, dermatologic and vascular ınchanged. Still positive impingement. For now, to Dr. Preslar for :onsideration of surgical opinion. Per therapy certainly Gilbert did not [ive maximum effort in therapy and we have little else to offer him from a :onservative standpoint.**

510-192314
312

CC: WC

COASTAL ORTHOPAEDIC ASSOCIATES, P.A

ugust 1, 2000 Gilbert Chavis
effrey C. Wilkins, M.D. /vlr Case No.: 20347

Returns today minimally changed. Neurologic, dermatologic, and vascular exams are unchanged. Shoulder exam is unchanged.

IMPRESSION: C6 radiculopathy. Rotator cuff tendinitis.

PLAN: I have recommended repeating a selective nerve root block. We will have this done at DISC, where the patient is comfortable in light of his previous complication. We have given him 120 Roxycodone today. Continue to work with the same restrictions if it is available. We will discontinue physical therapy.

CC: WC

August 15, 2000 Gilbert Chavis
~~James W. Yates,~~ Jr., M.D. /dsh Case No.: 20347
WILKINS

Returns today. His family talked him out of doing the C6 nerve block. He notes a significant amount of pain taking up to 10 Roxycodone a day. Neurologic, dermatologic and vascular unchanged.

IMPRESSION: C6 radiculopathy. Rotator cuff tendinitis.

Refer the patient to Dr. William Mills. He has a second opinion in the meantime. I think Gilbert's only significant chance for objective improvement would be relief of the C6 radiculopathy and probably followed by rotator cuff procedure in that order. We will attempt to discuss this case with Dr. Mills at next visit.

CC: WC

FORMS COMPLETED: 9/22/00

OFFICE MAILED: [illegible]

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

September 22, 2000
Jeffrey C. Wilkins, M.D. /dsh

Gilbert Chavis
Case No.: 20347

Returns today having some increased pain in low back. Saw another physician in Charleston who thought there was no tear. All of today's 20 minute examination discussing future treatment strategy and prognosis.

IMPRESSION: C6 radiculopathy. Rotator cuff tendinitis.

We refilled his Oxycodone and will have him see Dr. Mills on a day we are both here. Again, I think we must address his cervical spine. We have been unable to do so via injection due to his problem with his initial C6 nerve root block.

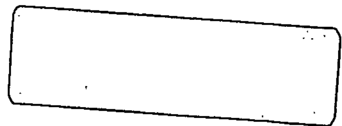
CC: WC

October 2, 2000
William L. Mills, M.D. /dsh

Gilbert Chavis
Case No.: 20347

Mr. Chavis returns. He is here today for evaluation of radicular symptoms in his right arm. On exam, reflexes are normal. Negative Hoffman and negative Spurling. His last MRI was in January, 2000.

PLAN: Repeat cervical MRI, followup after that.



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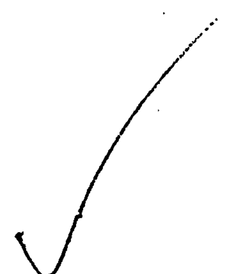
S COPY IS FOR THE INSURANCE CARRIER.

:l 20, 2001 Gilbert Chavis
.frey C. Wilkins, M.D. /pmc Case No.: 20347

r. Chavis returns today with continuing problems with his shoulder. Greater
.n half of today's 20 minute exam was discussing future treatment
:ategies and prognosis. We reviewed all of his notes, referred him to Dr.
reen in Columbia for a 5th opinion. Refilled his Roxicodone today. We have
:ttle else to offer. His repeat neck imaging was without particular
:hology.

CC: WC



GILBERT CHAVIS
20347
09/13/2001

Returns today. Did see Dr. Preslar, who reviewed his MRI and agreed that there is no need or likely benefit of any surgical intervention. We had a long discussion with Gilbert today. We do not feel that a referral to another neurologist is likely to be of any great benefit. Instead, we think that the folks in functional treatment will allow closure of his case, and that to go on with life would be more useful. Referred him to Dr. Midcap in Columbia for evaluation in their comprehensive pain management program.

Jeffrey C. Wilkins, M.D. /mjr
5554

GILBERT CHAVIS
20347
01/21/2002

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 • FAX: (843) 347-3305

550-441515 | 317

Still some difficulty with speech when he gets excited or agitated. He notes his right shoulder is doing well. He is having some new complaints of shoulder pain he relates to the FCE. He notes he cannot tolerate any less medication than he is currently on. Neurologic, dermatologic and vascular exams are unchanged.

Reviewed his FCE today which did reveal full effort in all phases of the testing with a maximal lift of 54 pounds.

IMPRESSION: Chronic pain.

PLAN: We will release him at this point. We consider him at maximum medical improvement. I do think the current amount of medication is necessary to maintain his current level of function. We will release him based on his FCE, which does reveal significant vocational ability, including a maximum lift of 54 pounds - knuckle to shoulder. Shoulder to head of 35 pounds. Other restrictions per the FCE.

Jeffrey C. Wilkins, M.D. /vlr
16664

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
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GILBERT CHAVIS
20347
02/13/2002

Complaining of shoulder pain and headaches. Neurologic, dermatologic, and vascular unchanged. Question left impingement. Negative right impingement syndrome with scapular squeezing.

IMPRESSION: Myofascial pain, impingement syndrome.

RECOMMENDATIONS: We injected him today. He noticed some improvement after subacromial injection. We will see him back in two to three weeks' time. He has asked about ending his case. We discussed with him that we are unable to relate any cognitive complaints to his CVA as brain stem should lead to absolutely no cognitive or memory issues at all.

Jeffrey C. Wilkins, M.D. /mjr
19123

James W. Yates, Jr., M.D. Orthopaedic Surgery Sports Medicine
J. Stewart Haskin, Jr., M.D. Orthopaedic Surgery Surgery of the Hand
A. Jay Preslar, III, M.D. Orthopaedic Surgery
William L. Mills, M.D. Orthopaedic Surgery Spinal Surgery
Jeffrey C. Wilkins, M.D. Physical Medicine & Rehabilitation Electrodiagnosis
Ross Ta Orthopa Surgery of th

GILBERT CHAVIS
20347
03/07/2002

550-441515/317

Returns today. Increased problem with his shoulder. He is better than last time. The shot really helped the shoulder for 3 to 4 days, and his headaches are better even now since the shot. Neurologic, dermatologic and vascular unchanged. Shoulder exam unchanged.

IMPRESSION: **Impingement syndrome.**

PLAN: Proceed with MRI of left shoulder. We think with history it is fairly aggressive. Intervention at this point is likely warranted.

Jeffrey C. Wilkins, M.D. /pmc
21203

550-441515 ; 317-HOD

GILBERT CHAVIS
20347
03/15/2002

2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 • FAX: (843) 347-3305

Returns today. He would like to see Dr. Wade and he has also come to see Dr. Preslar for chronic shoulder. See below. He needs something stronger for sleep. Neurologic, dermatologic and vascular exams unchanged. Positive impingement. Reviewed his MRI and it does reveal some impingement with some AC hypertrophy.

IMPRESSION: Impingement syndrome.

PLAN: Refer to Dr. Preslar for definitive treatment. He has exhausted therapy for this and other conditions in the past without improvement. He has already had an injection with temporary relief subacromially. Likely needs to be surgically intervened. We will also refer him to Dr. Randy Wade and note we discussed with him that we can not associate any psychological disturbances directed to his Worker's Comp claim on claims. In particular, he should have no significant psychological sequela directly related.

Jeffrey C. Wilkins, M.D. /kll
21978

GILBERT CHAVIS
20347
05/31/2002

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 • FAX: (843) 347-3305

550-44-1515
317

Returns today with continuing shoulder pain. He saw Dr. Preslar since we saw him last. He did have some temporary improvement with the AC joint. He does note his motion is better. Neurologic, dermatologic and vascular exams unchanged. He essentially has full flexion, excellent abduction with restricted rotation. He has more restriction at external rotation then at neutral. He has tenderness in the subscapularis region.

IMPRESSION: Myofascial pain.

PLAN: We did a trigger point into the subscapularis, 3 cc Lidocaine without Celestone injected. Note 1-2 jumps sign and immediate improvement in patient's neutral internal rotation. Refilled Roxicodone 5 mg #394 q 4.

Jeffrey C. Wilkins, M.D. /kll
30475

James W. Yates, Jr., M.D. Orthopaedic Surgery Sports Medicine
J. Stewart Haskin, Jr., M.D. Orthopaedic Surgery Surgery of the Hand
A. Jay Preslar, III, M.D. Orthopaedic Surgery
William L. Mills, M.D. Orthopaedic Surgery Spinal Surgery
Jeffrey C. Wilkins, M.D. Physical Medicine & Rehabilitation Electrodiagnosis
Ross Ta Orthopa Surgery of the

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 • FAX: (843) 347-3305

GILBERT CHAVIS
20347
06/21/2002

550-448871
317

Shot helped only temporarily. Neurologic, dermatologic, and vascular unchanged. Good range of motion with the shoulder except for isolated external rotation to approximately 30 degrees. Most other myofascial dysfunction today is in teres minor.

IMPRESSION: Myofascial pain.

RECOMMENDATIONS: We injected 3 cc of Lidocaine with no Celestone, which again led to improvement in patient's passive range of motion. Gave him OxyContin 15 mg #160 one p.o. q.4h. Also gave him samples of Geodone to see if this will help him sleep at nighttime. Hopefully this will be beneficial to his overall pain state.

Jeffrey C. Wilkins, M.D. /mjm
31778

James W. Yates, Jr., M.D. Orthopaedic Surgery Sports Medicine
J. Stewart Haskin, Jr., M.D. Orthopaedic Surgery Surgery of the Hand
A. Jay Preslar, III, M.D. Orthopaedic Surgery
William L. Mills, M.D. Orthopaedic Surgery Spinal Surgery
Jeffrey C. Wilkins, M.D. Physical Medicine & Rehabilitation Electrodiagnosis
Ross T Orthop Surgery of t

GILBERT CHAVIS
20347
07/08/2002

We request Mr. Chavis see Dr. Kang in second opinion. He continues to show very high rates of narcotic usage without corresponding severity of degenerative deficits. I would like Dr. Kang's opinion and assistance in management of this difficult case.

Jeffrey C. Wilkins, M.D. /pmc
33780

Jeffrey Wilkins, M.D.
Coastal Orthopaedics
1400 A. Hwy. 544
Conway, S.C. 29526

57760
File

Re: Gilbert Chavis

May 7, 1997

Dear Dr. Wilkins,

Thank you for your kind referral of Mr. Gilbert Chavis. Mr. Chavis was evaluated in our clinic on May 7, 1997, please refer to the enclosed initial eval for objective findings.

Assessment: 42 YOM with apparent tendonitis of right teres major and minor. Patient also has secondary myofascial restriction of the right upper trapezius.

Patient will be placed on a physical therapy treatment program consisting of MH, US, and passive stretching with muscle energy techniques to teres minor and major. Patient will also benefit from local US and therapeutic massage to the right upper fibers of trapezius and spray and stretch techniques. Patient will be instructed in therapeutic exercises consisting of cervical spine and right shoulder girdle mobility, strengthening, and stabilization exercises.

Again, thank you for your kind referral of Mr. Gilbert Chavis. If you have any questions or concerns with respect to his treatment plan or objective findings, please contact me at 347-1855.

Sincerely,

Colleen Volpe, RPT
Clinical Director

BEACH REHABILITATION AND INJURY CENTER
INITIAL PHYSICAL THERAPY EVALUATION
GILBERT CHAVIS
May 7, 1997

REFERRING PHYSICIAN: Dr. Wilkins
DX: Right Shoulder Impingement Syndrome and Myofasical Pain
FREQUENCY: 3 x week for 3 weeks

CURRENT HISTORY: Patient injured himself at work on April 8, 1996 while lifting a 65# pot from right to left. Patient noted onset of lumbar spine and right shoulder and arm pain immediately after. Patient states that he has been primarily been bothered by back pain and that his shoulder was not as much of a problem. Patient recently finds that his lumbar spine is much improved within the last 3 to 4 weeks since being put on new medications by Dr. Wilkins. Patient now is noticing his right shoulder more.

PAST HISTORY: Nothing relevant

PREVIOUS TREATMENT: Patient received 4 t 6 weeks of physical therapy in May of 1996 at Atlantic Physical Therapy. Patient also received 2 weeks of therapy at Rehability for his lumbar spine, followed by 6 weeks of Work Hardening in the fall of 1996 which aggravated his right shoulder pain. Patient also received physical therapy at Conway Hospital for 3 weeks last month following injection to his shoulder and lumbar spine. Patient's physical therapy at Conway Hospital was for his lumbar spine.

X-RAYS: Patient had x-rays taken of his lumbar spine in April 1996.

PRESENT MEDICATION: anti-inflammatory

GENERAL HEALTH: Patient is a diet controlled diabetic

OCCUPATION: Patient works 2 full time jobs, his first job is at AVX during the day where he is continuing to work but is presently not lifting. Patient's initial injury took place while working at AVX. Patient lost some time working at AVX last summer. Patient reports being laid off for 5 months after being injured from May to Oct. of 1996. Patient also works full time at Precision Sales Eastern which normally involves lifting, pushing, and pulling approx. 55 to 60#'s. Patient is presently on medical leave from this job until May 27 at the request of Dr. Wilkins.

PRESENT SYMPTOMS: Patient complaining of sharp burning pain in the right upper posterior arm which occurs intermittently with shoulder movement especially right shoulder flexion adduction and internal rotation. Patient also complains of intermittent burning pain in the right cervical spine and right upper trapezius with lifting involving the right shoulder. Patient's symptoms are eased by ceasing the aggravating movement.

GILBERT CHAVIS May 9, 1997

File
C-157760
312

S: ISQ

O: Treatment today - MH to the right shoulder and axilla, followed by local US to the teres minor and major insertion x 5 min. each, followed by passive stretches to teres major and minor x 5 reps. each with muscle energy techniques, treatment completed with therapeutic massage to right upper trapezius and right shoulder girdle.

Colleen Volpe RPT
Colleen Volpe, RPT

GILBERT CHAVIS May 12, 1997

S: Patient voiced no complaints.

Treatment today: patient's treatment same as previously noted.

P: Continue current treatment plan.
Lisa Harrelson, RPTA
Lisa Harrelson, RPTA

GILBERT CHAVIS May 14, 1997

S: ISQ

O: Continue MH, followed by local US and passive stretches to teres minor and teres major as previously, in addition high frequency IFC to the right shoulder.

A: No progress with present treatment at present.

P: Monitor progress and change treatment as needed.
Colleen Volpe RPT
Colleen Volpe, RPT

GILBERT CHAVIS May 16, 1997

S: Patient states he feels about the same.

Treatment today: Patient received MH to the cervical spine and right shoulder girdle as well as US and passive stretching with muscle energy techniques to teres minor and major, added on ROM exercises for shoulder and C-spine today.

P: Continue current treatment plan.
Lisa Harrelson, RPTA
Lisa Harrelson, RPTA

File

Patient reports that his symptoms settle quickly. Patient experiences an increase in stiffness in the morning and states that he wakes occasionally at night with pain. Patient notes an increase in his symptoms towards the end of the day. Patient's preferred sleeping position is in right side lying with his right arm up over his head which he is unable to do now due to increase pain.

O: Observation: unremarkable Patient also complaining of right lateral chest wall pain just inferior to the axilla.

Right shoulder ROM: Patient has full range of flexion, abduction, and hand behind the back but patient has reproduction of minimal pain at end ROM.

External rotation: clear

Special Test: Right shoulder quadrant is positive, passive stretch and resisted testing of supraspinatous and infraspinatous is clear. Passive and resisted testing of teres minor and teres major is positive.

Palpation: palpation of the AC joint is clear, palpation of the rotator cuff insertion and of the insertion of teres major is minimally painful. Patient also has increase tone and pain on palpation of the right upper trapezius trigger point.

Cervical spine ROM: Full and pain free

A: 42 YOM with apparent tendonitis of teres major and minor with soft tissue restriction and pain. Patient also has secondary myofasical restriction of the right upper trapezius right teres major and minor.

P: Patient will be placed on a physical therapy treatment program 3 x week for 3 weeks consisting of:

1. MH, Local US to the teres minor and major insertions
2. Passive stretching with muscle energy techniques to teres minor and major
3. US and therapeutic massage to the upper trapezius trigger point on the right
4. Spray and stretch
5. Therapeutic exercises - cervical spine and progressive right shoulder girdle mobility strengthening and stabilization exercises

G: Short Term Goals:

1. Improve pain by 50% within 2 weeks
2. Restore full pain free right shoulder girdle ROM within 3 weeks

Long Term Goals:

1. D/C patient with resolved pain and continued independent self stretching, strengthening, and stabilization exercises.

Treatment today: application to MH to the patient's cervical spine and right shoulder girdle x 15 min.

Colleen Volpe, RPT

Employee Name: CHAVIS, Gilbert

File
510-157760

POWERCHECK™

Employee: CHAVIS, Gilbert
Date: May 15, 1997
WC File#:
Social Security#: 248-04-2224
Employer: AVX CORPORATION
Address: 17th AVE.SOUTH
City, State: MYRTLE BEACH, SOUTH CAROLINA
Zip code: 29577
Job/Occupation: PASTE PROCESSOR
Diagnosis: "HURT BACK"
Referred by: DR. WILKINS

Recommendations for Employee ASSISTANCE LIFTING 50# pots and larger

SUMMARY: BELOW

Therapist Signature: C Floyd OTR/L
J. Lee OTR/L
Date 5/15/97

CLIENT WAS ASSESSED IN REGULAR WORK AREA. CAN PERFORM ALL JOB TASKS WITHOUT MUCH DIFFICULTY OR PAIN WITH THE EXCEPTION OF LIFTING POT .50 POUNDS PLUS FROM KNUCKLE TO SHOULDER OR HIGHER LEVEL. PAIN FROM BACK HAS SUBSIDED SIGNIFICANTLY AND PRIMARY COMPLAINT IS PAIN AND DISCOMFORT IN RIGHT, DOMINANT SHOULDER WHICH RADIATES TO ELBOW.

CLIENT STATES HIS PRIMARY GOAL IS DIMINISHED PAIN IN ORDER TO PERFORM ALL DUTIES. HE PRESENTLY DOES LIFT BUT ANYTHING OVER 50 POUNDS, HOWEVER, IT EXACCERBATES HIS SYNTOMS. PRESENTLY RECEIVING PHYSICAL THERAPY.

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Rev. January 1997

(This form need

Employee Name: CHAVIS, GILBERT

I. **Current Work Status** WORKING FULL DUTY

II. **Brief description of job requirements** LIFTING, STANDING, SITTING, BEND, REACHING

III. **Job tasks observed** SITTING, STANDING, WALKING, BEND, DEMONSTRATED LIFTING

IV. **Employee Risk Factors** LIFTING OVER 50 POUNDS

Risk Factors

Recommendations 2 man assist with Lifting Pots greater than 50#

Risk Factors

Recommendations

Risk Factors

Recommendations

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Rev. January 1997

(This form needs to be typed)
PWRCK 2

Employee Name: CHAVIS, GILBERT

JOB FACTOR PROFILE/SUMMARY

Use this chart as a guideline

NON MATERIAL HANDLING/POSITIONAL TOLERANCES ACTUAL PERFORMANCE

FUNCTIONAL ACTIVITY ASSESSMENT	FREQ	PHYSICAL REQ. FOR WORK GOAL (YES, NO, N/A)	THERAPIST OBSERVATION	COMMENTS
Assembly (Machine)	O	YES	YES	ASSEMBLE, BREAK DOWN
Balancing	O		YES	NO PROBLEMS
Carrying	O	YES	YES	18 - 20# approx. 30 yds.
Continuous Walking	O		YES	NO PROBLEM
Crawling	N	NO		
Filing	N	NO		
Fine Motor Coordination	F	YES	YES	HAND TOOL MANIPULATION
Forward Reaching	O	YES	YES	SELDOM
Ladder Climbing	N	NO		
Pivot twisting	O	YES	YES	SELDOM,
Rad/Ulnar Dev	O	YES	NO	SCREWDRIVER/WRENCH
Ramp Climbing	N	NO		
Repetitive Crouching/Squatting	N	NO		
Repetitive Kneeling	N	NO		
Repetitive Reach Above Shoulder	O	YES	NO	CAN REQUIRE 3#
Repetitive Reach Below Shoulder	O	YES	NO	SELDOM
Repetitive Stooping/Bending	O	YES	NO	SELDOM
Sitting	F	YES	YES	MONITORING MACHINE
Sorting	N	N/A		
Stacking	N	N/A		
Stair Climbing	N	N/A		
Standing	F	YES	YES	NO COMPLAINT
Standing/Walking	F	YES	YES	NO COMPLAINT
Static Crouching/Squatting	N	N/A	YES	
Static Kneeling	N	N/A		
Supine Position or Pronate Position	N	N/A		
Sustained Bending	O	YES	NO	
Sustained Reach Above Shoulder	O	YES	NO	CAUSES DISCOMFORT R.ARM
Sustained Reach Below Shoulder	O	YES	NO	NO PROBLEM
Sustained Sitting	F	YES	YES	MONITORING MACHINE
Sustained Standing	O	YES	YES	NO COMPLAINT
Typing	N	N/A		
Walking	O	YES	YES	NO PROBLEM
Writing	O	YES	NO	NO PROBLEM
Other				

Does your job require a vehicle? ____ Y __X__ N

If Yes, what type:

Specify any tools or machinery used at work: HAND TOOLS; PASTE MILL; HYDROLIC LIFT

Frequency: N=Never 0% O=Occassional (1-33% or 1 to 32 reps/days)
F=Frequent (34-66% or 33 to 200 rep/days) C=Constant (67 to 100% or greater than 200 reps/days)

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(This form needs to be typed)
PWRCK 3

Employee Name: CHAVIS, GILBERT

MATERIAL HANDLING - use as a guideline for employee performance versus employer requirements

	EMPLOYEE BODY MECHANICS/ POSTURE	REQUIRED FOR JOB	RECOMMENDATIONS	MISCELLANEOUS
Maximum wt lifted (lbs)		100#		
lifting range		100# KNUCKLE TO SHOULDER LEVEL		
how frequent?		3-5x/week	2-PERSON LIFT	
describe object/size		POT		
Frequent wt. Lifted (lbs.)	GOOD	18-20#		
lifting range		KNUCKLE TO KNUCKLE		
how frequent?		3x/day		
describe object/size	GOOD	JUG		
Repetitive Lifting Wt. (lbs.)	N/A			
how long prior to rest/break				
frequency in a day/week				
lifting range				
describe object/size				
Max. Push/Pull wt. w/wheels	N/A			
describe object size				
distance				
frequency				
Max. Push/Pull wt. without wheels	N/A			
describe object size				
distance				
frequency				
Maximum carry (lbs.)	GOOD	75-80#		
describe object size		JUGS/POTS		
distance		30 yards		
frequency		3x/day		

Body Mechanics:

GOOD	FAIR	POOR
Performs independently	Needs queing	Can't perform

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PWRCK 4

Employee Name: CHAVIS, GILBERT

Recommendations for *Employer's use only

ASSISTANCE LIFTING GREATER THAN 50 pounds

Workplace risk factors identified - (using results of worksheets)

RE-INJURY THROUGH LIFTING /POSSIBLY TWISTING

Risk Factors

Recommendations ASSISTANCE WITH HEAVY LIFTING TASKS GREATER THAN 50#

Risk Factors

Recommendations

Risk Factors

Recommendations

SUMMARY: BELOW

Therapist Signature:______________________ Date__________

MR. CHAVIS IS PERFORMING THE MAJORITY OF HIS REGULAR JOB DUTIES WITHOUT MUCH PROBLEM. HE STATES THAT HIS BACK PAIN HAS SUBSIDED SIGNIFICANTLY WITHIN THE PAST MONTH BUT STATES HE IS UNSURE IF THAT MAY BE DUE TO HIS MEDICATION (Naprosyn). HIS PRIMARY COMPLAINT IS SHOULDER PAIN WHICH RADIATES DOWN TO HIS ELBOW. HE EXPRESSED CONCERNS THAT HIS EMPLOYER DID NOT SEND HIM TO A PHYSICIAN FOR STATED

*To be shared with employer only

2 weeks AFTER INITIAL INJURY. HE HAS RETAINED AN ATTORNEY.
HE HAS BEEN THROUGH EXTENSIVE MEDICAL EVALUATIONS, A WORK CONDITIONING PROGRAM AND IS PRESENTLY RECEIVING PHYSICAL THERAPY FOR HIS SHOULDER, ARM TO ELBOW.
HE STATES HIS ONLY ACTIVITIES OUTSIDE OF WORK ARE THROWING THE BALL TO HIS DAUGHTER: OCCASIONAL GOLF AND FISHING. NO MENTION OF A 2nd JOB.

IF ACCOMODATIONS ARE MADE TO ASSIST HIM WITH THE OCCASIONAL LIFTING OF POTS GREATER THAN 50# ; then IT APPEARS FEASIBLE FROM HIS REPORTS, DEMONSTRATIONS AND OUR OBSERVATIONS, THAT HE IS CAPABLE OF PERFORMING AT THE REQUIRED LEVEL AS A PASTE PROCESSOR.

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Rev. January 1997

(This form needs to be typed)

C. Tucker Weston, M. D. AADEP, ACFE

1410 Barnwell St.
Columbia, S.C. 29201
Telephone (803) 256-2376
Fax (803) 256-2378

January 20, 1998

Mr. Bruce G. Dew
Attorney at Law
1735 St. Julian Place, Suite 300
Columbia, South Carolina 29204

Re: Gilbert R. Chavis
SSN: 248-04-2224
DOB: 12-07-54
616 McKinley Way
Conway, SC 29526
Employer: AVX
DOI: 04-08-96

Dear Mr. Dew:

In response to your letter of January 13, 1998, the above captioned individual was seen and examined in my office for an independent orthopedic evaluation on January 20, 1998. This report is rendered with his permission. The following history was obtained.

HISTORY: The patient states that on April 8, 1996, about 9 to 9:30 a.m., he was employed at AVX as a paste processor. He was working at his regular post, making up a binder solution. He was picking up a pot of binder and twisted to his right to pick the pot up and twisted back to his left. He was tilting the container to pour the binder solution into the pot. As he reached down to pick up the binder solution, he felt a burning sensation in the right low back. The right shoulder also started burning. After emptying the binder, he sat it back down and reported the incident to his supervisor, George Jones.

He was sent to the plant nurse, Margaret. He was given muscle relaxants and advised to return the following day if it did not clear up. The following day, it was worse and he went back to see the plant nurse. She gave him some more pills to take with him and use.

He states that he kept working, and the back and shoulder kept worrying him. About one week later, he was sent to see Dr. Asbury Williams, the regular company physician.

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Dr. Williams x-rayed his lower back, and advised him that the x-rays were negative. Dr. Williams prescribed Naprosyn and gave him an injection in his buttocks.

He states that after about two weeks the pain and burning in the right upper extremity cleared up and did not concern him any further. He states that the back continued to worry him and he continued under Dr. Williams care until he was referred to Dr. William L. Mills at the Coastal Orthopaedic Associates on June 12, 1996.

Prior to going to Dr. Mills, he had physical therapy for four weeks as ordered by Dr. Williams.

Dr. Mills sent him to the Rehab office for further physical therapy for six weeks. Dr. Mills saw him again on July 23rd, and also on September 23rd of 1996. At that time, he rated him at the maximum medical improvement with a five per cent over all impairment (5%).

He returned to Dr. Mills again in October, and in November of 1996, he went back to Dr. Mills with the back pain getting worse. The pain also returned to his right shoulder.

Dr. Mills's notes from December 4, 1996, state that he is being followed up from his lumbar MRI. The MRI was reviewed and by my interpretation no abnormality was seen. No evidence of a focal disc herniation. No nerve root compression. Sed rate was normal. It was Dr. Mill's opinion that there was no surgical problem.

On December 27, 1996, he was seen in consultation by Thomas B. Harden, M.D. of the Strand Orthopaedic Consultants. Dr. Harden's notes state that he thinks that he might have an impingement syndrome of the right shoulder probably overuse and strain of the lumbar spine.

A lumbar spine, single view, on December 27th, from the Conway Hospital, there are five lumbar type vertebra. There is a transitional vertebra between L5 and the sacrum, but overall alignment on the one view is good and the pedicules are intact.

On March 18, 1997, Dr. Mill's referred Mr. Chavis to Jeffery C. Wilkens, M.D. for an orthopedic consultation. Dr. Wilkens's notes state that he had an impression of sacroilitis, improved, shoulder myofascial pain, improved. Dr. Wilkens discharged him on December 2, 1997, and rated him as a DRE Category II, injury to cervical spine with a 5% whole person impairment rating. He did not rate the lumbar spine.

MAR

The patient states that at the time of the original injury, he was working two full time jobs, the job at which he was injured at AVX, and he was also working at Precision Southeastern as a material handler.

About May of 1997, Dr. Wilkens took him off of his Precision Southeastern job and he has not worked but the one job at AVX since that time. At the present time, he is only working for AVX. He states that he is working the regular shifts there and making his regular hours with no loss time.

CHIEF COMPLAINT: On January 20, 1998 - "I have pulling and pain in the right side of my neck down to the upper arm halfway to the elbow." He states that it is more of a burning sensation than a real pain sensation. It is aggravated when he has to lift above his chin. He states that there is weakness in the right arm. Numbness in the arm when he coughs or sneeze.

"My lower back hurts and aches all the time. If I ride for a long period of time and get out of the car, it is aching worse. Occasionally, I feel like I have pressure in my back and on a heartbeat, it will throb." Occasionally has numbness in the right leg. He has had some in the last month.

"Sometimes if I hiccup, I feel a pain straight up my back. It is a sharp type pain. Heavy lifting aggravates the pain. Since this injury, it has been very difficult to have a sex relations unable to have erections." Dr. Wilkens referred him to Dr. Gawith for a urological checkup, but he did not offer him any solutions.

Past History: At the age of 10 months had a tracheotomy. Growth removed from the peritoneum at age 13. Fracture of nose playing football at age 16. Fracture right 5th metatarsal age 29. No previous injuries on the job. Under the care of Dr. Asbury Williams for diabetes.

EXAMINATION: On January 20, 1998 - This is a 43 year old, married, white male who stands 5'6 1/4" in height barefooted and weighs 195 lbs. in shirt and trousers.

On examination of the cervical spine, there is no tenderness over the posterior occipital nerves. There is no headache. There is full forward flexion, hyperextension, rotation of the chin to the right and left, and lateral bending of the head to the right and left. These motions only cause a mild pulling in the right of the cervical spine.

On palpation, there is some tenderness and mild muscle spasm over the right infra spinatus muscle. No other tenderness or muscle spasm is noted over the posterior shoulders or dorsal spine. There is mild tenderness over the right of the cervical spine.

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There is no tenderness in the scalenus notches anteriorly. No tenderness or muscle spasm in the sternocleidomastoid muscle.

There is mild tenderness over the right coracoid. No other tenderness noted about the right shoulder.

On examination of both upper extremities, there is a full range of motion in all of the joints including the shoulder, elbow, forearm, wrist, hand and fingers. Reflexes are equal and active throughout. There is normal sensation on testing with the sharp pinwheel. There is normal circulation. There is good muscular strength and a normal appearance of the skin.

On examination of the thoracic cage and dorsal spine, there is no pain on compression of the ribs in an AP or lateral direction. No tenderness or muscle spasm along the dorsal spine.

On examination of the lumbosacral spine with patient standing, he stands erect. The spine is straight. There is no scoliosis or kyphosis noted. The iliac crests are level. The gluteal creases are level. He carries the right shoulder higher than the left. He is righthanded.

On palpation, there is tenderness and mild to moderate muscle spasm in the right of the lower lumbar spine and tenderness at the right sacroiliac joint. There is mild tenderness and muscle spasm in the left of the lower lumbar and left sacro-iliac joint. There is mild tenderness in the right sciatic notch and no tenderness in the left sciatic notch.

On bending forward, he is unable to get his fingertips closer than four inches to his toes. Hyperextension is mildly limited and more painful. On bending laterally, he is able to get his fingertips to the joint line at the knees. He is able to walk on tiptoes and heels, squat and sit on heels and rise to the standing position without difficulty.

With patient lying flat on back on table on examination of the abdomen, it is soft with no masses, no tenderness, and no scars. On testing with the sharp pinwheel, there is normal sensation over the anterior torso and both lower extremities except for the lower half of the right lower leg on the medial aspect down to the big toe on the right foot. Reflexes including abdominal cremasteric, patella, and AChilles are physiological. There is good strength in the extensors and flexors of both great toes.

With patient lying flat on back on table both legs measure 33 1/2 inches from the anterior superior iliac spine to the internal malleolus. Eight inches below the anterior superior iliac spine, both thighs measure 23 inches in circumference.

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Twelve inches below the anterior superior iliac spine, both thighs measure 20 inches in circumference. Twenty-five inches below the anterior superior iliac spine, both calves measure 15 inches in circumference. These measurements show that the legs are of equal length and size throughout with no muscular atrophy.

With patient lying flat on back on table, straight leg raising on the right goes to 75 degrees with beginning pain and pulling with increasing pain up to 90 degrees. Straight leg raising on the left goes to 90 degrees with only mild pain. Straight leg raising with both legs together becomes painful at 75 degrees with more pain up to 90 degrees. Acute abduction of the right thigh with the heel on the left knee causes right low back pain. Acute abduction of the left thigh with the heel on the right knee causes some pain in the right lower lumbar spine. Acute flexion of the right thigh on the abdomen with the left leg hyperextended causes right low back pain, not as severe as the pain on abduction. Acute flexion of the left thigh on the abdomen with the right leg hyperextended is normal. Sudden dorsi flexion of either foot with the extended leg raised 30 degrees is normal.

With patient lying flat on back on table and legs extended, he is able to reach up and get his fingertips to within four inches of his toes with pulling and pain in the low back. With patient lying flat, knees flexed and feet flat, he is able to come to the situp position with pain in the low back. With patient lying flat, knees flexed and feet flat, he is able to raise the pelvis off of the table. He is also able to draw the knees to the chest.

With patient lying flat on face on table, the most acute tenderness and muscle spasm is in the right lower lumbar and right sacroiliac. Mild tenderness and muscle spasm in the left lower lumbar and left sacroiliac. Mild tenderness in the right sciatic notch and no tenderness in the left sciatic notch. On testing with the sharp pinwheel, there is normal sensation over the posterior torso and both lower extremities.

The MRI of 12/2/96, has been reviewed by me and I agree that there is no evidence of a disc and no indication for any surgical procedure. A Myelogram on 8/21/97, has also been reviewed by me. The films show normal findings with no evidence of a herniated nucleus pulposus. Also films of a CT Scan done on 8/21/97 with contrast. I do not see any evidence of a herniated nucleus pulposus.

SURGICAL CONCLUSION: This patient has a history of having suffered an injury on April 8, 1996, while working at AVX, as a paste processor with injury to the right shoulder and

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2 1998

right low back. As a result of this injury, he was first seen by the plant nurse and then seen by the plant physician, Dr. Asbury Williams, who later referred him to Dr. William L. MIlls, Orthopedist at Conway, SC. Dr. Mills followed him for several months and had consultation by Dr. Harden, another orthopedist. He was later also seen by Dr. Wilkens, M.D., Orthopedist.

He has been thoroughly worked out and has had CT SCan, MRI, and myelogram, and has not had any evidence of a herniated disc or any condition that would indicate the need for any surgical procedure.

At the present time, he is continuing to have pain in the right of the cervical spine into the right upper arm, and continuing to have right low back pain.

On examination by this examiner on January 20, 1998, there is mild tenderness in the right of the cervical spine extending down into the cap of the right shoulder, halfway down to the right elbow. There is some tenderness over the right coracoid and tenderness over the right scapula.

There is tenderness and muscle spasm in the right lower lumbar and right sacroiliac, and mild tenderness in the right sciatic notch. There is some diminished sensation on the inner side of the right calf from halfway down the calf to the great toe on the right foot. There is pain on the leg tests on the right, particularly on straight leg raising and acute abduction of the right thigh with the heel on the left knee.

I do not believe that there is any indication for hospitalization. I do not see any indication for surgery. I see no evidence of a herniated nucleus pulposus. I would recommend continued conservative therapy with over-the-counter medications, heat and massage with liniment, and exercises. I am also suggesting to him the proper positions for sleeping, getting in and out of a car, and other activities.

In using the Guide to the Permanent Impairment of the AMA, 4th Edition, 2nd Printing, page 3/102, DRE lumbosacral category II, Minor Impairment more nearly fits the description of his present condition which results in a five per cent (5%) whole person impairment.

As noted in the history above, this patient states that he has had very much difficulty with sex relations since his injury, his inability to maintain an erection. It would be my advice that he should have a urological consultation prior to any settlement of his case, to see if there could be some help offered to him by a kidney specialist.

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Again, as a result of the injury of April 8, 1996, there is a

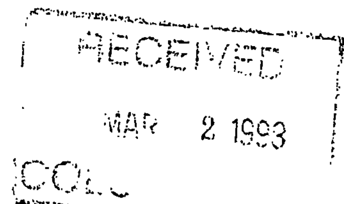
five per cent (5%) permanent partial overall bodily impairment. This patient has reached the maximum point of improvement.

Any further information that I might render, kindly advise.

Very truly yours,

C. Tucker Weston, M.D.

CTW/ag



DISC Imaging
1136 Bowman Road
Mount Pleasant, SC 29464

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 06/07/99
REFERRED BY: JEFFREY WILKINS, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

CLINICAL INFORMATION: The patient is a 197-pound, 5'5", 44-year-old male who presents with history of injury and subsequent pain. His physician suspects possible rotator cuff pathology.

TECHNIQUE: The patient is examined in the High Field Signa Horizon LX MR System which functions at 1.0 Tesla. The shoulder coil is used to obtain high resolution images of the shoulder. **SERIES:** 1) AX, T2*, GRE, 4 mm; 2) Oblique COR, T2, FSE, 4 mm; 3) Oblique COR, proton, FSE, 4 mm; 4) Oblique COR, T1, SE, 4 mm; 5) Oblique SAG, T2, FSE, 4 mm.

CONTRAST: None. **SEDATION:** None.

GLENOHUMERAL JOINT: There is normal alignment between the humeral head and the glenoid. No joint effusion is present. Axial images show no evidence for labral pathology.

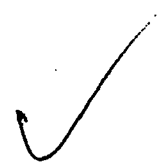
BONES: There is prominent arthrosis of the acromioclavicular joint with a large osteophyte of the under surface of the distal clavicle. With this exception, the bones are normal.

ROTATOR CUFF: Evaluation of the rotator cuff shows abnormal high signal in the under surface of the distal cuff noted on coronal images #3 through #5 on page #3. The upper surface of the cuff appears to be intact. Consequently this most likely represents a partial thickness tear on the under surface of the distal anterior supraspinatus. The remaining cuff tendons are intact.

OPINION: MRI of the right shoulder demonstrates abnormal signal in the cuff, most likely representing a partial tear on the under surface or joint side. Tendinosis is also a second possibility.

BEVERLY M. GENEZ, M.D.PHD

BMG/smt-60



DISC Imaging
1136 Bowman Road
Mount Pleasant, SC 29464

PATIENT: CHAVIS, GILBERT R.
SSN # 248-04-2224
DATE: 10/23/99
REFERRED BY: A. JAY PRESLAR, III, M.D.
TYPE OF EXAM: MRI RIGHT SHOULDER
PT #: 01-95-91

(CONTINUED - PAGE 2)

OPINION: Heterogeneous fluid within the subacromial subdeltoid bursa, most likely resulting from prior decompression. Abnormal signal intensity within the distal rotator cuff may represent a combination of edema and tendinosis. No focal, full thickness rotator cuff tear is identified on the current examination.

TARA NOONE, M.D.

BEVERLY M. GENEZ, M.D.

RECEIVED
JAN 07 2000
COLUMBIA, SC

MYRTLE BEACH MRI, INC.
4701-A Oleander Drive
Myrtle Beach, SC 29577
843-449-7900

PATIENT: CHAVIS, GILBERT R.
SS#:248-04-2224 SEX: M DOB: 12/7/54
DR. WILLIAM MILLS

MRI OF CERVICAL DATE: 2/28/01

CLINICAL HISTORY: Neck pain radiating into both arms and hands; rule out disc herniation.

STUDY PARAMETERS: Sagittal T1, Sagittal T2, Axial T1 and Axial T2

FINDINGS: Straightening of the normal curvature is seen. The bone marrow signal intensity is within normal limits. The bony spinal canal caliber is at the lower limits of normal. C5-6 shows posterocentral protrusion of disc compatible with a small central or subligamentous disc herniation. C4-5 shows asymmetric narrowing of the left neural foramen. The differential includes a left-sided bone spur versus a radial tear of the annulus. Comparison with previous study shows no interval change.

IMPRESSION:

1. C5-6 shows a small posterocentral or subligamentous disc herniation which results in borderline spinal stenosis. This is similar to previous study dated 1/8/2000.

2. C4-5 shows asymmetric narrowing of the left neural foramen, either secondary to a bone spur or a radial tear of the annulus. This is also unchanged when compared with previous study.

Paul J. Rubis, M.D.

tl

Thank you for this referral!

C:\WPDOCS\MYR\CHAVIS.GIL

OPEN MRI & CT OF MYRTLE BEACH

OPEN MRI & CT OF MYRTLE BEACH
900 21ST Avenue North
Myrtle Beach, SC 29577
(843)916-1700 fax (843)916-9460

PATIENT NAME : Chavis, Gilbert

DATE OF BIRTH : 12/07/54

PATIENT PHONE : 347-5748

REFERRING PHYSICIAN: Dr. Jeff Wilkins

EXAM DATE: 03/12/02

MRI LEFT SHOULDER

HISTORY: 47 year old male with persistent left shoulder pain and limited range of motion.

TECHNIQUE: Multiple coronal proton density, T2, and STIR images of the left shoulder were obtained. In addition, multiple sagittal T2 along with axial gradient images of the left shoulder were obtained without the use of intravenous contrast material.

FINDINGS: The marrow signal within the left proximal humerus is unremarkable. There is a type II left acromion with mild lateral down-sloping and a high riding left proximal humerus causing mild narrowing of the left subacromial space. There are mild to moderate hypertrophic changes present within the left acromioclavicular joint causing 1 to 2 mm of superior effacement at the distal left supraspinatus muscle anteriorly. Specifically, there is mild attenuation at the distal left supraspinatus tendon without disruption or retraction. The infraspinatus and subscapularis tendons are intact. There is mild abnormal fluid signal within the subdeltoid bursa. In addition, there is mild fluid signal within the left glenohumeral joint extending into the subcoracoid recess. The coracoacromial ligament is intact. The proximal biceps tendon and glenoid labrum show no evidence of complete disruption or detachment respectively.

IMPRESSION:
1. MILD TENDINOPATHY WITHIN THE DISTAL LEFT SUPRASPINATUS TENDON WITHOUT ROTATOR CUFF TEAR.
2. MILD TO MODERATE DEGENERATIVE ARTHROPATHY WITHIN THE LEFT AC JOINT CAUSING 1 TO 2 MM OF SUPERIOR EFFACEMENT AT THE DISTAL SUPRASPINATUS MUSCLE AND TENDON ANTERIORLY.
3. MILD LEFT SUBACROMIAL/SUBDELTOID BURSITIS.

Jerome McCabe, M.D./smm
Radiologist

Dictated on 03/12/02

OPEN MRI & CT OF MYRTLE BEACH

O. _N MRI & CT OF MYRTLE BEACH
900 21ST Avenue North
Myrtle Beach, SC 29577
(843)916-1700 fax (843)916-9460

POSTED
DATE

PATIENT NAME: Chavis, Gilbert

DATE OF BIRTH: 12/07/54

HOME PHONE : 843-347-5748

REFERRING PHYSICIAN: Dr. Tom Chambers

550-441515
317

MRI LEFT SHOULDER

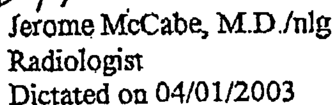
DATE OF EXAM: 03/31/2003. There is a previous study available for comparison dated 03/12/2002.

HISTORY: 48 year old male with persistent left shoulder pain.

TECHNIQUE: The following sequences were obtained using a Siemens 1.0 Tesla closed unit: multiple coronal oblique T1, dual-echo with fat saturation, and STIR images of the left shoulder were obtained. In addition, multiple sagittal dual-echo along with axial gradient images of the left shoulder were obtained without the use of intravenous contrast material.

FINDINGS: The marrow signal within the left proximal humerus is unremarkable. There are mild hypertrophic changes present within the left acromial clavicular joint. There is a type II left acromion with mild lateral downsloping causing very mild narrowing of the left subacromial space. Specifically, there is mild diffuse thickening and hyperintense signal within the anterior portion of the distal left supraspinatus tendon without full thickness tear or retraction. The infraspinatus and subscapularis tendons are intact. The coracoacromial and coracoclavicular ligaments are unremarkable. The proximal biceps tendon is intact. The glenoid labrum is mildly blunted anteriorly without detachment.

IMPRESSION:
1. MILD TENDINOSIS WITHIN THE ANTERIOR PORTION OF THE DISTAL LEFT SUPRASPINATUS TENDON WITHOUT ROTATOR CUFF TEAR.
2. MILD DEGENERATIVE HYPERTROPHY WITHIN THE LEFT AC JOINT CAUSING 1-2 MM OF SUPERIOR EFFACEMENT AT THE DISTAL LEFT SUPRASPINATUS MUSCLE CENTRALLY.
3. TYPE II LEFT ACROMION WITH MILD LATERAL DOWNSLOPING WITHOUT SIGNIFICANT ANATOMICAL NARROWING OF THE LEFT SUBACROMIAL SPACE.



Jerome McCabe, M.D./nlg
Radiologist
Dictated on 04/01/2003

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
J. Stewart Haskin, Jr., M.D.
A. Jay Presler III, M.D.
William L. Mills, M.D.
Jeffrey C. Wilkins, M.D.

MUSCULOSKELETAL EVALUATION

Gilbert Chavis

Date: July 1, 1999
Case No: 20347
Age Race Sex:
Referred By:

COMPLAINT: Right shoulder pain.

HISTORY: The patient is a very pleasant 44-year-old right hand dominant gentleman who works in the lab at AVX. He does a lot of pushing and pulling and some lifting of weights, all less than 50 pounds. He apparently injured his right shoulder at work on December 1, 1998. He picked up a pot and had to extend his arms to set it down with immediate onset of pain in the right shoulder. He has been seen and nicely treated by Dr. Wilkins. He has had a trigger point injection in the area of discomfort in the triceps and a subacromial injection. He did not see significant improvement with either of these. He has had an MRI done that is felt to show a partial tear.

His primary complaint at this time is pain. It is constantly present in the day and night, occasionally will wake him up from sleep. The pain is worse if he does overhead activities. Overall, the pain is better than it was initially but it has stabilized and not improved from that point. He is back to work in a light duty position.

PAST HISTORY: Pertinent for some type of injury to the back and shoulder area two years ago. He states the back was treated. The shoulder was not really treated or diagnosed and it eventually got better.
ALLERGIES: None.
MEDICATIONS: Glipizide. MAJOR MEDICAL: Non-insulin dependent diabetes.
SURGICAL: Status post throat surgery as a child.
SOCIAL HISTORY: Denies cigarettes and alcohol.

PHYSICAL EXAM: He is an alert, pleasant, healthy appearing gentleman in no acute distress. I don't see any atrophy. No tenderness dorsally over the AC joint. He has some anterior lateral subacromial tenderness. His range of motion shows 170 degrees of forward flexion, internal rotation to T12,

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external rotation 35; compared to 165, T11 and 35 on the left. He has some pain with full forward flexion impingement but no real discomfort with Hawkin's sign. There is good strength in all three directions.

X-RAYS / LAB: Plain x-rays show slight type II acromion. MRI is felt to show a partial thickness joint side tear. I don't see any evidence of a full thickness tear.

IMPRESSION: I agree with Dr. Wilkins, he probably has some impingement and discomfort related to a partial tear.

RECOMMENDATION: I have recommended and done a diagnostic/therapeutic injection today. He has reported to Alison that he has no discomfort in the shoulder with the Lidocaine in place. We will let him monitor that over the next several weeks and we will re-evaluate him in 3-4 weeks.

A. Jay Preslar, III, M.D.

dsh

CC: WC

July 22, 1999
A. Jay Preslar, III, M.D. /vlr

Gilbert Chavis
Case No.: 20347

. Chavis comes back stating the previous injection gave him good improvement in his pain for 6 days. The pain has now returned and is back to his baseline. His primary complaint is pain. It is worse with certain motions, especially overhead activity. In addition, he has had intermittant pain radiating down into the fingers. This is not constant. It can affect any of the five digits. On physical exam, he has some discomfort with impingement testing. No real pain with Hawkins. His greatest tenderness is in the lateral subacromial region with palpation. No real tenderness with palpation over the AC joint.
IMPRESSION: Unchanged.

PLAN: I think the response to the injection concurs with our diagnosis. In light of that, I think his options are to live with the discomfort or consider surgery. The anticipated surgical result would be improvement in pain that he got with the injection. I have told him the symptoms radiating into the hand are not coming from the shoulder. They are intermittent and variable and therefore don't appear to represent an ongoing nerve compression lesion. We have discussed the risks of an operation, which include primarily infection (the patient is diabetic). At this time we will plan an arthroscopic evaluation of the right shoulder with an arthroscopic subacromial decompression. Dictation is done on the hospital line.

CC: WC

August 18, 1999
A. Jay Preslar, III, M.D. /ajf

Gilbert Chavis
Case No.: 20347

OPERATIVE NOTE.

FINDINGS: 1. Partial thickness supraspinatous rotator cuff tear. 2. Subacromial impingement from the acromion as well as some impingement from the distal lateral clavicle.

PROCEDURE: Right shoulder evaluation under anesthesia, debridement of partial thickness rotator cuff tear, subacromial decompression and resection of lateral inferior clavicle. FINDINGS: No evidence of instability or an anterior inferior labral abnormality. He had a small partial thickness

rotator cuff tear in the supraspinatus which was debrided and decompression.

FOLLOW-UP PLAN: He will be seen back in the office in seven to ten days for a wound check.

FORMS COMPLETED: 8/25/99
OFFICE MAILED: @

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COLUMBI...

August 30, 1999
A. Jay Preslar III, M.D. /we

Gilbert Chavis
Case No.: 20347

He comes in doing much better. He actually has excellent motion today. I can take him up to 170 degrees. His incisions are benign.

DIAGNOSIS: Unchanged.

PLAN: I think he is doing well. However, he really has not used it much overhead so we don't know how he will do ultimately. Today I want to start him on physical therapy working on aggressive rotator cuff strengthening protocol. He has excellent motion and we really don't need for the therapist to work on that. We will hold him out of work while we start on this rehab

program. We will plan to see him again in 4 weeks. Plan to return him to regular or light duty at that time.

September 23, 1999
A. Jay Preslar, III, M.D. /we

Gilbert Chavis
Case No.: 20347

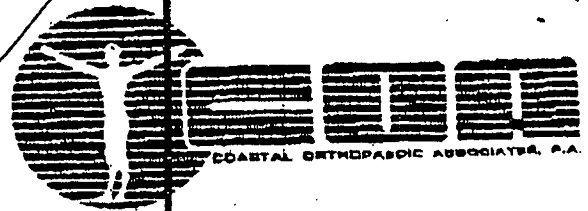
Mr. Chavis is now about 6 weeks postop and he reports continued problems with the shoulder. He states it is no better than it was before surgery. He has a complaint of pain with certain motions and also states he can only hold the arm in 1 position when he lays down at night. He describes a burning sensation in the shoulder as well as pain in the posteromedial aspect of the elbow. He had 1 episode of numbness in the middle digit but that has not recurred.

DIAGNOSIS: Unchanged.
PLAN: The numbness was an intermittent problem. Unless it recurs I would do

nothing else with regard to that. The tenderness at the elbow is not really over the cubital tunnel or the medial epicondyle. It appears to be in the posteromedial triceps muscle region. I think we should watch that at this piont in time. With regard to the shoulder I do think he will get improvement as he works on rotator cuff strengthening and I recommend he continue with therapy for that. He should also continue to work on maintaining his range of motion. With regard to work we will get him back to a light duty status. We will see him again in 1 month and may be near the end of what we have to offer him.

CC: WC

FORMS COMPLETED: 10/1/99
OFFICE MAILED: ✓



October 12, 1999
Jay Preslar, III, M.D. /vlr

Gilbert Chavis
Case No.: 20347

Mr. Chavis comes in stating he is having more problems with the arm. He states he is having increased pain. He is also having popping with movement. He states the popping is not always associated with discomfort. On exam, clinically the shoulder looks fairly good with a 170 degrees of forward flexion. Negative impingement sign. No discomfort with Hawkins. It is difficult to elicit point tenderness with palpation. There is no major subacromial tenderness. He has occasional tenderness at the posterior aspect of the AC joint, but this is not reproducible. X-rays today, Bigliani, shows a nice decompression compared to his preop films.

DIAGNOSIS: Ongoing pain, right shoulder, uncertain etiology. I think the popping is probably related to scar tissue.

PLAN: I think it would be reasonable to try an injection. I will see if that helps his symptoms. I think this has the potential to benefit him, especially since he has had a decompression already to help open up the space. He has to leave at this time to go pick up his daughter from school and we will plan to have him come in Thursday for an injection. If that does not help him, the other option would be a repeat MRI. If that shows progression of his partial thickness tear, he would need an open procedure. If it does not show progression, I think he is at maximum medical improvement.

CC: WC

FORMS COMPLETED: 10/15/99

OFFICE MAILED:

October 14, 1999
A. Jay Preslar, III, M.D. /dsh

Gilbert Chavis
Case No.: 20347

He comes in for his subacromial injection which is done (moderately difficult). We will see how thta does forhim and and re-evaluate him three weeks.

CC: WC

in workers carrier

IS COPY IS FOR THE INSURANCE CARRIER.

ober 29, 1999 Gilbert Chavis
Jay Preslar, III, M.D. /dsh Case No.: 20347

ie comes in still complaining of pain. He states the injection did not help with his discomfort. He states he is having more popping in the shoulder and having pain in the shoulder he is unable to live with. On exam, he does ve a significant amount of subacromial crepitance with motion of the arm in abduction. He is somewhat tender at the AC joint.

verbally discussed the MRI report with DISC Imaging and they do not see progression of the tear to a full thickness tear.
DIAGNOSIS: Ongoing right shoulder pain, uncertain etiology.

AN: At this point in time, I think his options are to live with it or consider open exploration with distal clavicle resection. He would need to understand that this may improve his symptoms but to the degree the popping related to scar tissue, this certainly could recur. At this point in time, is not sure he wants to undergo a procedure. We will go ahead and release him to full duties with a 30 pound lifting restriction and he will think about all of this and contact us.

CC: WC

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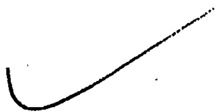


COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

January 17, 2000 Gilbert Chavis
A. Jay Preslar, III, M.D. /dsh Case No.: 20347

He comes back his cervical MRI which indeed shows moderate central bulge at C5-6, somewhat more eccentric to the right than the left.

DIAGNOSIS: (1) Unchanged. (2) I think some of his discomfort could be referred from this cervical spine lesion.

PLAN: I am going to try a selective nerve root injection and will see if this helps diagnostically/therapeutically. We will then re-evaluate him in a week or ten days after that and hopefully get the letter from Dr. Elmington and then make further decisions.

CC: WC

February 1, 2000 Gilbert Chavis
A. Jay Preslar, III, M.D. /dsh Case No.: 20347

Mr. Chavis comes in still having severe pain in that right shoulder. He states the pain has gotten progressively worse and is now worse than it was before surgery. He went down to DISC for selective nerve root injection and apparently had some type of reaction and that has actually required further workup. He is scheduled for an MRI of his brain next week and followup by Dr. Groblewski. Today, we have the note from Dr. Elvington, Pee Dee Orthopaedics in Florence, who feels like, according to the note, the distal clavicle resection and assessment of the decompression is warranted. Mr. Chavis says, that while it is not in the note, verbally he recommended exploring the partial tear and reconstruction of that along with recommending

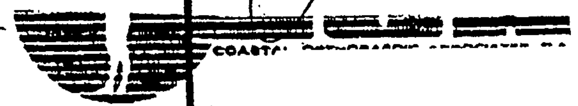
further evaluation of the neck.

DIAGNOSIS: Ongoing right shoulder pain, probably related to a combination of distal arthrosis, partial rotator cuff tear and possibly residual impingement.

PLAN: I have had a long talk with Mr. Chavis today. I think it would be reasonable to do an open exploration distal clavicle resection, assess the decompression and debride the partial thickness tear and repair it. I would anticipate that this will give him some improvement. He understands, however, that it is very difficult to predict how much, and certainly there are no guarantees. Part of his concern at this time is popping in the shoulder which I think is related to scar tissue and certainly scar tissue

will reform. In addition, with the problems related to the selective nerve root injection, we really don't know how much his symptoms might be referred from the cervical spine. He apparently got no relief with whatever portion of the injection they did. We discussed risks, including blood loss and nerve damage as well as unknown potential for improvement. He understands all of this and wishes to proceed. Dictation is done on the hospital line.

CC: WC

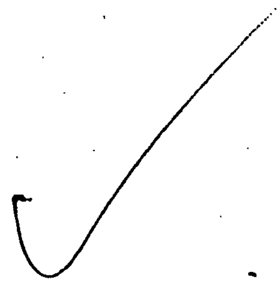


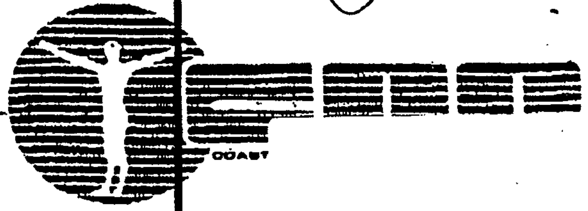
550- .1515
Gilbert Chavis

ebruary 25, 2000 Gilbert Chavis
. Jay Preslar, III, M.D. /pmc Case No.: 20347

Mr. Chavis apparently came in today to see Dr. Wilkins and has apparently told Dr. Wilkins that he is no longer comfortable with me taking care of him orthopaedically. I would, therefore, recommend that he be referred to Dr. Elvington at Pee Dee Orthopaedics in Florence for his further orthopaedic care. We will arrange that appointment for him. We will give him pain medicines until the date of that appointment and after that he would need to get his medicines from Dr. Elvington. There have also been questions about his being evaluated by Dr. Groblewski and the relationship of that work up to his Workers Comp. Injury. He apparently had some type of episode when he was down at Disc, and this was related to a test that we recommended as part of

work up and treatment of his Workers Comp. injury. Therefore, I feel that the evaluation and treatment by Dr. Groblewski is related to his Workers Comp. problem AT THIS POINT IN TIME. However, it is certainly possible that the ultimate decision would be that the changes seen on the brain MRI preexisted any of these problems, and it would at that point in time be determined that it is independent of his Workers Comp. case. I am not in a medical position to make that determination. That would need to be done by a neurologist, and we have referred him to Dr. Groblewski.





PDOA
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W.N. (WILL) GINN, III, CMPE
EXECUTIVE DIRECTOR

550-44/5/5

Date	May 25, 2000	Case #	196-190 WC
Name	Gilbert R. Chavis	Age	45 WM
Address	616 McKinley Way, Conway, S.C. 29526	Ref by	Dr. Elvington

CC: Neck and right shoulder and arm pain.

HPI: This 45 year old, right handed, white male is kindly referred over by Dr. Elvington for evaluation of cervical disc bulge. This gentleman has had a remote work related injury to his right shoulder, in December of '98, that occurred at AVX. He had subsequent arthroscopic surgery elsewhere that has not lead to any significant improvement and Dr. Elvington has been consulted to determine if further surgical intervention may be of help. In the course of work-up, it was determined that he had a disc bulge at C-5-6 and given the radicular component of some of his symptoms, spinal evaluation was requested.

MH: Past medical history has been previously noted. He is taking Tylox for pain intermittently.

E: Five foot, five inch, 195 pound white male in no acute distress.

He has a surgical scar from a tracheostomy from early years. There are arthroscopic scars over the right shoulder. Shoulder motion is limited. He has some impingement signs and tenderness is noted about the subdeltoid region. He also has some mild tenderness in the right trapezius. No torticollis or loss of cervical lordosis. Gentle motion is tolerated well in all planes. Motor function in the upper extremities is normal. He has no reflex asymmetry and no long track findings.

X-RAY: Radiographic studies, plain films, show slightly decreased cervical lordosis otherwise normal.

MRI scan from 01-08 at Disc Imaging shows a central disc bulge at C-5-6. No significant compressive pathology is noted here.

CLINICAL
D: Rotator cuff tear, right shoulder.
Cervical disc bulge C-5-6.

Con't on page four (4)

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...ENCE, SOUTH CAROLINA
(843) 662-5233

...IS, GILBERT R. (196-190 WC)
FOUR (4)

Con't from page three (3)

COMM: This gentleman has a somewhat perplexing situation, given his previous history of a "stroke" from an epidural steroid injection done back in January. He appears to have made good recovery from this. I have told him, from my standpoint, there is no intervention required for this mild central disc bulge. He was cautioned however that some of his radicular symptoms conceivably could come from this and that he could not expect complete resolution of all of his symptoms from whatever type of shoulder surgery Dr. Elvington feels is required. He seems to have realistic expectations about this and I think it is appropriate for him to proceed with whatever Dr. Elvington recommends. (Edwards/dab)

../00 Gilbert is still having significant pain. The majority of his pain is in the forearm and hand, not in the shoulder. After a long discussion with this I don't believe that anything I could do in his shoulder will make him better. It certainly won't make his hand feel better and this is the majority of his problem. He also has some neck pain. I have nothing to offer him Orthopaedically. I think this is related to the stroke and/or the injection. We will refer him back to Dr. Groblewski, give him some pain medication and some Neurontin to see if this will help him in the meantime but we will not make another appointment to see him back for me. He will be out of work until seeing Dr. Groblewski. (Elvington/km)

-/00 pg 1-4 faxed to Dr. Groblewski (km)

..-8-00 HCFAs X2 & update to Liberty Mutual (ag)
Update faxed Cheryl Furbish, RN

GILBERT CHAVIS
20347
09/06/2001

Mr. Chavis is referred back by Dr. Wilkins for evaluation of his right shoulder. Currently, he states that the shoulder, if anything, is slightly better than it was several year ago when we last saw him. He states it aches more than anything and doesn't really have the shooting pain that he used to have. Indeed, his biggest complaints at this time are related to numbness in the fourth and fifth fingers of both hands as well as pain on the top of both feet. He states it has begun since he had his stroke. With regard to the shoulder, he states there is tenderness posterolateral and this occasionally radiates up toward the neck. He also notices swelling over the top of the shoulder but that is not usually an area where he has discomfort.

PHYSICAL EXAM: He has 170 degrees of forward flexion, internal rotation to T12, external rotation to 20 compared to 165, T11 and 20 on the left. He has good strength in all three directions. Today, he has slight tenderness with deep palpation over the AC joint but that is not an area where he normally has pain. There is slight swelling there compared to the contralateral side. No real tenderness with palpation anterior lateral subacromial area. The area where he generally has pain is at the posterior lateral edge of the acromion that is nontender today.

Since we last saw him he apparently has seen Dr. Hartzog in Charleston who told him he really did not see anything suggesting a tear on his previous MRI. He saw Dr. Green a month or so ago who got a Gadolinium MRI and did not see anything significant on that or recommend any particular treatment.

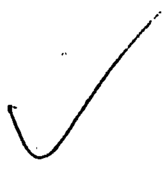
X-rays: Today we had reviewed that Gadolinium MRI. Overall, it looks quite good. I see absolutely no muscle atrophy. His supraspinatus looks quite normal. I don't see any evidence of Gadolinium going up into the cuff. On one particular view there is a small white area that perhaps represents a minimal tendonopathy. It would appear to be that the previous partial thickness tear has probably healed. There is fluid in the AC joint and the findings are consistent with a ganglion cyst related to the AC joint.

DIAGNOSIS: At this point in time, I think he has some arthrosis in that right AC joint and an associated ganglion cyst. He has minimal tenderness there and I would not recommend any treatment of that at this time. I think his rotator cuff is doing quite well. It appears to me that the partial thickness tear is probably healed. I certainly would not [illegible]

... regard to his other symptoms,

think he probably needs to have a followup with a neurologist. Now that Dr. Groblewski has left the area, I will try to arrange to have Dr. Wilkins find him another neurologist. I will see him back as needed.

A. Jay Preslar, III, M.D. /dsh
4814



GILBERT CHAVIS
20347
03/19/2002

Mr. Chavis is in after referral from Dr. Wilkins for evaluation of his left shoulder. He states he has had ongoing left shoulder pain that has been mild and intermittent in nature since his stroke. It has become progressively worse since his FCE in 1/01. Dr. Wilkins treated him for impingement syndrome with a left subacromial injection on 2/13/01. He states this helped three to four days, then the pain returned. MRI was ordered for further evaluation of the shoulder. He states that the pain has been increasingly worse over the past three to four days. It seems to be worse when he begins to wind down in the evening. He notes no real increase in the pain at night, however. States he is unable to sleep on his left shoulder. He is currently taking some pain pills but not any anti-inflammatories. He is not doing any exercises for the left shoulder at this time. He does state up front that if at all possible he would prefer trying some physical therapy and nonsteroidals for the shoulder if we feel that is reasonable. He also has some additional complaints today of ongoing migraine headaches as well as some pain in both feet that has been present since his stroke. He is requesting a possible referral to a neurologist for further evaluation.

PHYSICAL EXAMINATION: Of the shoulder, he has excellent range of motion equal to the right side. He has excellent strength in all three directions. He has mild discomfort with Hawkins and impingement. He is tender to palpation over the AC joint as well as the anterior subacromial region. We have reviewed his MRI today. It reveals a mild left subacromial bursitis and mild tendinopathy of the supraspinatus. Type 2 acromion. Mild to moderate degenerative changes at the AC joint.

DIAGNOSIS: Left shoulder impingement syndrome and AC joint arthrosis.

PLAN: We agree that getting into a formal therapist to work on rotator cuff stretching and strengthening would be a good option. We will set this up. We will also start him on Bextra 10 mg q.d. to help with the discomfort. We will refer him to a neurologist for followup of his other noted problems. Return to clinic in one month for further evaluation and management.

William F. Rigney, III, PA-C /mjr
For A. Jay Preslar, III, M.D.
22235Chart Copy

GILBERT CHAVIS
20347
04/08/2002

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.
2376 Cypress Circle, Suite 300
Conway, South Carolina 29526
(843) 347-7222 • FAX: (843) 347-3305

550-441515-H
317

Followup of his left shoulder problems. His chief complaint today is of ongoing migraine headache that has been present since this past Friday. He is requesting a neurology referral today. He has been in formal therapy for the past three weeks with no significant change with the shoulder. He is still having increased nighttime pain. He has been taking Bextra with no relief.

PHYSICAL EXAMINATION: Of the shoulder, again today he has excellent range of motion equal to the right side in all directions. Excellent strength in all three directions. His greatest area of tenderness remains over the AC joint with less tenderness over the anterior subacromial region.

DIAGNOSIS: Left shoulder impingement syndrome and AC joint arthrosis.

PLAN: We will refer him to Dr. Benjamin for followup of his migraines. We have made that appointment today to get him in as soon as possible. He will return to clinic status post neurologist appointment for further evaluation of the shoulder. On return, he needs preclinic true AP, axillary, Bigliani, and Zanca views of the left shoulder.

William F. Rigney, III, PA-C /mjr
For A. Jay Preslar, III, M.D.
24171

James W. Yates, Jr., M.D. Orthopaedic Surgery Sports Medicine | J. Stewart Haskin, Jr., M.D. Orthopaedic Surgery Surgery of the Hand | A. Jay Preslar, III, M.D. Orthopaedic Surgery | William L. Mills, M.D. Orthopaedic Surgery Spinal Surgery | Jeffrey C. Wilkins, M.D. Physical Medicine & Rehabilitation Electrodiagnosis | Ross Tay Orthopaec Surgery of the Foot and Ankle | Sports Medicine

GILBERT CHAVIS
20347
04/16/2002

550-448871 | 317-HOD

Mr. Chavis comes back in still having problems with his left shoulder. He states it is doing somewhat worse. He previously had an injection done by Dr. Wilkins which he states helped for about three days. He is using heat on it. He states he is doing the exercises at home. He has pain in the shoulder and down into the upper arm area. He also has pain in the left forearm area. He sleeps on his back. He states he is unable to lay on his left shoulder. On physical exam, I don't see any atrophy. He has some mild pain with palpation at the AC joint. No major anterior subacromial tenderness. He has 140 degrees of flexion limited by discomfort. Internal rotation at L5, external rotation 25 (compared to 35 on the right). Good strength in all three directions. X-rays show a type II acromion.

DIAGNOSIS: Unchanged.

PLAN: I think the next step would be to try one more injection and see if that gives him any temporary or long lasting improvement. He needs to continue with his exercise program. If he doesn't get improvement with these things, the next option would be consideration of surgical intervention.

A. Jay Preslar, III, M.D. /dsh
25144

550-441515
317

GILBERT CHAVIS
20347
07/09/2002

Mr. Chavis comes in for followup of his left shoulder pain. He states the AC joint injection helped for about 5-6 days and then the pain returned. He also states that Dr. Wilkins did some posterior muscle injections and that helped with the pain going down into the arms. He continues to complain of significant problems with all four extremities primarily pain and he also has sensation of bugs crawling on his feet at night time. He is managed with pain medicines by Dr. Wilkins but they have apparently had a misunderstanding and he was referred to Dr. Kang for pain medications sometime in the last day or two.

DIAGNOSIS: Based on the MRI as well as his response to a subacromial given to him by Dr. Wilkins in the past and our recent AC joint injection, I think he might get some improvement in the shoulder pain from an arthroscopic subacromial decompression and distal clavicle resection. However, in talking to him today it appears his major problem is the multiple extremity symptoms and not the shoulder problem. This being the case, I would hold off on surgery at this time. If he can treat these symptoms conservatively with medications, I would recommend that. Again, he has asked about the four extremity symptoms and I have again deferred that as outside my area of expertise. With regard to surgery, in addition, I have mentioned the possibility, he might want to have it done at MUSC because of the neurological problems he had with the neck injection in case there were any neurological problems associated with surgery.

A. Jay Preslar, III, M.D. /dsh
33360

250-448871-H
359
550-441515-T3

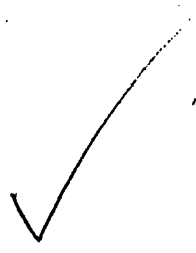
-11-00 Pt. Gilbert Chavis

r. Chavis has called numerous times "demanding" a pain med refill / each
me RWW has answered "No" - Pt. very unhappy c̄ this when I spoke c̄ him on
10. I explained to Pt. we have not received the records from Dr. Grobleski that
WW requested regarding further Tx. + until that time there is nothing we
n do / Pt. states his "lawyer will be calling to handle this!" / on 4-10 Pts.
nsurance carrier (Resha c̄ Liberty Mutual) called requesting RWW see this Pt. to
anage his pain" while the Pt. is "in the process" of obtaining the records
equested. He needs to go to pain management center!
esha @ Liberty Mutual informed
RWW's response - R → RWW (not what we do!)

GILBERT CHAVIS 3/30/00

I have reviewed Gilbert's findings. I don't think he is presently a candidate for surgical intervention. I have referred him back to Dr. Grobleski and Dr. Preslar for further care. Gave him one last Rx for Darvocet. Return visit PRN.

RICHARD W. WARD, M.D. /pc



590 - 441515

CHAVIS, GILBERT R.
MUH # 961173
PATCOM # 456391275
September 15, 2000

MUSC Bone and Joint Center

This patient comes in complaining of neck and right shoulder pain. This has been going on now for several years. He had a right shoulder arthroscopy done in August of 1999 by Dr. Preslar in Conway. He has also been found to have some neck and arm problems. His arm situation sounds like radiculopathy. He has had an MRI that shows some bulging disks. He has also had 2 MRIs of his shoulder. Apparently, these injuries are work related. He used to work in an electronic chip factory, but has not been back to work since his shoulder surgery. He says he was recently terminated from the company. Currently, he complains of right shoulder pain radiating up into his neck and he has pain radiating down into his arm. He complains of numbness in the small and little fingers bilaterally. He has been told he needs neck surgery.

His past medical history is notable for diabetes and kidney stones. Family history is significant for cancer. Current medications include oral diabetic medicines. He does not smoke or use alcohol. His review of systems is notable for weakness, dizziness, fatigue, numbness, headaches, sleep and vision problems, and shortness of breath.

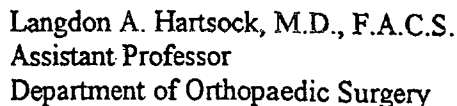
On exam, he is a pleasant, well appearing, well dressed white male in no acute distress. Height 5'5", weight 195 pounds. Examination of his neck reveals full range of motion including flexion, extension, right and left rotation. His right shoulder has some decreased range of motion. He can flex 120°, abduct 120°. He has internal rotation of 80°, external rotation of 70°. His motor strength in both upper extremities is 5/5 in shoulder abduction, elbow flexion-extension, wrist flexion-extension, and grip. Sensation is intact to light touch. Radial pulses are 2+.

His MRI of his neck and shoulder are reviewed. I do not see a torn rotator cuff on the right shoulder and his neck MRI shows the disk bulges.

Assessment:

1. Right shoulder impingement, subacromial bursitis, and decreased range of motion.
2. Cervical spondylosis.

Plan: I explained to the patient that I do not think he has a rotator cuff tear. I am sure that Dr. Preslar would have repaired a rotator cuff tear at the time of his arthroscopy if there had been one present. I think he probably has some motion loss and some subacromial bursitis. I am recommending that he go through some physical therapy for that. He says that one of Dr. Preslar's partners wants to see him about doing some neck surgery, and I also gave him the name of the Carolina Spine Institute here in Charleston if he wants another opinion.



Langdon A. Hartsock, M.D., F.A.C.S.
Assistant Professor
Department of Orthopaedic Surgery

LAH/pmts:ss

cc: Dr. Arthur J. Preslar, III
Mr. Bruce G. Dew, Attorney at Law

E: GILBERT CHAVIS DATE: March 29, 2001

CHART NO: 20347

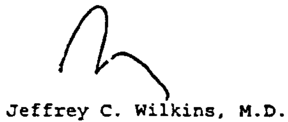
ELECTROMYOGRAPHIC REPORT

Muscle	Innervation	Positive Waves	Fibril-lation	Fasci-culation	Motor Unit Action Potentials
Paraspinals Right	C4-T1	0	0	0	normal no., amp. & duration
Right					
Deltoid	Axillary C56	0	0	0	normal no., amp. & duration
Biceps	Muscolocutan. C56	0	0	0	
Triceps	Radial C78	0	0	0	
Pronator Teres	Median C67	0	0	0	
First Dorsal Interosseous	Ulnar C8T1	0	0	0	
Opponens	Median C8T1	0	0	0	

NERVE CONDUCTION VELOCITIES

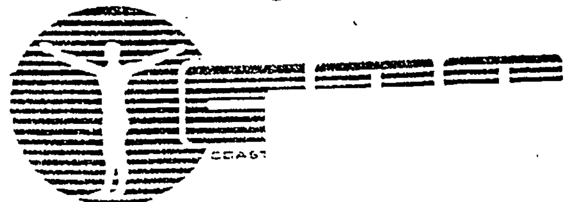
Nerve	Distal Latency Milliseconds	NL	Amplitude mV or mcv	NL	Conduction Velocity Meters/Sec.	NL
Right						
Median Sensory	3.6	<3.6	30	>25		
Ulnar Motor (to ADM)	2.8	<4.3	6.1	3-5	50/57	
Ulnar Sensory	3.5	<3.6	25	>15		

IMPRESSION: NORMAL EMG. NO EVIDENCE OF NEUROPATHY, MYOPATHY, RADICULOPATHY, CUBITAL OR CARPAL TUNNEL SYNDROME.



Jeffrey C. Wilkins, M.D.

JCW/vlr



wc 550-441515 Hod.
Carol Lovern

MIDLANDS ORTHOPAEDICS, PA
1910 BLANDING STREET
COLUMBIA, SC 29201

SC

GILBERT R. CHAVIS
12/07/54

ACCOUNT #: 128471
SSN: 248 04 2224

8-07-01

PRESENT ILLNESS: Mr. Chavis is being seen for an IME. He was referred by Dr. Wilkins at Coastal Orthopaedics. Apparently on 12/1/98, he was at work and was lifting a pot for a lady that was too heavy. He extended his arm out to place the pot on the table, he felt an immediate burning sensation. He was seen by Occupational Health later that day, and he was sent for some x-rays and referred to Coastal Orthopaedics in Conway for a work up. He had a RCR in 8/99. He said he had no change from before his surgery, and he had postoperative therapy which also gave him no relief. He had injections x 4, and he had minimal relief. He now complains of pain to his shoulder joint and under his arm pit area. This radiates to the elbow at times with some paresthesias being present. This was generalized on the inside of the arm. He had an MR arthrogram done in 6/01. He says all movements are painful, and he says he hurts down his arm to his hand. He says that it hurts in his neck area, and it is constant and unbearable, and it occurs even at rest and bothers him all day long and interrupts his sleep. He is made worse with resting or any type of shoulder motion.

During his work up, because of paresthesias, he had a cervical work up. His EMG/NCS were normal on 3/29/01. He had a cervical myelogram on 3/15/01 which was normal. He had a CT scan of his cervical spine which revealed no focal disk protrusions. He also underwent a lateral selective epidural block for selective right C6 nerve block with some alleviation of the shoulder pain, but apparently he suffered a stroke around the time of his nerve block, and his pain, he states from that time, went down to his 4th and 5th digits. Recent MRI of the shoulder 6/29/01 revealed increased signal intensity at the AC joint which would represent arthritic change, and he has no evidence of rotator cuff extension. He had a normal arthrogram as well.

PAST HISTORY:
Allergies: CODEINE.
Medications: Glipizide, Glucophage, and Roxicodone.
Surgeries: Right shoulder surgery, 1999.
Illnesses: Diabetes, previous history of ulcers.

SOCIAL HISTORY: He has children and does not live alone. He does not smoke and does not drink.

FAMILY HISTORY: Cancer, diabetes, and stroke.

FAMILY PHYSICIAN: Ashley Smith, Doctor's Care of Conway.

REVIEW OF SYSTEMS:
General Health: Non-contributory
Ears, Eyes, Nose & Throat: Non-contributory
Respiratory: Occasional shortness of breath.
Cardiac: Dizziness and lightheadedness.
Skin: Non-contributory
GI: Sometimes has indigestion and heartburn.
Urinary: Non-contributory
Neurological: Non-contributory
Hematologic: Non-contributory

Present Weight: 195 pounds. Present Height: 5'5".

PHYSICAL EXAMINATION: The patient has plus-minus AC joint pain, it is mild to moderate; same with greater tuberosity. External rotation with the elbow at the side is 30 to 35 degrees bilaterally. Full forward elevation and full abduction. 90 degrees of abduction with external rotation is 85 to 90 on the left, 85 on the right. External rotation with the elbow at the side is the same. Internal rotation is the same at T11 to T12. He has good strength. Impingement provocative tests reveal plus-minus Yergason's and Speed test, negative isolated supraspinatus. 90 degrees of abduction with resisted external rotation is not painful, plus-minus resisted internal rotation, negative Hawkins' and O'Brien's tests.

RADIOGRAPHS: MRI, etc., are as stated above. AP AC joint and supraspinatus outlet view of the shoulder were obtained of the right shoulder reveals some degenerative changes with some cystic changes about the AC joint. He is now a type I Bigliani acromiomorphology, and he has had a decompression of the inferior aspect of the distal clavicle.

DIAGNOSIS:
1. PAINFUL RIGHT SHOULDER, S/P ARTHROSCOPIC DECOMPRESSION AND PARTIAL THICKNESS ROTATOR CUFF DEBRIDEMENT.
2. MILD AC JOINT ARTHRITIS, RIGHT SHOULDER.

DISPOSITION & RECOMMENDATIONS: The patient has good strength and has discomfort with impingement provocative tests which would be relatively normal for postoperative shoulder. Some of his symptoms may be coming from his AC joint, however, on his exam today, I did not think that an AC joint resection would

restore the pain that he is getting down his arm, and differentiating that from his C6 cervical radiculopathy would be very difficult. I do not feel that an AC joint resection would necessarily make those symptoms go away; however, isolated AC joint pain may be improved slightly.

RETURN APPOINTMENT: DISCHARGED--IME ONLY.

WORK STATUS: WITH REGARDS TO SHOULDER COMPLAINTS--PUT HIM ON A 50 TO 60 POUND WEIGHT RESTRICTION BELOW CHEST LEVEL AND 20 TO 30 POUNDS CARRYING AND LIFTING ABOVE CHEST LEVEL ON AN INFREQUENT BASIS.

According to the AMA Guidelines to the Evaluation of Permanent Impairment, 4th Edition, the patient has a 5% impairment rating to his right shoulder as a result of his injury and continued discomfort.

Michael S. Green, M.D.

MSG/lbp
c: Jeffrey C. Wilkins, M.D. via fax

PALMETTO HEALTH

THE CENTER FOR PAIN MANAGEMENT

PATIENT: Gilbert Chavis

PHYSICIAN: Matthew E. Midcap, M.D.

DATE: September 28, 2001

MEDICAL RECORD #: 590429

cc: CHSSC

Jeffrey Wilkins, M.D.

HISTORY: Patient is seen for initial consultation and evaluation. He is a 46-year-old gentleman referred by Dr. Jeffrey Wilkins with a number of complaints of pain. His biggest complaint is burning pain in his hand and feet. He also has muscle spasms of his low back and right shoulder pain. Mr. Chavis has a remote history of a back injury in approximately 1994. He also has a history of a right shoulder injury on the job on 12/1/98. He has seen a number of physicians for this including Dr. Edwards, Dr. Ellergen, Dr. Hartzog, Dr. Green, and Dr. Ward. He is followed currently by Dr. Wilkins. At some point and time, he was undergoing treatment for this. He ultimately had a CVA approximately a year ago on 1/25/00, which he states effected his memory, his speech, his right hand, and ambulating at the time. He states that he has since pretty much recovered everything except his memory. He states that his wife and child tell him that he forgets to do things that he has either promised to do or that he has been told. He has been out of work for one year and nine months. He states that he was fired from his job. He states that his hand and feet pain is there all the time, as far as that burning pain. The back pain is worse with activities such as bending and lifting. The shoulder pain is worse with working over his head. He states that lying on his back with his arm by his side helps the shoulder pain. The hand and feet burning pain is helped by medication. He is prescribed oxycodone 5 mg by Dr. Wilkins. The patient states that he is taking in upwards of #20 of these q.d. He states that he is taking 3 at a time right now, even though they are prescribed 1-2 q.4-6h., he is taking a bit more than prescribed by Dr. Wilkins. Mr. Chavis states that Dr. Wilkins is aware of this though. He recently had an evaluation by Dr. Green who did not feel as though surgery was in order for the right shoulder. The patient states that he was told that he had a rotator cuff problem. When asking the patient, his worst pain is his burning hand and feet pain. He states that he has numbness and tingling in his fingers and muscle spasms of the back. He has problems sleeping. Although, he has not worked, he states that he tries to be active at home; he drives; he mows the grass; he does small things around the house such as cleaning.

REVIEW OF SYSTEMS: Remarkable for dizziness, forgetfulness, headache, and insomnia. MUSCULOSKELETAL: When you ask the patient about a specific area, he has pain really almost body-wide. GENITOURINARY/GASTROINTESTINAL: He denies any bowel or bladder difficulties. CARDIOVASCULAR: He denies any chest pain or shortness of breath. HEENT: He denies any visual, auditory, or swallowing difficulties at this time. SKIN: He denies bruisability. REPRODUCTIVE: He denies any erectile difficulties.

SURGICAL HISTORY: Remarkable for tracheostomy at 10 months of age. He states that he had a mass excised from his perineum at age 13. He had a previous arthroscopy of his right shoulder in 1999.

MEDICAL HISTORY: Remarkable for non-insulin-dependent diabetes and CVA on 1/25/00. He states that he has a history of bleeding ulcers.

ALLERGIES: The patient has medical allergies to CODEINE.

CURRENT MEDICATIONS: Include oxycodone which he is using up to 20 q.d., glipizide, and Glucophage.

DRUG, ALCOHOL, AND TOBACCO HISTORY: The patient does not smoke. He does not drink alcohol.

SOCIAL HISTORY: The patient formerly worked for a textile company. He has a GED level of education.

FAMILY HISTORY: Remarkable for cancer, stroke, diabetes, and alcoholism.

PHYSICAL EXAMINATION: Exam reveals a pleasant, well-developed, well-nourished, muscular gentleman in no apparent distress at rest. Height 5 feet 5 inches. Weight 195 pounds. Blood pressure 149/99. Pulse 65. Respirations 16. Temperature 95.2 degrees. Mental status examination shows the patient to be awake, alert, and oriented. He has good memory. He has good distant memory as far as his medical history, specific dates, treatments, and medications. I do not see any evidence of a memory impairment at this time. His affect and mood seem appropriate. HEENT examination shows the pupils to be equal, round, and reactive. Extraocular motions are intact. The mouth opens well. The neck is supple with full range of motion. There is no JVD or adenopathy. The heart is regular. The lungs are clear. By exam of the upper extremities, he has full range of motion of the shoulders, elbows, wrists, and hands. Pulses in the upper extremities are good. He has some pain with abduction of the right shoulder past 90 degrees, but he does get it to full range of motion. There is perhaps a little bit of limitation with rotation on the right, but not significant. He has full range of motion of the hips, knees, and ankles. Pulses in the lower extremities are good. Musculoskeletal exam shows some tenderness throughout the lower cervical paraspinals and the suprascapular trapezius area, but no real trigger points here. There is some diffuse lower back tenderness, but the patient has good range of motion of the lumbar spine, flexing forward to 90 degrees, extending to 10 degrees. Neurologic examination shows cranial nerves II through XII to be intact. Motor groups in the upper extremities are 5/5. Sensory exam is intact. Motor groups in the lower extremities are 5/5. Sensory exam is intact. Reflexes are 1-2+and equal.

DIAGNOSTIC STUDIES: An MRI of the right shoulder is the only imaging study that we have; this showed increased signal of the AC joint. Post-arthrogram did not see any instability abnormality of the labrum joint or rotator cuff.

ASSESSMENT: Peripheral neuropathy. This perhaps could be a late effect of the stroke, although having bilateral, just stocking-glove-type distribution, neuropathic pain post cerebrovascular accident would be extremely unusual. A thalamic pain syndrome is usually one-sided. I do not get any abnormalities by his neurologic exam. Usually there is some hypesthesia. As far as his shoulder pain, the imaging studies do not demonstrate any abnormality of the rotator cuff. Dr. Green has not felt that the patient is a surgical candidate. Also, Mr. Chavis is taking quite a bit of oxycodone at this time, yet still rating his pain as a 7. He is extremely physically active. His memory seems to be intact, although, he has never been neuropsychiatrically tested for finer memory matters.

RECOMMENDATIONS: My recommendations for Mr. Chavis are the following:

1. I am not sure what the Full Pain Program here would have to offer him.
2. My recommendations for Dr. Wilkins are that he wean Mr. Chavis down off of the oxycodone. I have suggested starting him on some Gabitril. If he is unable to tolerate the Gabitril, then I would use one of the other antiepileptics to provide him coverage of some of this burning pain, as far as the hand and feet pain. I feel that they are a bit more able to cover that type of pain, especially post-stroke-type pain.
3. Mr. Chavis has good strength. He has really fairly good range of motion. My overall plan would be to have a Functional Capacities Evaluation done and see where he is. Dr. Wilkins perhaps can rate Mr. Chavis. At that time, I would suggest that Mr. Chavis be put through some Vocational Rehabilitation to see if he is capable of work at this time.
4. If there is some question about his memory post-CVA, then he could be neuropsychiatrically tested to assess his memory fully.

DISPOSITION: We will make any further recommendations from the full treatment team. I did give him a prescription for Gabitril today.

Matthew E. Midcap, M.D. 10/12

HEALTHSOUTH

Conway, South Carolina

FUNCTIONAL CAPACITY EVALUATION

PATIENT: Gilbert R. Chavis
EMPLOYER: AVX
DATE OF INJURY/ILLNESS: 12/01/98
DATE OF EVALUATION: 01/08/02
DATE OF REPORT: 01/10/02
HEALTHSOUTH I.D. NO.: 248-04-2224

REFERRED BY: Jeffrey Wilkins, M.D.
PHYSICIAN: Jeffrey Wilkins, M.D.
INSURANCE CARRIER: Liberty Mutual
INSURANCE REP.: Carol Lovett
INSURANCE I.D. NO.: 550441515

VITAL SIGNS

HEIGHT: 65" WEIGHT: 195 lbs.
RESTING HEART RATE: 82 bpm

HAND DOMINANCE: RIGHT
RESTING BLOOD PRESSURE: 145/88 mm/Hg

FUNCTIONAL CAPACITY EVALUATION SUMMARY REPORT

PURPOSE OF ASSESSMENT

Gilbert Chavis was referred to HEALTHSOUTH Conway, South Carolina for assessment of his current physical and functional capabilities.

SUMMARY OF RESULTS

Gilbert is a 46 year old male with the current diagnosis of upper scapular, onset 12/01/98. He reported that the injury took place when he picked up a "pot" for a fellow female employee and felt an immediate burning sensation in his right shoulder while reaching his arms forward to place the "pot" onto a table. His endurance/aerobic capacity was found to be undeterminable (refer to endurance profile) for 46 years of age. Deficits found in the musculoskeletal evaluation include: Decreased flexibility in bilateral lower extremities due to pain, complaints of numbness in bilateral 4th and 5th digits left greater than right, left bicep pain and numbness and bilateral hands tingling on dorsal aspect. Also decreased bilateral upper extremity range of motion for internal rotation and right upper extremity flexion and abduction. Isometric strength testing revealed consistency of effort on 13 out of 13 tests. Functional testing revealed that he is presently lifting in the medium category of work (according to U.S. Department of Labor Standards) as demonstrated by an occasional floor to knuckle lift of 54 lbs., knuckle to shoulder lift of 35 lbs., shoulder to overhead lift of 35 lbs., and carry of 49 lbs. 100 feet with pivoting. During positional tolerance testing, Gilbert demonstrated tolerance of repetitive bending, overhead reaching, forward reaching, sustained squatting, stooping, sustained kneeling, stair climbing, pushing/pulling and sitting on a frequent basis and standing and walking on an occasional basis.

LIFTS: Floor to knuckle =54 lbs.
12" to knuckle =54 lbs.
Knuckle to shoulder =35 lbs.
Shoulder to overhead =35 lbs
CARRY:49 lbs.
STATIC PUSH:29.33 ft/lbs.
STATIC PULL:31.33 ft/lbs.

RESULTS

The results of this evaluation indicate that Gilbert R. Chavis is currently lifting in the medium physical demand level as classified by the U.S. Department of Labor.

SUBJECTIVE HISTORY

Gilbert is a 46 year old male with the current diagnosis of upper scapular, onset 12/01/98. He is presently not working. Current medication includes: Glucophage, Glipizide, Roxycodone and Advil.

Previous treatment for this injury/illness (as reported by patient)includes:
X-Ray on 12/5/98, MRI in 6/99, Myelogram, EMG 8/12/00 and Ultrasound. Mr. Chavis reports all tests came back normal except MRI which revealed a right rotator cuff tear. Mr. Chavis also reports seeing 11 different physicians for this injury including 7 Orthopedists, 2 Neurologists, his family practitioner and a company doctor. Mr. Chavis reports undergoing a rotator cuff repair surgery on 8/19/99 which he reports worsened his symptoms. He also attended 6 weeks of Physical Therapy 3 times per week where he received massage, ultrasound, heat, ice, and various exercise programs which began on approximately 9/01/99 and went through approximately 10/15/99. Overall Mr. Chavis rates his overall outcome of all his previous treatment as worsening his symptoms.

Gilbert reported moderate pain at an intensity of 5 (0 = no pain; 1,2,3 = low; 4,5,6 = moderate; 7,8,9 = severe 10 = emergency pain). He reported that his pain ranges from 3 at best to 8 at its worst. He states that reaching above his shoulders aggravates his symptoms, and that lying flat in bed on his back with 2 pillows under his head provides relief. Perceived abilities include: sitting 180 minutes, standing 5 minutes, walking 15 minutes, driving 180 minutes, and lifting 40 lbs.

Additional subjective information includes: Mr. Chavis reports that he had a CVA on 01/25/00.

OCCUPATIONAL HISTORY

An occupational history was obtained by the patient. Mr. Chavis reports that his title with AVX was Paste Processor. He reports that he worked for AVX for 12 years; 8 years and 3 months as a Paste Processor and approximately 4 years as a line worker and in the QC department. His weekly income at the time of injury was $ 410.00 per week and is currently receiving $263.69 per week from Workers Compensation. According to Mr. Chavis, his job requirements were as follows: Maximum weight lifted was upto 100 lbs. approximately once per week from floor to shoulder height with an object described as a 3 ft. tall cylinder. Frequent weight lifted was upto approximately 40 lbs. 8-10 times per day from floor to shoulder height with objects described as 3-4 gal. pots. Repetitive weight lifted was 10-15 lbs. 3-4 times per day for 30-45 minutes straight at lifting ranges at waist height and carrying approximately 20 feet with an object described as a "big stainless steel salad bowl." The maximum weight pushed or pulled was greater than 300 lbs. 3-5 times per day over a distance of approximately 100 feet on a wheeled cart with an object described as a 36 inch diameter pot approximately 2 and 1/2 feet tall. The maximum weight he reorted carrying was 40-50 lbs. over a distance of approximately 40 feet 5-6 times in a row about once per week with objects described as bags of material.

Mr. Chavis reports his non-material handling requirements were as follows: Sitting for 60 minutes, standing for 3 minutes, constant walking, repetitive bending for 45-60 minutes, frequent overhead reaching, writing, forward reaching and repetitive reaching, sustained squatting approximately 9 times per day for about 45 seconds each, kneeling approximately 9 times per day for about 45 seconds each, frequent stooping, occasional pivot twisting, assembly work, stacking, filing, supination/pronation and radial/ulnar deviation. Mr. Chavis reports having to use machinery including 3 roll mills, dynamill, scales and hydrolic lifts. Mr. Chavis also reports that transitional or light duty work was available at his workplace which was reported to be the same job with lifting restrictions for nothing over 50 lbs. According to the patient his physical demand level for the above described position was Medium.

MUSCULOSKELETAL SCREEN

GAIT: No abnormalities noted.

POSTURE: Fair, does not change positions.

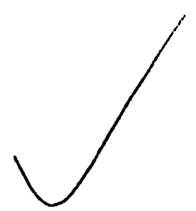
FLEXIBILITY: Bilateral lower extremities are within normal limits, bilateral upper extremities are limited by pain.

RANGE OF MOTION: True cervical flexion=37(full), extension=38, left lateral flexion=40, right lateral flexion=44, left rotation= 63, right rotation=62.

STRENGTH: Bilateral upper and lower extremities are 5/5.

NEUROLOGICAL: Complains of numbness in bilateral 4th and 5th digits left greater than right. Left lateral biceps pain and numbness. Bilateral hands tingling on dorsal aspect.

SOFT TISSUE ASSESSMENT: Tender C-spine and bilateral scapula and posterior shoulders/rotator cuff.



ENDURANCE/CONDITIONING PROFILE

he American Heart Association "cardiovascular profile" ranked Gilbert in the HIGH RISK category for the development of cardiovascular disease and his resting heart rate was 82 bpm and resting blood pressure was 145/88. Mr. Chavis was not able to complete single stage treadmill protocol secondary to having had a CVA in the past. Mr. Chavis did allthough tolerate 12 minutes and 7 seconds on the treadmill at a pace of 1.4 mph with a peak HR of 115 and post BP of 158/90. Patient stopped test secondary to increased pain in lower back.

FUNCTIONAL CAPACITY EVALUATION

A thorough "functional" evaluation was completed. The safe maximal limits for the material handling activities and the positional tolerance activities are summarized within the included charts.

The material handling (physical demands) and non-material handling (positional) tolerances were assessed.

CONSISTENCY OF EFFORT TESTING:

Maximal Voluntary Effort Testing was performed using the Chatillon strain gauge and the Jamar hand dynamometer.

Isometric Consistency Test

Test	Trials (Pounds of Force) Trial 1	Trial 2	Trial 3	Average	Standard Deviation	Coefficient of Variation*
Strain Gauge Squat Lift	270.00	0.00	0.00	90	127.28	141%
Isometric Push	28.00	32.00	28.00	29.33	1.89	6%
Isometric Pull	32.00	30.00	32.00	31.33	0.94	3%
Isometric Arm Curls	72.00	68.00	72.00	70.67	1.89	3%
	0.00	0.00	0.00	0.0	0.00	!Zero Divide
	0.00	0.00	0.00	0.0	0.00	!Zero Divide
	0.00	0.00	0.00	0.0	0.00	!Zero Divide

Comments: BP prior to testing was 145/88, peak HR's during testing ranged from 104 - 118. BP after testing was 156/88 and HR = 125, patient complained of pain in his neck and elbows at level 6 during testing.

Maximal Voluntary Effort Test

Grip Test	Grip Position 1			2			3			4			5		
Right Hand	87	103	92	120	122	125	120	110	109	110	104	110	94	90	90
Average	94.00			122.33			113.00			108.00			91.33		
Coefficient of Variation*	7%			2%			4%			3%			2%		
Left Hand	73	75	72	120	118	119	111	105	103	104	99	93	84	88	94
Average	73.33			119.00			106.33			98.67			88.67		
Coefficient of Variation*	2%			1%			3%			5%			5%		

* Consistency of effort is determined by a Coefficient of Variation of 20% or less (Guides to the Evaluation of Permanent Impairment, Fourth Edition, page 64).

Comments: BP prior to grip test was 188/78 and after was 154/88. A bell shaped curve was produced bilaterally indicating consistency of effort.

150 Waccamaw Medical Park • Conway, SC 29526 • (843) 347-7141 • Fax (843) 347-

MATERIAL HANDLING (Physical Demands):

Activity	Demonstrated		Job Requirement by Patient		Adequate for Job
	Occasional	Frequent	Occasional	Frequent	Yes/No
Floor to Knuckle (lbs.)	54.00	38.00	100.00	40.00	No
Knuckle to Shoulder (lbs.)	35.00	25.00	100.00	40.00	No
Shoulder to Overhead (lbs.)	35.00	25.00	0.00	0.00	Yes
100 Ft. Carry (lbs.)	49.00	34.00	50.00	15.00	No
	0.00	0.00	0.00	0.00	
	0.00	0.00	0.00	0.00	

Comments: BP prior to occasional lift test was 156/88 and peak HR's ranged from 105 - 132, BP after occasional lifts was 154/88. Bp prior to frequent lift testing was 154/88 and peak HR's ranged from 140 - 150, BP after frequent lifts was 188/78. Patient required verbal cues to correct body mechanics.

NON-MATERIAL HANDLING (POSITIONAL TOLERANCE):

Activity	Demonstrated	Job Requirement by Patient	Adequate for Job (Yes/No)
Sitting	55 min.	60 min.	No
Standing	5 min.	3 min.	Yes
Walking	12 min. 07 secs.	constant	No
Climbing Stairs	frequent	none	N/A
Activity	**Demonstrated Occasional/Frequent/Constant**	**Job Requirement by Patient Occasional/Frequent/Constant**	**Adequate for Job (Yes/No)**
Trunk Bending (sustained)	Not Tested	Not Required	N/A
Overhead Reach (sustained)	Frequent	Frequent	Yes
Crawling (10 feet)	Not Tested	Not Required	N/A
Squatting (repetitive = 5x's)	Not Tested	Not Required	N/A
Kneeling (sustained)	Frequent	Frequent	Yes
Stooping (repetitive = 5x's)	Frequent	Frequent	Yes
Crouching (sustained squat)	Frequent	Frequent	Yes
Ladder Climbing (repetitive)	Not Tested	Not Required	N/A
Trunk Twisting (5 x's)	Not Tested	Occasional	N/A
Forward Reaching (sustained)	Frequent	Frequent	Yes
Forward Reaching (repetitive)	Frequent	Frequent	Yes
Pushing/Pulling (5x's/20 feet)	Frequent	Frequent	Yes
Trunk Bending (repetitive)	Frequent	Frequent	Yes

Comments: Patients BP prior to testing was 158/90 and peak HR's ranged from 105 - 134, BP after testing was 158/90 and 1 minute post HR=101. Patient reported pain level 6 prior to testing and pain level 5 after. Patient completed non-material handling test in 35 minutes.

NON-MATERIAL HANDLING

Name: Gilbert Chavis
Date: 01-08-02

	HR	P	HR	P	HR	P	HR	P	HR	P
Sustained bending (1 min.)										
① **Repetitive bending (5 x)**	118	6	119	5	116	5	120	6	112	5
② **Overhead reaching (1 min.)**	126	7	127	6	126	5	121	6	121	6
~~**Forward reaching (1 min.)**~~										
③ **Sustained squat (1 min.)**	117	3	108	4	105	5	117	6	109	4
⑦ **Repetitive** ~~**squat**~~ Stooping **(5 x)**	124	5	122	5	126	6	121	5	120	5
④ **Kneeling (1 min.)**	114	3	124	4	120	7	134	5	133	4
⑥ ~~**Ladder**~~ Stair **climbing** ~~**(3x3 rungs)**~~ (2x4 steps)	125	5	127	4	131	6	124	5	126	4
Crawling (ft.)										
⑤ **Push/pull (50 ft.)**	119	5	114	4	122	6	114	5	123	4

Comments:

Pain prior = 6
Pain post = 5
B/P prior = 158/90
B/P post = 158/90
HR prior = 129
HR post = 101 p̄ 1 min

Start time = 4:20pm
Stop time = 4:55pm
Total = 35 min.

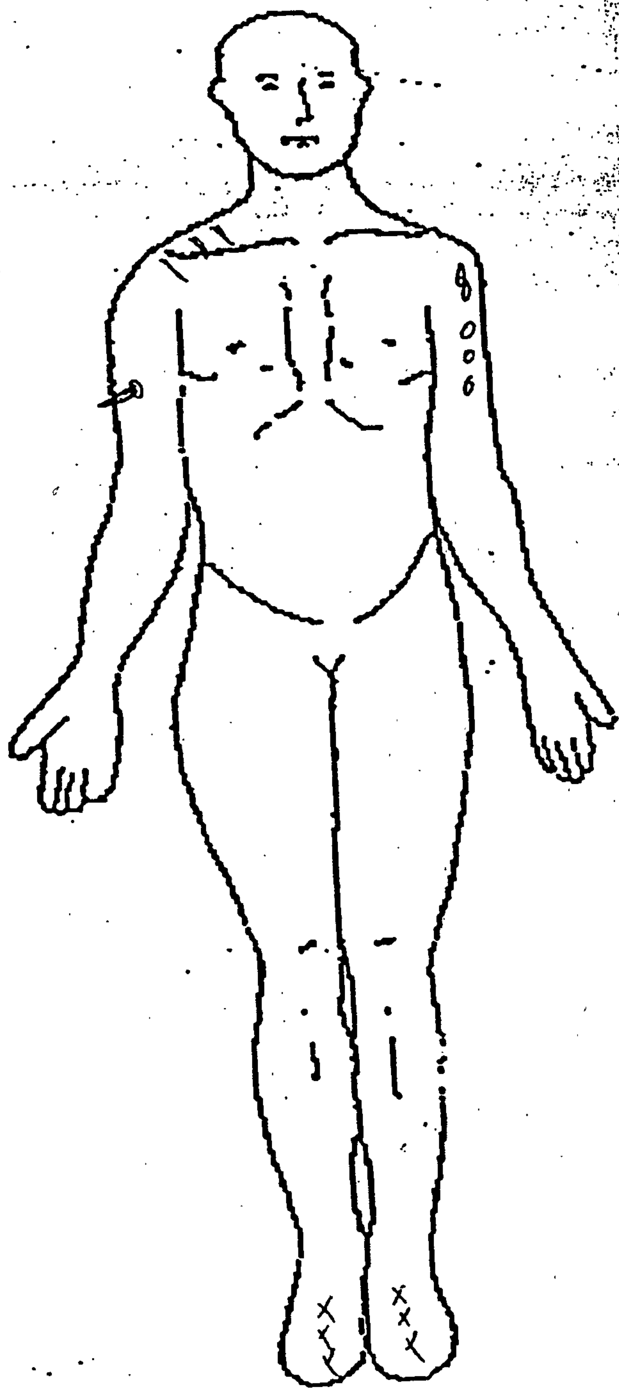
Occasional: 1-4x/hr. or <2.5 hrs/day
Frequent: 5-24x/hr. or 2.5 to 5.5 hrs/day
Constant: >24x/hr. or > 5.5/hrs/day

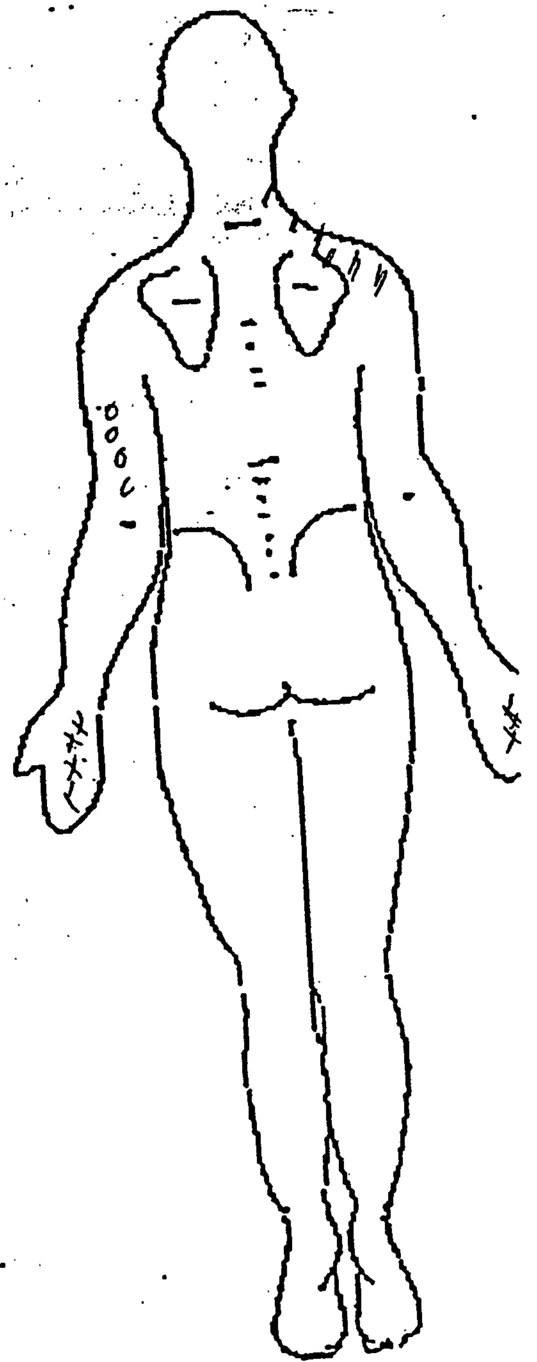
Patient Name: Gilbert ? Chavis Date: 1/18/07 File Number: ____

Pain Drawing

Mark the areas on the diagram where you feel the pain sensation on your body. Use the appropriate symbol to describe pain. Mark areas of radiation. Include all affected areas. Score only for lumbar spine diagnosis.

Numbness	Pins & Needles	Burning	Stabbing
======	000000	XXXXXX	//////
======	000000	XXXXXX	//////
======	000000	XXXXXX	//////





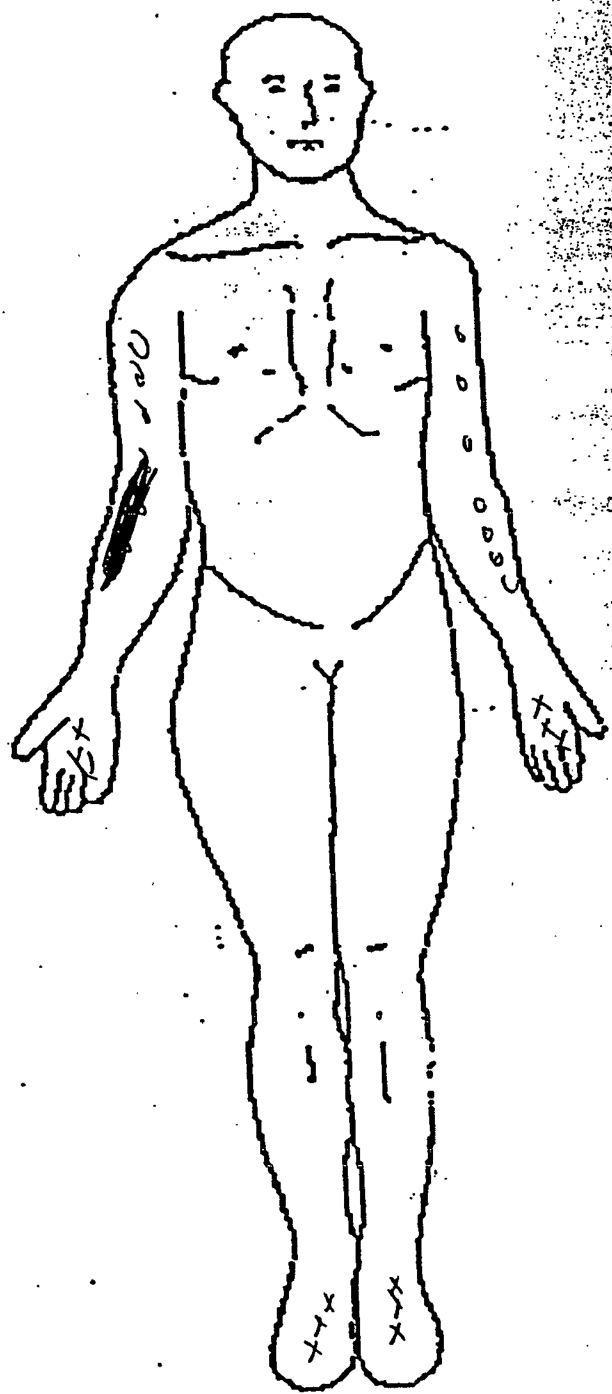
Score ____

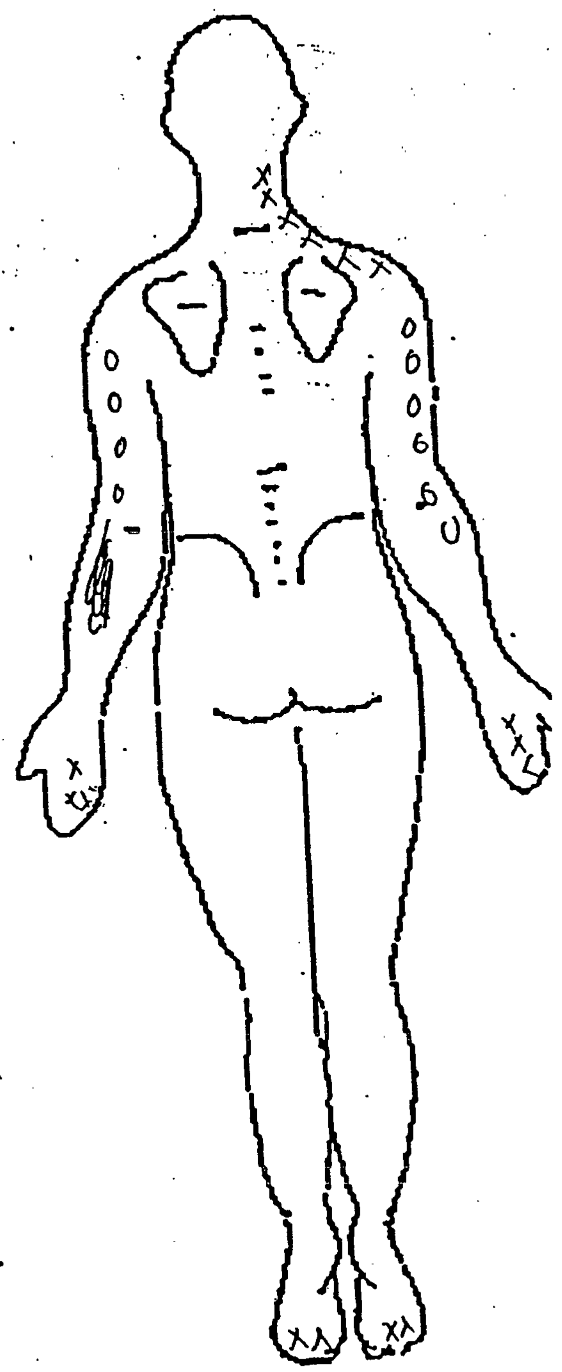
Patient Name: Gilbert P Chavis Date: 1 18 ... File Number: ______

Pain Drawing **Post-Test**

Mark the areas on the diagram where you feel the pain sensation on your body. Use the appropriate symbol to describe the pain. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Stabbing
======	000000	XXXXXX	//////
======	000000	XXXXXX	//////
======	000000	XXXXXX	//////





Score ______

Thank you for referring Gilbert R. Chavis to HEALTHSOUTH Conway, South Carolina. If you have any further uestions regarding this evaluation or any recommendations made, please do not hesitate to contact us at:

HEALTHSOUTH Conway, South Carolina
150 Waccamaw Medical Park
Conway, SC 29526
Phone: (843) 347-7141
Fax: (843) 347-1674

Professionally,

Ian W. McClure, COTA/L | Murray Cooper LPT

Ian W. McClure
Senior COTA/L

Murray Cooper
LPT

cc: Dr. Jeffrey Wilkins, M.D.
Carol Lovett
Chart

Pain, Spine & Sports Medicine

C. Gregory Kang, M.D. • Phone: (843) 232-8118

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass. Unit 201 • Surfside Beach SC 2957

550-441515/317

PATIENT: GILBERT CHAVIS
DATE: 9/4/02

Brief History:
Mr. Chavis returns for follow up. These are his main complaints. He continues to have pain in the left side of his neck, upper shoulder. He also has continued paresthesias and tingling in the left 4th and 5th digits. He is also having elbow discomfort. He was recently seen and evaluated by Dr. White regarding ulnar neuropathy at the elbow.

Mr. Chavis reports that he is making progress as far as his physical therapy. The spasms in his neck and shoulder area seem to be a little better. He is still having a lot of problems with pain in that distribution, worse with use of the left arm.

Examination:
He continues to have myofascial tender points and trigger points in the upper trapezius and cervical paraspinals. He has a positive Tinel's sign in the left elbow. There is continued atrophy of the left hand intrinsic muscles as well as decreased sensation in the left 4th and 5th digits. Strength is also diminished in the hand intrinsics.

Laboratory Data:
I reviewed his cervical spine MRI. He has a mild cervical disc herniation at T5/6. We did an EMG/nerve conduction study of the upper extremities and this reveals bilateral carpal tunnel syndrome which was relatively mild. He also has a focal ulnar neuropathy on the left side at the elbow consistent with cubital tunnel syndrome/tardy ulnar palsy. He has evidence of de-enervation based on needle exam in the left first dorsal interossei muscle as well.

Diagnostic Impression:
(1) Left rotator cuff tendonitis, chronic
(2) C5/6 disc herniation
(3) Cervical myofascial pain
(4) Left focal ulnar neuropathy at the elbow with evidence of de-enervation of hand intrinsic muscles.
(5) Mild bilateral carpal tunnel syndrome

Recommendations:
(1) I have recommended Gilbert try another course of cervical traction and slowly work him up to about 25 to 30 lbs. if he can tolerate this.
(2) His other option is to undergo a cervical epidural steroid injection but he is not interested in this after what happened the last time he had a cervical spine procedure.
(3) Continue with left shoulder rehabilitation.

PATIENT: GILBERT CHAVIS

(4) Continue follow up with Dr. White and possibly surgical release of the ulnar nerve on the left side.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Cc: Dr. White
Worker's Compensation

550·441·15/317 93

C. Gregory Kang, M.D. • Phone: (843) 293-8868 • Fax: (843) 293-8869
Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

PATIENT: GILBERT CHAVIS
DATE: 9/25/02

Procedure Note: Trigger Point Injections

Trigger point was identified in the left upper trapezius muscle. 2cc of 1% Xylocaine and 4mg of Dexamethasone was injected into the trigger point. 25 gauge, 1 ½" needle was used to infiltrate the medication. The patient tolerated the procedure well. There were no complications.

C. GREGORY KANG, MD
Physiatrist

CKG/ajw

RECEIVED
OCT 07 2002

435

Pain, Spine & Sports Medicine

C. Gregory Kang, M.D. • Phone: (843) 293-8868 • Fax: (843) 293-88

Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

550.441515/317

PATIENT: GILBERT CHAVIS
DATE: 10/16/02

Brief History:
Mr. Chavis returns for follow up. He has had physical therapy now for several months. He reports no significant improvement in the neck and shoulder pain. He is still having difficulty lifting the left arm. He is still having pain in the left elbow with paresthesias and weakness in the left hand. The Roxicodone is giving him temporary relief. He is having no significant impact from the Zonegran yet. He continues to have tension type headaches that begin in the back of his neck into his head.

Examination:
He still has some tenderness in the upper trapezius muscles especially on the left side. He has a positive impingement sign on the left. Subacromial bursa is tender. AC joint is also tender. Cervical spine ROM is normal. The left hand has some intrinsic muscle wasting. He has decreased sensation in the ulnar nerve distribution. Positive Tinel's sign in the left elbow.

Diagnostic Impression:
(1) Left focal ulnar neuropathy at the elbow with damage to the ulnar nerve. He is due to have surgery for that. This is not a work related condition.
(2) Chronic left rotator cuff tendonopathy with impingement syndrome
(3) Cervical degenerative disc disease

Recommendations:
(1) We will go ahead and discontinue therapy.
(2) He is to have his left ulnar nerve released by Dr. White.
(3) We will check back with Mr. Chavis after his surgery.
(4) Increase Zonegran to 300mg q hs

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Pain, Spine & Sports Medicine

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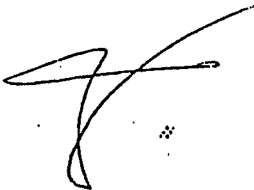
Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

PATIENT: GILBERT CHAVIS
DATE: 10/17/02

Brief History:
Gilbert returns to my office. He is extremely upset because the pharmacy would not fill his prescriptions. The pharmacist basically told Mr. Chavis that I was treating him for a non-worker's comp related condition. I told Mr. Chavis that this is completely incorrect. I am treating his left shoulder rotator cuff tendonopathy with impingement syndrome. I am treating him for neck pain with radiation to the shoulder secondary to degenerative disc disease of the cervical spine. I have diagnosed a non-worker's comp related condition which is left focal ulnar neuropathy at the elbow. This has been referred to hand surgeon Dr. White for decompression of the nerve. In any case, I explained this to Mr. Chavis and he understood.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw



...n,
& Sports
...edicine
C. Gregory Kang, M.D. • Phone: (843) 293-8868 • Fax: (843) 293-8...
Community Medical Center - South Strand
5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

550-441515 |317

PATIENT: GILBERT CHAVIS
DATE: 10/28/02

Brief History:
Mr. Chavis returns for follow up after his ulnar nerve transposition. He has continued pain in the neck and left shoulder region. He has had a course of physical therapy which has not helped him to any significant degree he reports. He is taking some Percocet 10/325 which were given to him by Dr. White. Gilbert reports that this seems to be more helpful than the Roxicodone. He is not having to take the Percocet as much as he does the Roxicodone.

He still has not been able to fill his prescription for Fioricet of Zonegran.

Examination:
He has continued pain and tenderness in the cervical paraspinals and left upper trapezius. The left arm is in a sling. I am not able to check his ROM at this time.

Diagnostic Impression:
(1) Left rotator cuff tendonitis
(2) Impingement syndrome
(3) Cervical degenerative disc disease with a bulge at C5/6

Recommendations:
(1) Discontinue Oxycodone
(2) Start Percocet 10/325, 2 tablets t.i.d. p.r.n. severe pain
(3) Zonegran 300mg q hs whenever he can get that started
(4) Fioricet 1 to 2 q d p.r.n. migraine headache or occipital headaches
(5) We may need to repeat cervical spine MRI to reassess Mr. Chavis' neck pain and shoulder pain.
(6) At some point he may need another surgical opinion.

C. GREGORY KANG, MD
Physiatrist

CGK/ajw

Pain,
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Medicine

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5046 U.S. Hwy. 17 Bypass, Unit 201 • Myrtle Beach, SC 29588

550-441515
317

PATIENT: GILBERT CHAVIS
DATE: 11/20/02

Brief History:
Mr. Chavis returns for follow up. He says the numbness in the left hand is better after the ulnar nerve release and transposition. His main complaint continues to be the left shoulder. There is decreased ROM now. Increased pain. More muscle spasms in that area. The arm is not very functional at this time. He is still wearing a sling. He recently saw Dr. McAffrey for his neurological evaluation.

He also reports the Percocet 10/325 are not very effective. He would like to go back to Roxicodone for his pain.

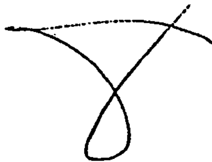
Examination:
He is in no acute distress. He has about 50 to 60 degrees of shoulder abduction before he has pain. He has a positive impingement sign. The shoulder is tender along with the muscles around that area. He has pretty good elbow ROM passively to full extension as well as extension. Supination is slightly decreased on the left side. Neurologically no changes.

Diagnostic Impression:
(1) Left rotator cuff tendonopathy with impingement syndrome
(2) Cervicothoracic myofascial pain
(3) C5/6 disc bulge with degenerative disc disease
(4) Cervical radicular symptoms to the left arm

Recommendations:
(1) Roxicodone 15mg t.i.d. p.r.n. pain
(2) Start physical therapy to the left side of his shoulder and arm to increase ROM and strength
(3) Follow up in a month

C. GREGORY KANG, MD
Physiatrist

CGK/ajw



PATIENT: GILBERT CHAVIS
DATE: 03/03/2004

Brief History:
This patient returns today for follow up. He reports that the Bextra is helping with a lot of his pain. He is still having pain in the left groin and left side of his lower back. It tends to radiate into the lateral side. He is tolerating his other medicines with no significant side effects. He is still having some discomfort in the left shoulder and arm but the range of motion is markedly better. The arm has become significantly more functional. He is still having pain in the neck and shoulder area as well.

Examination:
On examination today the patient has tenderness in the cervical paraspinals and left upper trapezius. The left shoulder has full abduction. In the lumbosacral spine he has some tenderness in the left gluteal and sacroiliac joint region. The left trochanteric bursa is slightly tender. Hip external rotation seems to aggravate his pain the most. Neurologically there are no new focal deficits.

Diagnostic Impression:
1. Left rotator cuff tendonitis status post arthroscopic surgery with excellent improvement.
2. Cervical disc displacement with radiculitis.
3. History of cerebellar cerebrovascular accident.
4. Chronic back pain with radicular pain to the left leg.

Recommendations:
1. Refill oxycodone.
2. Continue Bextra 10 mg twice a day.
3. Continue Neurontin.
4. I am recommending a trial of epidural injections. He previously responded to these injections for back and leg pain.

C. Gregory Kang, M.D.
Physiatrist

CGK/dhm
Cc: Worker's Compensation.

CAROLINA NEUROLOGICAL CLINIC, L.L.P.

ALTON E. BRYANT III, M.D.
JAMES L. BUMGARTNER, M.D.
THOMAS H. DUKES, III, M.D.
THOMAS S. HUGHES, M.D.
CHARLES S. JERVEY, M.D.
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125 Doughty Street
Suite 460
Charleston, SC 29403
(843) 723-0202
Fax (843) 723-1052

PATIENT: GILBERT CHAVIS
DATE: JUNE 1, 2004
REFERRING PHYSICIAN:
FOR: INDEPENDENT MEDICAL EVALUATION

HISTORY: The patient is a 49 year old white male referred for an independent medical evaluation. In January of 2000, the patient was sent for cervical selective epidural block because of ongoing pain into his right shoulder which was thought to possibly be radicular. This pain was apparently due to an on the job injury. According to the procedure note dictated by Dr. David Goltra, he has a selective right C6 nerve root block. He had a syncopal episode during the procedure which lasted for approximately one minute. When he awakened he was nauseated and mildly disoriented, and his right shoulder pain was gone. He was sent to East Cooper Hospital and was admitted by Dr. David Wenzel in the neurology service for observation. According to Dr. Wenzel's note he had a head CT scan which showed no abnormality. I did not see the CT scan report nor the films, however. According to Dr. Goltra's procedure report he had a needle directed toward the right C5-6 neural foramen, and a neurogram was performed using a small amount of Omnipaque, and this documented opacification of the nerve root shealth. Following that a mixture of 1 cc Xylocaine and 80 mg Depo-Medrol were injected in the perineural space. Upon removing the needle a small amount of blood return was obtained. Direct compression was applied to the lateral neck. At approximately the time when the needle was removed the patient had an episode of syncope.

According to Dr. Wenzel's history and physical the patient had persistent nausea as well as an episode of vomiting at the hospital, but no further episodes of confusion. He also was reporting a headache and feeling tired. He had no visual complaints nor focal weakness or focal numbness. Dr. Wenzel did not observe any further episodes of confusion although the patient did later have complaints of difficulty with his memory.

When I spoke with Mr. Chavis today he indicates that his primary complaints at this time are pain and numbness in his left shoulder area which is exacerbated by raising his left upper extremity into the air. His back pain is another source of major complaint and a burning pain which he has in the distal lower extremities and upper extremities bilaterally. He also has been experiencing erectile dysfunction, and that is another of his major complaints.

He later had an EMG/nerve conduction study conducted by Dr. Hodge, who is a neurologist. This was done of the right upper extremity and right supraparaspinal region and was a normal study. This was dated 6/16/2000. He had another EMG/nerve conduction study dated 7/31/02, and that was

done by Dr. Gregory Kang, who is a physiatrist. According to his study the median sensory nerve distal latencies were delayed bilaterally, and the left ulnar sensory nerve response was absent. Bilateral median motor distal latencies were slightly delayed, and the left ulnar motor nerve had slowing of the conduction velocity across the elbow and an amplitude drop across the elbow, but was otherwise normal. There were denervation changes in the left first distal interosseous muscle which is ulnar nerve territory.

He has also been undergoing orthopaedic evaluation and treatment. He had an MRI dated 6/07/99 which showed probable partial tear in the rotator cuff on the right.

Following his syncopal episode and hospital admission he had MRI of the brain dated 2/07/00, which showed evidence of a stroke in the right cerebellar hemisphere and right mid brain immediately above the cerebellar peduncle on the right side measuring 2-3 mm. The stroke in the right cerebellar hemisphere measured 1 x 2 cm, and these appeared subacute. He had a follow up scan done in approximately April of 2000 which showed almost complete resolution of the stroke. Mr. Chavis had neuropsychological testing done by Randolph Waid in May and June of 2002. This showed notable variability in his performance on memory/learning tasks with evidence of reduced capacity for immediate learning/memory but no evidence of rapid forgetting or amnestic syndrome. On his assessment he indicated that Mr. Chavis was generally efficient commensurate with his intellectual/education level on tasks of assessing executive/higher reasoning skills. He also was found to have chronic pain and comorbid depression and difficulty with anxiety.

PAST MEDICAL HISTORY: Significant for diabetes, which is controlled with oral medications.

MEDICATION ALLERGIES: Codeine.

MEDICATIONS: He currently is on Roxicodone, Glucophage, Avandia, Lopid, Lipitor, Glucotrol, aspirin, vitamins, and Bextra.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: He denies smoking or alcohol.

PHYSICAL EXAMINATION: On exam the patient is alert and oriented X3. He arrived at our office in Mt. Pleasant on time and was well dressed and pleasant and cooperative. Cranial nerves II-XII intact to protocol. Sensation is intact to sharp versus dull in the face and extremities except for the right index finger. There was no distal shading to pinprick. Vibration sensation was intact X 4 extremities.. Motor exam shows symmetrical bulk and tone with 5/5 strength throughout and no pronator drift. COORDINATION - he had minor mechanical difficulty opposing the thumb and small finger on his hand, although this was symmetrical bilaterally. He did well with alternating

finger movements with each of his other fingers bilaterally. He had good finger to nose coordination as well as heel to shin coordination and has normal gait. He did have some difficulty with heel to toe walking however. Reflexes are symmetrical throughout at approximately 1+. Romberg showed minimal instability after approximately 30 seconds.

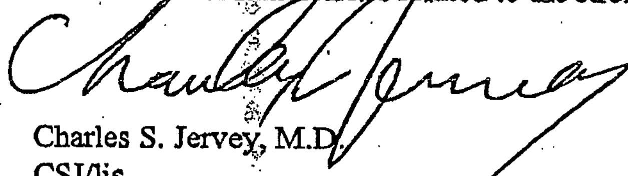
IMPRESSION: Mr. Chavis had a stroke in 2000 involving the cerebellum and right brainstem although relatively small size. He did experience nausea, vomiting, and vertigo, which have resolved. He has ongoing complaints of burning pain in both hands and both feet. This would not be expected from a cerebellar stroke, and the bilateral nature of his symptoms suggest this is a systemic disorder and not related to his stroke. The most common cause of symptoms such as that is diabetic neuropathy. He does have diabetes and in between his first nerve conduction study and his second nerve conduction study he has developed some abnormalities in his peripheral nerve testing indicating that he has likely developed peripheral neuropathy. That would be the most probable explanation for those symptoms.

He also has complaints in his left shoulder which I do not think are related to his stroke either.

In addition he has ongoing complaints of memory difficulty. I would not expect permanent memory impairment related to cerebellar stroke. Even large strokes of the cerebellum are usually not associated with any memory impairment. He does have problems with depression, and depression is a well known contributing factor to problems with memory.

In addition he also mentions having problems with erectile dysfunction. I do not think that is related to his stroke. Erectile dysfunction is a common problem in diabetics and is caused by the development of peripheral neuropathy. Depression and use of narcotic medications can also contribute to that type of problem.

At this point in time the only neurologic impairment that may be related to his stroke is that he has some difficulty with heel to toe walking. That can also be caused by peripheral neuropathy, however. In my experience patients with small cerebellar hemisphere strokes usually get complete resolution of all of their symptoms from their stroke and for those that don't, I would expect no more than minor residual deficits related to the stroke.



Charles S. Jervey, M.D.
CSJ/ljs
cc: Trask & Howell, Attorneys via fax 881-8784

Brian L. West, Ph.D.
Charleston Psychiatry, LLC
9217 University Blvd., Building C Suite 2B
Charleston, SC 29406
843-572-9800

June 21, 2004

Roy A. Howell, III
763 Johnnie Dodds Boulevard
Mt. Pleasant, S. C. 29464

RE: Gilbert Chavis vs. AVX Corporation
Worker's Compensation Carrier File No. 9826170, Date of Accident: 12/07/98
Worker's Compensation Carrier File No. 9927964, Date of Accident: 12/27/99

Dear Mr. Howell,

As per your request, I saw Mr. Chavis on 06/01/04. As you know, he is a 49-year-old male who reports a work-related accident on 12/07/98 while employed by the AVX company in Myrtle Beach, S. C. Details regarding that injury and its effect on his shoulder are outlined elsewhere. With regards to the current request of neurocognitive dysfunctions, the patient underwent a procedure by Dr. Goltra for his right shoulder pain. In that procedure, an epidural block was placed in the cervical area on 01/25/00 and the patient experienced an episode of syncope and reportedly a loss of consciousness. Upon arousing, he was nauseated and disoriented. A CT scan of the brain was performed without evidence of hemorrhage or edema. He was seen by neurology (Dr. Wenzel) and observed for 23 hours. Although Dr. Wenzel had requested an extended time of observation the patient chose to go home. Subsequently, an MRI revealed evidence of probable cerebrovascular accidents in the right cerebellar hemisphere and in the pons.

In sequelae, the patient has had continued pain-related issues including the initial injury of the right shoulder and cervical spondylosis. He was followed by Dr. Hartsock and more detailed information of these concerns is in his findings. The patient was referred to a pain management program at Palmetto Health facility. He was evaluated by Dr. Metcalf who diagnosed peripheral neuropathy. At this point, Mr. Chavis had reported memory deficits perhaps secondary to the CVA and was seen by Dr. Drummond (psychologist) who diagnosed a moderate depression as well as a pain disorder associated with psychological and medical conditions.

The patient was then referred for a neuropsychological evaluation conducted by Dr. Randy Waid in May and June of 2002. In that study, Mr. Chavis's Wechsler Adult Intelligence Scale, III Revision had a full-scale IQ of 91 and in low end of average range. This placed him at the 27th percentile. There was significant differential between verbal and performance measures and his verbal IQ is 88 and performance IQ is 99. Mr. Chavis's working memory as assessed through the Wechsler was at the 66th percentile and perceptual organizational skills at the 58th percentile while processing speed was at the 39th percentile. Verbal comprehension was at the 9th percentile and does suggest limited verbal skills.

His achievement scores suggest impoverished educational development with standard scores of 81 for reading, 70 for spelling, and 91 for arithmetic.

In the neuropsychological portion of the exam, Dr. Waid provided the Stroop which was in average ranges. Seashore Rhythm Test was also in average ranges. He was also in average ranges on the PASAT.

The patient was then provided the Wechsler Memory Scale, III Edition with above-average working memory results. However, his General Memory Index score was a 78 and at the 7th percentile. In interesting contrast, Mr. Chavis was then administered the California Verbal Learning Test, II Edition and his five-trial learning procedure is in average ranges. Although he had some excessiveness for intrusive errors apparently his recalls were within average ranges.

On remaining tasks, such as visuospatial and executive functions apparently Mr. Chavis was in average ranges with the exception of the Judgment of Line Orientation Test.

In emotional and psychiatric measures, the patient apparently indicated significant psychological distress with probable depression. The Multi-Dimensional Pain Inventory was also administered and the patient is reporting intense pain interfering with daily activities.

Dr. Waid concludes that Mr. Chavis's neurocognitive evaluation while there is some evidence of immediate learning and memory concerns, there is not support for rapid forgetting or amnestic syndrome and, in general, Mr. Chavis is intact for neurocognitive functions.

In reviewing these test results, it would appear that while there are some inconsistencies and variabilities there is not a consistent pattern that would suggest short-term memory loss. Instead, Mr. Chavis's inconsistencies in test performance may well be due to psychological interferences related to a depression and effects from pain. Frequently these will cause variability in performance depending on intensity of pain and psychological distress at the time of testing. It is important to note that the neurocognitive test battery was apparently administered over multiple test dates and over the course of approximately a month. Therefore, depending on time of administration there may have been some variability due to the patient's ongoing psychological condition. It may be prudent to have this patient re-evaluated given that the former assessment was greater than two years ago. A current assessment would allow for addressing such questions as whether he has reached maximum medical improvement and whether there is any evidence of any sustained psychological impairments.

If I can be of any additional assistance in your evaluation of this case, please do not hesitate to contact me.

Sincerely,

Brian L. West, Ph.D.
Licensed Clinical Psychologist/Neuropsychologist

BLW:igh
cc: File

VIA FAX: 1-843-881-8784
& EXPRESS MAIL

July 27, 2005

Roy A. Howell, III, Esquire
Trask & Howell, L.L.C.
763 Johnnie Dodds Boulevard
PO Box 2167
Mt. Pleasant, South Carolina 29465

RE: Gilbert Chavis vs. AVX Corporation
WCC File Nos.: 9826170 and 9927964
Carrier File Nos.: WC550-441515 and WC550-448871

Dear Mr. Howell:

Thank you for sending this file to me for review. I have reviewed the following records:

Radiology Reports:

01/25/00 - David D. Goltra, Jr., M.D.
02/07/00 - William Weadock, M.D., Conway Hospital
04/05/00 - Ashley D. Kent, M.D., Eastern Carolina Neurological Associates of Conway, Carotid Ultrasound
04/13/00 - David D. Goltra, Jr., M.D., Disc Imaging
12/16/03 - Steven Epstein, M.D., Open MRI & CT of Myrtle Beach

Daniel B. Groblewski, M.D.
(Eastern Carolina Neurological Association of Conway)

01/31/00 - Letter addressed to Lewis Lawson, M.D.
02/15/00 - Follow-up Note
04/18/00 - Follow-up Note
04/18/00 - Handwritten Note
04/18/00 - Letter addressed to Bruce G. Dew, Attorney-At-Law
06/09/00 - Re Evaluation Note

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Greenville, SC 29616

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1040-E Thousand Oaks Blvd.
Greenville, SC 29607

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800/355-1989
FAX: 864/675-0851
http://www.forensicnetwork.com

Records reviewed (cont).

Richard W. Ward, M.D.
(Strand Orthopaedic Consultants)
__/11/00 - Handwritten Note
03/30/00 - Office Note

Randolph Waid, Ph.D.
Undated Report - Neuropsychological Consultation/Evaluation of May 2nd, 15th, 29th, and June 12th, 2002

Michael McCaffrey, M.D.
(Strand Regional Specialty Associates)
11/18/02 - Worker's Compensation Evaluation
09/22/03 - Follow-up Visit

Charles S. Jervey, M.D.
(Carolina Neurological Clinic, LLP)
06/01/04 - Independent Medical Evaluation

James R. Merikangas, M.D.
(Georgetown University Hospital Neuropsychiatry Program)
06/19/03 - Addressed to J. Edward Bell, III

Brian L. West, Ph.D.
(Charleston Psychiatry, LLC)
06/21/04 - Letter addressed to Roy A. Howell, III

Notations from these records that this examiner felt were significant to his opinions are included in Appendix I of this report.

Actually, the records reviewed revealed little about Mr. Chavis pre-injury. The records do indicate the following:

1. His medical history was significant for chronic diabetes for over ten years.

2. He had a 10th grade education.

3. He repeated the 6th grade.

4. He obtained a GED after three attempts, the last post-CVA, indicating some improvement.

6. He had been diagnosed by the South Carolina Department of Vocational Rehabilitation as having a Reading Disorder (which is a learning disorder)..

7. He is currently in his fourth marriage.

8. He is apparently out of work.

9. It appears he is being treated for a right rotator cuff tear that was some type of work-related injury.

10. He apparently was being treated for pain related to this injury with some type of epidural nerve block.

11. Apparently, it is felt that related to the epidural, he had the dissection of a vertebral artery resulting in a CVA in the right cerebellar hemisphere. Evidence of that injury includes the following:

01/31/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Association of Conway
Addressed to Lewis Lawson, M.D.

...HISTORY: As you recall, the patient is a 45-year-old male with a history of diabetes who now presents for evaluation of syncope.

According to the patient, one week ago this past Tuesday, he was at Mt. Pleasant Disc Imaging for what sounded like an Epidural nerve block. Supposedly, the patient has been having disc and shoulder discomfort. He remembered having two occasions of pain during the injection and somewhere just around the 2nd episode of pain in his neck, he supposedly blacked out. No records are available and there was no witnessed seizure activity. The patient has no recall of the event, no bowel or bladder incontinence was noted and no tongue biting. He was taken to Roper Hospital for evaluation and was admitted. To the best of his knowledge, the day after blacking out, he felt very weak and had difficulty talking. By the evening time, the patient could sit up, but had some difficulty. He was walking with assistance. He still felt somewhat groggy and sleepy the next day. Some time during the hospitalization, he had feelings as if something were crawling up his legs. His speech was supposedly also affected, more specifically having

difficulty getting words out. I do not have records of this hospitalization, but supposedly he was discharged after about 24 hours...

02/07/00
William Weadock, M.D.
Conway Hospital
Radiology

BRAIN W/ AND W/O CONTRAST...
IMPRESSION: ABNORMAL SIGNAL AND ENHANCEMENT INVOLVING THE RIGHT CEREBELLAR HEMISPHERE AND RIGHT MID BRAIN. THESE ARE LIKELY THE SEQUELLAE [sic] OF SUBACUTE ISCHEMIA. RECOMMEND REPEAT STUDY IN 3 MONTHS TO FURTHER CHARACTERIZE THESE LESIONS...

02/15/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Follow-up Note

...On Friday, 2/11/00, the patient called in with a bad headache, which had lasted for about 3 days in duration. Symptoms were slow in onset, but he seemed to complain of a pain that was coming from his neck area, up over the back of his head. Almost at the same time I received a report of his MRI scan, which showed a right cerebellar stroke...

IMPRESSION:
1) Probable right cerebellar infarct, etiology unclear at this point...

Certainly, the patient does have a risk factor for cerebrovascular disease, which would include diabetes. Association to his Epidural injection and syncopal spell is unclear...

04/13/00
David D. Goltra, Jr., M.D.
Disc Imaging
Imaging Report

...OPINION: The area of signal abnormality in the right cerebellar hemisphere, presumably representing a cerebellar infarction, has diminished considerably in size since the prior study and is only seen with certainty on one slice of the T2 weighted sequence. There is no abnormal enhancement or restrained diffusion in this region...

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Follow-up Note

...IMPRESSION AND PLAN:

1) *Right cerebellar CVA, probable thromboembolic or directly/indirectly related to injection...*

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Addressed to Bruce G. Dew, Attorney-At-Law

...1) *Mr. Chavis was suffering from ataxia, intermittent diplopia and also possibly some speech slurring, which I believe are secondary to his right cerebellar CVA. He has had workup so far to include non-invasive carotid studies and an echocardiogram, which have been unremarkable. Because of the association of his symptoms to the Epidural injection, it is very possible that this stroke could have resulted from the Epidural injection. This has been documented in previous literature as well. Also, I believe this could have caused his syncopal spell.*

2) *It is very unlikely that this represented a pre-existing condition and certainly could be a direct/indirect cause of the injection. Possible pre-existing aggravation could result from diabetic atherosclerotic disease, but this speculative...*

11/18/02
Michael McCaffrey, M.D.
Strand Regional Specialty Associates
Worker's Compensation Evaluation

...HISTORY OF PRESENT ILLNESS: This 47 year old right handed white male states that on 01/25/00 while at Disk Imaging in Mount Pleasant, SC at the approximate time of 1:15 p.m. bodily injury occurred in the following manner. The patient was undergoing a selective nerve root block by Dr. David Goltra at Disk Imaging in Mount Pleasant, SC. He had an episode of loss of consciousness during this injection and woke with left sided weakness and dysarthria. He was taken to Cooper River Medical Center and admitted at that time. He stayed over night but

requested to go home the following day. He was seen by Dr. Groblewski approximately 2 days later for continued left sided weakness and dysarthria. Symptoms lasted for the next 6 to 8 months and he has been disabled since then secondary to left sided weakness.

IMPRESSION & PLAN:

1. *Previous right CVA with left sided weakness...*

09/22/03
Michael McCaffrey, M.D.
Strand Regional Specialty Associates
Follow-up Visit

...IMPRESSION & PLAN:

1. *Previous right CVA with left-sided weakness...*

12/16/03
Steven Epstein, M.D.
Open MRI & CT of Myrtle Beach
Radiology Report

MRI OF THE BRAIN AND PITUITARY WITH AND WITHOUT CONTRAST...

IMPRESSION:

1. *THERE IS NO ADENOMA IDENTIFIED WITHIN THE PITUITARY GLAND.*
2. *THERE IS A SMALL OLD INFARCT IN THE RIGHT CEREBELLAR HEMISPHERE WITHIN THE PICA DISTRIBUTION.*

06/01/04
Charles S. Jervey, M.D.
Carolina Neurological Clinic, LLP
Independent Medical Evaluation

HISTORY: ...According to Dr. Goltra's procedure report he had a needle directed toward the right C5-6 neural foramen, and a neurogram was performed using a small amount of Omnipaque, and this documented opacification of the nerve root shealth [sic]. Following that a mixture of 1 cc Xylocaine and 80 mg Depo-Medrol were injected in the perineural space. Upon removing the needle a small amount of blood return was obtained. Direct compression was applied to the lateral neck. At approximately the time when the needle was removed the patient had an episode of syncope...

Following his syncopal episode and hospital admission he had MRI of the brain dated 2/07/00, which showed evidence of a stroke in the right cerebellar hemisphere and right mid brain immediately above the cerebellar peduncle on the right side measuring 2-3 mm. The stroke in the right cerebellar hemisphere measured 1 x 2 cm, and these appeared subacute. He had a follow up scan done in approximately April of 2000 which showed almost complete resolution of the stroke...

IMPRESSION: Mr. Chavis had a stroke in 2000 involving the cerebellum and right brainstem although relatively small size. He did experience nausea, vomiting, and vertigo, which have resolved. He has ongoing complaints of burning pain in both hands and both feet. This would not be expected from a cerebellar stroke, and the bilateral nature of his symptoms suggest this is a systemic disorder and not related to this stroke...

06/19/03
James R. Merikangas, M.D.
Georgetown University Hospital Neuropsychiatry Program
Addressed to J. Edward Bell, III

...Mr. Chavis is an unfortunate gentleman who suffered a stroke as the result of an improperly performed cervical spine injection. A misplace needle injured a vertebral artery, causing a cerebrovascular accident involving his cerebellum and brainstem. As a result he is left with permanent neurological and psychological impairments...

Dr. Goltra then performed a lateral selective epidural block in the cervical area on January 25, 2000. It was noted "Upon removing the needles a small amount of blood returned (sic) was obtained and direct compression was applied to the lateral neck. At approximately the time that the needle was removed the patient had an episode of syncope, which lasted for approximately one minute. When he awakened, he was nauseated and mildly disoriented. When he recovered from this he stated that his right shoulder pain was gone." Following that, a CT scan of the brain was performed with axial images showing no hemorrhage, edema or other abnormality. Unfortunately, subsequent MRI scans revealed the patient had a stroke. With reference to a prior examination of February 7, 2000 and an MRI of April 13, 2000, "There is a subtle area of signal abnormality in the right cerebellar hemisphere. Relative to the prior study the area of signal abnormality in the right cerebellar hemisphere is diminished in size, markedly. The lesion is not apparent on flair images and there is no abnormal enhancement, retrained or increased diffusion in this area. Small high signal focus in the right pons is again seen and is unchanged." This was also read by David D. Goltra, Jr., M.D...

He was subsequently seen on February 15, 2000, by Daniel B. Groblewski, M.D., who noted that he was complaining of imbalance and episodic diplopia and he had three days of bad headache. The MRI showed a right cerebellar stroke. Dr. Groblewski's note of April 18, 2000, states the impression "Right cerebellar cerebrovascular accident, probably thromboembolic or directly/indirectly related to injection". In his letter to Bruce G. Dew, Attorney at Law, dated April 18, 2000, Dr. Groblewski gives the opinion "Because of the association of his symptoms to the epidural injection, it is very possible that his stroke could have resulted from the epidural injection. This has been documented in previous literature as well. Also, I believe this could have caused his syncopal spell". He went on to state further "It is very unlikely that this represented a pre-existing condition and certainly could be a direct/indirect cause of the injection (sic)".

These records available for review would indicate that related to that infarct, Mr. Chavis appears to have made an excellent recovery. He likely has little, if any, cognitive deficits related to this injury as indicated by Dr. Waid's neuropsychological evaluation, which would be entirely consistent with Mr. Chavis' pre-existing history of a 10th grade education, obtaining a GED on the third attempt, a Reading Disorder, and possible depression.

Please note the following excerpts from Dr. Waid's report:

Undated
L. Randolph Waid, Ph.D.
Neuropsychological Consultation/Evaluation

...Neurobehavioral Status: *...There was no evidence of psychomotor retardation or excitation. Mr. Chavis had no difficulty with test instructions and worked in a straight forward, diligent fashion...*

[PLEASE NOTE that in interpreting Dr. Waid's report of T-scores and percentiles, that any T-scores between 40-60 are well within THE average range, as well as any percentile scores between 16 and 84. T-scores between 30-40 and percentiles between 2-16 are in the low average range. All scores above a T-score of 30 and a percentile of 2 should be considered as non-impaired for Mr. Chavis.]

Language Functions: *There was no aphasic or agnostic symptomatology. Conversational speech was prosodic, fluent, of normal rate and tone without evidence of dysarthria. Mr. Chavis did not demonstrate any word finding difficulties in conversational speech. His performance on*

a formal test of verbal fluency was well within the average range (87th percentile). There was no evidence of receptive language dysfunction.

<u>Intellectual/Academic Achievement</u>: Mr. Chavis' performance on the Wechsler Adult Intelligence Scale-III (WAIS-III) classified his intellectual functioning to be in the average range with a Full Scale I.Q. of 91, a Verbal I.Q. of 88, and performance I.Q. of 99. Mr. Chavis' Full Scale I.Q. places him at the 27th percentile compared to age related peers. There was a significant discrepancy in his performance on verbal, educationally oriented tasks (21st percentile) compared to visual spatial integration tasks (47th percentile), a finding likely reflective of his lack of full educational attainment.

WAIS-III analysis revealed Mr. Chavis to score in the average range on tasks assessing working memory (66th percentile) and perceptual organizational skills (58th percentile). He was also in the average range on tasks assessing processing speed (39th percentile). He demonstrated significant weakness on verbal comprehension tests (9th percentile), again a finding likely related to his lack of profiting from formal educational experiences.

Analysis of separate WAIS-III scale performance was consistent with his lack of formal educational attainment as he was deficient with regard to his performance on tests assessing vocabulary skills (9th percentile) and general fund of information (5th percentile). In contrast, Mr. Chavis demonstrated strength on tests assessing letter/number sequencing (84th percentile) and matrix reasoning (84th percentile)...

Mr. Chavis' performance on the Wechsler Test of Adult Reading provided a prediction of intellectual functioning that was consistent with that obtained in the current evaluation.

<u>Attention/Memory Functioning</u>: In addition to suffering from chronic pain, Mr. Chavis' primary complaint as the result of a cerebellar stroke was one of decreased capacity for attention/ concentration and memory functioning.

In the current evaluation, Mr. Chavis demonstrated mildly slowed processing speed for word ($T = 42$) and color ($T = 44$) stimuli. He remained mildly slow but without added decrement on a divided attentional task ($T = 41$). Mr Chavis scored in the average range on an attentional task demanding discrimination of rhythmic sounds ($T = 57$). In contrast, he was impaired on a task demanding discrimination of speech sounds and matching them to their phonemes ($T = 39$). Mr. Chavis was able to meet the demands of the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed, attention/concentration, and immediate learning. He demonstrated a good initial trial performance with expected decrements in his performance as

the trials became more rapid and demanding. His total recall performance on the PASAT was within average limits (T = 46).

Mr. Chavis was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory functioning. Mr. Chavis demonstrated significant impairment in his performance across WMS-III tasks, attaining a general memory index score of 78 placing him at the 7th percentile. Mr. Chavis was deficient in his performance on WMS-III tasks assessing immediate auditory memory (6th percentile) as well as immediate visual memory (7th percentile). Mr. Chavis' performance on delayed auditory memory tasks fell at the 9th percentile with performance on delayed visual memory tasks falling at the 14th percentile. Mr. Chavis performed efficiently on WMS-III tasks assessing working memory (88th percentile).

Analysis of separate WMS-III scale performance revealed Mr. Chavis to be below average across a variety of immediate learning tasks including recall of orally presented story material and free recall of family pictorial stimuli. Mr. Chavis had difficulties retaining and recalling orally presented story material after a period of delay (percent retention = 50). Immediate learning and reproduction of visual designs placed him at the 63rd percentile. Yet, Mr. Chavis had difficulties retaining and reproducing visual designs after a period of delay (16th percentile).

Mr. Chavis was administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Chavis' total recall score after five administrations of the word list placed him at the 48th percentile compared to age related peers. Observation of test performance revealed mild impairment in his initial learning trial, but a good ability to profit from repetitive administrations as he demonstrated the expected learning curve. Mr. Chavis showed a generally good ability to remain and recall word list information in a short and long delay, free and cued recall process. There was evidence of mildly excessive intrusive errors. Mr. Chavis performed efficiently on a recognition task demanding that he discriminate target from non-target words.

Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Chavis' performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 58th percentile. Mr. Chavis was less efficient in his performance on a task demanding fine discriminations of lines in space (9th percentile). On a visuographic sequencing test involving the serial processing of numbers, he was within average limits (T = 59). When the task became more demanding, involving alternations between numbers and letters in sequential fashion, he remained within average limits (T = 61).

<u>Executive/Higher Reasoning Skills</u>: Mr. Chavis had no difficulties inhibiting and sequencing fine motor movements on go-no go types of tasks. He was able to meet the demands of a word genertivity test as well as the set shifting skills associated with Trail Making Test-Part B.

On the WAIS-III, Mr. Chavis was variable in his performance but generally scored in the average range on tasks demanding higher reasoning and problem solving skills.

Mr. Chavis was efficient in his performance on the Wisconsin Card Sorting Test. He showed a good ability to methodically generate hypotheses, to discern the correct hypotheses, as well as to shift the basis of his responding when the externally imposed demands of the task necessitated this. He attained the expected categories on this test with a low rate of perseverative errors and one failure to maintain set.

<u>Sensory/Motor Functioning</u>: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile, auditory, or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Chavis performed errorlessly on a tactile finger recognition test. He had no difficulty recognizing tactile forms in his extremities.

Mr. Chavis reports being right hand dominant. There has been obvious pain and physical limitations affecting his upper extremities, particularly with regard to physical exertion and reaching overhead. On a test demanding fine motor speed (Finger Tapping Test), Mr. Chavis performed within average limits. He was less efficient, scoring in the impaired range bilaterally, on a test demanding fine motor speed and dexterity (Grooved Pegboard Test). Mr. Chavis was noted to ambulate without difficulty or complaint...

<u>Summary/Integration</u>: ...Acutely after sustaining the stroke, he experienced confusion and other neurocognitive difficulties that would be expected. He has shown significant improvement with the passage of time.

Neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected considering the location of the stroke. Attention/concentration appears to be intact, though there was notable variability in his performance on memory/learning tasks. Indeed, there is compelling evidence of reduced capacity for immediate learning/memory, but no evidence of rapid forgetting or amnestic syndrome. There is no compelling evidence for impairment affecting visual spatial skills, receptive or expressive

language functions, or sensory perceptual functions. Mr. Chavis was generally efficient and commensurate with his intellectual/educational level in his performance on tasks assessing executive/higher reasoning skills...

There is no extreme interference in his overall cognitive processing...

Additionally, while it would not be unreasonable for Mr. Chavis to have depression given the injury that he had, this depression would be more likely related to his pain. Pain and depression are often seen as comorbid disorders. Depression can often present with pain. In fact, pain may be the most salient feature. Please note that Depression and pain are often interlinked. In an article titled "Beyond Depression: The Somatic/Affective Interface" by Schatzberg and Korn (2002) states that:

> "Depression has traditionally been viewed as a syndrome with an affective core accompanied by associated problems such as sleep, appetite, decreased concentration, loss of interest, fatigue, and suicidal behaviors. Yet somatic symptoms are often present and may be the primary presenting problem in some individuals. These physical symptoms are wide ranging and include complaints such as headache, constipation, back pain, chest pain, dizziness, musculoskeletal complaints and weakness. The lack of recognition of depression in the face of physical symptoms has resulted in the tendency by medical practitioners to misdiagnose and undertreat depression."

These authors go on to state:

> "Depressed patients often present to the primary care physician with physical manifestations rather than dysphoric mood. In a study by Kirmayer and colleagues, 70% to 80% of patients with significant depressive symptoms manifested somatic symptoms as well...In a study of 150 depressed inpatients, pain complaints were present in 92% of patients at intake as measured on the self-report 90-item Symptom Checklist. Complaints of headache and chest pain were more common in women, whereas complaints of myalgia and numbness were more frequently reportedly in men...In an international study of medical clinics conducted in 14 countries on 5 continents, somatic symptoms were common in each of the centers. A total of 45% to 95% of patients (average, 69%) with major depression presented only with somatic complaints. Unexplained physical symptoms were reported by half to the depressed patients, and 11% of the participants denied any symptoms of depression..."

DSM-IV-TR reports on page 371, discussing Major Depressive Disorder, is that "Individuals with chronic or severe general medical conditions are at increased risk to develop Major Depressive Disorder. Up to 20%-25% of individuals with certain general medical conditions (e.g., diabetes, myocardial infarction, carcinomas, stroke) will develop Major Depressive Disorder during the course of their general medical condition."

This depression could be related to Mr. Chavis' pre-existing pain, pre-existing diabetes, and possibly his stroke.

Despite his stroke, Mr. Chavis has made an excellent recovery as indicated by the following:

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Follow-up Note

...The patient follows up today and tells me that he has been doing much better. His walking is back to about 90%, still with occasional balance difficulty, but no falls. His diplopia has completely resolved. He still gets a little tired easily and his voice will occasionally stutter. But, overall he seems to be improving...

I explained to Mr. Chavis that it was certainly possible that he could have some residual neurological deficit, although even at this point he has shown dramatic improvement being relatively close to his baseline...

Undated
L. Randolph Wald, Ph.D.
Neuropsychological Consultation/Evaluation

...Summary/Integration: ...He has shown significant improvement with the passage of time. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected considering the location of the stroke...

Mr. Chavis likely experiences a mild reduction in overall neurocognitive functioning consistent with the location of stroke. There is no extreme interference in his overall cognitive processing...

06/01/04
Charles S. Jervey, M.D.
Carolina Neurological Clinic, LLP
Independent Medical Evaluation

...IMPRESSION: Mr. Chavis had a stroke in 2000 involving the cerebellum and right brainstem although relatively small size. He did experience nausea, vomiting, and vertigo, which have resolved. He has ongoing complaints of burning pain in both hands and both feet. This would not be expected from a cerebellar stroke, and the bilateral nature of his symptoms suggest this is a systemic disorder and not related to this stroke. The most common cause of symptoms such as that is diabetic neuropathy. He does have diabetes and in between his first nerve conduction study and his second nerve conduction study he had developed some abnormalities in his peripheral nerve testing indicating that he has likely developed peripheral neuropathy. That would be the most probable explanation for those symptoms...

...In my experience patients with small cerebellar hemisphere strokes usually get complete resolution of all of their symptoms from their stroke and for those that don't, I would expect no more than minor residual deficits related to the stroke.

06/21/04
Brian L. West, Ph.D.
Charleston Psychiatry, LLC
Letter addressed to Roy A. Howell, III

...Dr. Waid concludes that Mr. Chavis' neurocognitive, evaluation while there is some evidence of immediate learning and memory concerns, there is not support for rapid forgetting or amnestic syndrome and, in general, Mr. Chavis is intact for neurocognitive functions...

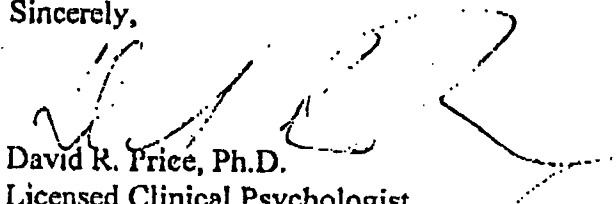
SUMMARY

The records reviewed would indicate that Mr. Chavis likely did experience a cerebellar infarct on 01/25/00. This does appear to be related to his nerve block treatment. The evidence also strongly suggests that Mr. Chavis has returned to his pre-stroke level of functioning. It is unlikely that he has any cognitive deficits related to this small stroke. His cognitive ability appears to be consistent with his pre-injury level of functioning.

Mr. Chavis could still be depressed. Depression would be linked, not only to his diabetes and the most likely source, his pain, but could possibly be related to this stroke in this litigation. In any event, Mr. Chavis has made an excellent recovery. Any problems he now has are likely related to his pre-existing pain complaints and the effects of his diabetes, such as the peripheral neuropathy.

Thank you for sending this claim to me for review. Should you have any questions or comments, please don't hesitate to call upon me.

Sincerely,



David R. Price, Ph.D.
Licensed Clinical Psychologist
Adjunct Associate Professor
Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina
Adjunct Associate Professor
Department of Social and Behavioral Sciences, University of South Carolina-Spartanburg

Appendix I

Medical Chronology

RE: Gilbert Chavis

01/25/00
David D. Goltra, Jr., M.D.
Radiology

CT BRAIN...
FINDINGS: Axial images through the brain demonstrate no evidence of intracranial mass, hemorrhage, edema or other abnormality. Bony structures are normal in appearance.

OPINION: CT of the brain is within normal limits.

01/31/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Association of Conway
Addressed to Lewis Lawson, M.D.

Thank you for referring Mr. Chavis to our clinic for evaluation of his syncopal spell.

HISTORY: As you recall, the patient is a 45-year-old male with a history of diabetes who now presents for evaluation of syncope.

According to the patient, one week ago this past Tuesday, he was at Mt. Pleasant Disc Imaging for what sounded like an Epidural nerve block. Supposedly, the patient has been having disc and shoulder discomfort. He remembered having two occasions of pain during the injection and somewhere just around the 2nd episode of pain in his neck, he supposedly blacked out. No records are available and there was no witnessed seizure activity. The patient has no recall of the event, no bowel or bladder incontinence was noted and no tongue biting. He was taken to Roper Hospital for evaluation and was admitted. To the best of his knowledge, the day after blacking out, he felt very weak and had difficulty talking. By the evening time, the patient could sit up, but had some difficulty. He was walking with assistance. He still felt somewhat groggy and sleepy the next day. Some time during the hospitalization, he had feelings as if something were crawling up his legs. His speech was supposedly also affected, more specifically having difficulty getting words out. I do not have records of this hospitalization, but supposedly he was discharged after about 24 hours.

Unfortunately, the patient has been complaining of persistent difficulty. He has felt sleepy and weak all week long. His speech is getting better, he still complains of difficulty getting words out. He feels off-balanced when he ambulates, but he has not fallen. Also, he complains of diplopia mainly on trying to focus on the TV. The only other visual disturbance was seeing bugs out the corner of his eyes crawling up the wall and this was during his 1st night of hospitalization, but this has not been a problem since that time.

Overall, there has been an interval improvement in the patient's symptoms. He is not taking any sedating type medications. The patient has never experienced a seizure, alteration of consciousness, oral facial automatism or syncope. He denies any chest pain, heart palpitations or shortness of breath.

PAST MEDICAL HISTORY: He is allergic to Codeine. The patient's history is positive for diabetes (approximately 8 years), right shoulder arthroscopy secondary to rotator cuff tear from a lifting accident, August 1999, resection of a growth from the rectum at the sage of 13, paratracheal injury at 10 months of age. The patient's history is negative for hypertension, CVA, MI, migraine headaches, seizures and tobacco.

MEDICATIONS: Glipizide for diabetes...

IMPRESSION:
1) Syncope. The most likely explanation is probably neurocardiogenic secondary to pain.
2) Persistent lethargy, ataxia, speech difficulty. Unclear.
3) Diabetes.

The patient's neurological examination appears to be intact. I reassured the patient regarding the syncope in that I doubt that this was an epileptic event. Most other records or information suggests otherwise. I do not have an explanation for his persistent neurological complaints and certainly cannot associate it to a direct effect of the Epidural injection...

02/07/00
William Weadock, M.D.
Conway Hospital
Radiology

BRAIN W/ AND W/O CONTRAST...
IMPRESSION: ABNORMAL SIGNAL AND ENHANCEMENT INVOLVING THE RIGHT CEREBELLAR HEMISPHERE AND RIGHT MID BRAIN. THESE ARE LIKELY THE SEQUELLAE [sic] OF SUBACUTE ISCHEMIA. RECOMMEND REPEAT STUDY IN 3 MONTHS TO FURTHER CHARACTERIZE THESE LESIONS...

02/15/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Follow-up Note

HISTORY: The patient is a 45-year-old white male with diabetes who was sent to my office for evaluation of syncope on January 31st. Per my initial evaluation, his examination seemed to be

non-lateralizing, although his complaints were of concern, which included imbalance and episodic diplopia, which may have suggested a posterior fossa problem. On Friday, 2/11/00, the patient called in with a bad headache, which had lasted for about 3 days in duration. Symptoms were slow in onset, but he seemed to complain of a pain that was coming from his neck area, up over the back of his head. Almost at the same time I received a report of his MRI scan, which showed a right cerebellar stroke. At that time the patient informed me that although he had been having a headache, his other neurological symptoms including imbalance and visual disturbance, seemed to be slowly getting better. He was instructed to report to the emergency room for evaluation of his headache, which seems to be a new complaint. In the emergency room, it was noted that he had some neck and occipital lobe discomfort, which was thought to be secondary to chronic neck pain, possibly tension. He also described interval improvement after taking a shower. He received some conservative treatment with IV medication and he was discharged from the emergency room in improved condition. The patient desired to leave the emergency room because he was to take a test on Saturday morning. He was instructed to follow up with my office today...

There are no other new neurological complaints. No previous history of migraine headaches. He has had this type of headache in the past...

IMPRESSION:

1) Probable right cerebellar infarct, etiology unclear at this point.
2) Right rotator cuff tear.
3) Diabetes.
4) Headaches, probable muscle contraction type.

Certainly, the patient does have a risk factor for cerebrovascular disease, which would include diabetes. Association to his Epidural injection and syncopal spell is unclear...

The patient is going to be started on Elavil 25 mg to advance to 2 tablets after one week as tolerated for his headaches. I have provided him with a prescription of Midrin to use for abortive therapy...

__/11/00
Richard W. Ward, M.D.
Strand Orthopaedic Consultants
Handwritten Note

Mr. Chavis has called numerous times "demanding" a pain med refill / Each time RWW has answered "No" / Pt. very unhappy $_c$ this when I spoke $_c$ him on ____[off page]. I explained to Pt. we have not received the records from Dr. Grobleski [sic] that RWW requested regarding further tx. + until that time there is nothing we can do / Pt. states his "lawyer will be calling to

handle this!" / On 4-10 Pts. insurance carrier (Resha c Liberty Mutual) called requesting RWW see this Pt. to manage his pain "while" the Pt. is "in the process" of obtaining the records requested.
Resha @ Liberty Mutual informed
RWW's Response → He needs to go to pain management center! (not what we do!).

03/30/00
Richard W. Ward, M.D.
Strand Orthopaedic Consultants
Office Note

I have reviewed Gilbert's findings. I don't think he is presently a candidate for surgical intervention. I have referred him back to Dr. Grobleski [sic] and Dr. Preslar for further care. Gave him one last Rx for Darvocet. Return visit PRN.

04/05/00
Ashley D. Kent, M.D.
Eastern Carolina Neurological Associates of Conway
Carotid Ultrasound

...IMPRESSION: No hemodynamically significant clot or lesion identified on either side.

04/13/00
David D. Goltra, Jr., M.D.
Disc Imaging
Imaging Report

MRI BRAIN, W/O AND W/ CONTRAST...
OVERVIEW: Midline sagittal images of the brain show no evidence of a developmental abnormality. The pituitary and pineal regions appear normal. There is no evidence of cerebellar tonsillar herniation.

POSTERIOR FOSSA: There is a subtle area of signal abnormality in the right cerebellar hemisphere oriented in the slice plane and seen only on one slice on the T2 weighted sequence. Relative to the prior study, the area of signal abnormality in the right cerebellar hemisphere is diminished in size, markedly. The lesion is not apparent on flair images, and there is no abnormal enhancement, restrained or increased diffusion in this area.

Small high signal focus in the right pons is again seen and is unchanged.

Signal voids are evident along the visualized course of both vertebral arteries.

SUPRATENTORIAL COMPARTMENT: Evaluation of the supratentorial compartment shows normal size lateral ventricles and cortical sulci. The nuclear structures are normal in their appearance. There are no areas of abnormal signal intensity, no evidence of abnormal enhancement and no evidence of mass lesion.

OPINION: The area of signal abnormality in the right cerebellar hemisphere, presumably representing a cerebellar infarction, has diminished considerably in size since the prior study and is only seen with certainty on one slice of the T2 weighted sequence. There is no abnormal enhancement or restrained diffusion in this region.

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Follow-up Note

HISTORY: The patient is a 45-year-old white male with the diagnosis of diabetes, pending right shoulder rotator cuff repair with cerebellar CVA. He has had symptoms of ataxia and diplopia. Echocardiogram was performed at Conway Hospital 3/22/00 and was basically unremarkable. We obtained an MRI scan of the brain through disc imaging 4/13/00 and I understand previous films were available for comparison and the results of the MRI scan showed the right cerebellar infact [sic] has diminished in size. There was no abnormal enhancement or other abnormalities noted on the imaging. The patient follows up today and tells me that he has been doing much better. His walking is back to about 90%, still with occasional balance difficulty, but no falls. His diplopia has completely resolved. He still gets a little tired easily and his voice will occasionally stutter. But, overall he seems to be improving...

IMPRESSION AND PLAN:

1) Right cerebellar CVA, probable thromboembolic or directly/indirectly related to injection...

...I explained to Mr. Chavis that it was certainly possible that he could have some residual neurological deficit, although even at this point he has shown dramatic improvement being relatively close to his baseline. If there are any other questions regarding his neurological status, I would be glad to see him in follow-up for re-evaluation.

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Handwritten Note

...Remarks: Will release but no work until evaluation by orthopedics.

04/18/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Addressed to Bruce G. Dew, Attorney-At-Law

...1) Mr. Chavis was suffering from ataxia, intermittent diplopia and also possibly some speech slurring, which I believe are secondary to his right cerebellar CVA. He has had workup so far to include non-invasive carotid studies and an echocardiogram, which have been unremarkable. Because of the association of his symptoms to the Epidural injection, it is very possible that this stroke could have resulted from the Epidural injection. This has been documented in previous literature as well. Also, I believe this could have caused his syncopal spell.

2) It is very unlikely that this represented a pre-existing condition and certainly could be a direct/indirect cause of the injection. Possible pre-existing aggravation could result from diabetic atherosclerotic disease, but this speculative.

3) Non-invasive vascular studies were performed to help determine if there were any flow abnormalities in the blood vessels or signs of plaque build-up, echocardiogram to rule out thrombus formation and repeat MRI scan to be sure that the abnormality or stroke was slowly resolving and did not represent something else, like a neoplasm or cancer. Although my suspicion is low for a clotting abnormality, I believe it would be important to have a coagulopathy screen performed, given his rather young age and history of stroke...

06/09/00
Daniel B. Groblewski, M.D.
Eastern Carolina Neurological Associates of Conway
Re Evaluation Note

The patient is well known to myself from my initial evaluation for a cerebellar stroke who is now being followed by Pee Dee Orthopedics for possible impingement syndrome in the right shoulder. The patient has been experiencing increasing pain beyond his shoulder and arm area now into the forearm and hand. He was evaluated by Dr. Edwards for an MRI scan of the cervical spine which was performed to rule out radiculopathy, which showed some disc bulging at C5-6 but no significant entrapment or impingement on nerve roots. He is referred on for a neurological evaluation of his hand and forearm pain. The patient tells me that the pain below his elbow into the forearm and hand started following his stroke. Basically it is an aching type discomfort that sometimes is sharp and extends through the medial aspect of the forearm and into

the hand involving digits four and five completely and part of three. There is no numbness, loss of sensation, dysesthesias and really denies any significant weakness. He has recently been started on Neurontin which seems to help some and is at a dose of 30 mg t.i.d. He is still taking Oxycodone two tablets every four to six hours. He is complaining of some episodic imbalance with no falls as well as constipation. His other medications include Glipizide, Glucotrol.

PHYSICAL EXAMINATION: ...The remainder of his extremities are easily 5/5 proximal to distal. Reflexes in the upper extremities are about 2 symmetrical as well as in the lower extremities. He has a flexor plantar response bilaterally. Finger to nose and heel to shin testing are intact and his gait shows a good toe, tandem and heel walk. Sensory testing of the upper extremities shows only a mild decrease to pain of the dorsum of the hand medially. Otherwise no significant deficits to primary modalities. He has a negative Tinel's sign at the elbow and wrist. There is minimal tenderness to deep palpation in his metacarpal joints. He has some mild tenderness to the right paracervical region as well as over the shoulder in a non-trigger point fashion.

IMPRESSION:
Right upper extremity discomfort to the forearm and hand, will consider ulnar neuropathy, less likely radiculopathy with normal MRI scan.

I reassured the patient that his cerebellar stroke should not cause this discomfort. He is going to be scheduled for an EMG nerve conduction study right upper extremity. I encouraged him to advance his Neurontin as tolerated to two three times a day. I added a Catapres patch and encouraged him to cut back on his Oxycodone as much as possible. I also explained that his constipation was a result of the narcotics and he should be taking Milk of Magnesia at bedtime, pushing plenty of fluids. I will see him back after the electrical studies.

Undated
L. Randolph Waid, Ph.D.
Neuropsychological Consultation/Evaluation

...Dates of Evaluation: May 2nd, 15th, 29th, and June 12th, 2002

Reason for Referral: Gilbert R. Chavis is a 47-year-old married male referred for neuropsychological evaluation by Jeffrey C. Wilkins, M.D. Mr. Chavis has been under Dr. Wilkins' care for chronic pain and was referred for neuropsychological evaluation due to concerns of having suffered a cerebellar stroke while undergoing conduction of a nerve block in January of 2000.

Mr. Chavis was sen in multiple evaluative contacts commencing on May 2nd, 2002. I also had the opportunity to conduct a separate interview of his wife on May 29th, 2002.

History of Presenting Difficulties: ...Germane to the current evaluation, Mr. Chavis' difficulties commenced following a work related accident on 12/01/98 while employed for the AVX company in Myrtle Beach. Subsequent to this injury, he underwent arthroscopic rotator cuff debridement for a partial thickness tear and also a subracromial [sic] decompression by Dr. Preslar in August of 1999. Reportedly, prior to operative procedures, injections and physical therapy proved to be non-efficacious. Mr. Chavis underwent previous evaluations due to persistent pain and second opinion evaluation with regard to being a candidate for surgical procures.

Germane to the current evaluation, Mr. Chavis underwent a procedure by David D. Goltra, Jr., M.D. for right shoulder pain. Reportedly, during the procedure, he experienced a "syncopal episode" necessitating transfer of his care to the East Cooper Regional Medical Center. Reportedly, following the injection, he "abruptly stopped talking, exhibiting flexor posturing of both upper extremities and staring for two minutes, after which he became violently nauseated and vomited several times and was somewhat confused and disoriented." At East Cooper, he underwent neurological evaluation and admission for observation. Upon arrival to the East Cooper facility, he remained persistently nauseated and vomited on at least one occasion. There was report of headache. Records reveal that a CT scan was reportedly conducted...

Reportedly, family members stayed in communication with David Goltra, M.D. and subsequent care at the East Cooper hospital. The following day, Mr. Chavis requested discharge. Per referral by Lewis Lawson, M.D., Mr. Chavis came under the care of Daniel B. Groblewski, M.D. Initial evaluation (1/31/00) was for assessment of syncope as well as persistent lethargy, ataxia, and speech difficulty. An MRI of the brain was requested (2/07/00) and revealed an abnormal signal enhancement involving the right cerebellar hemisphere and right mid-brain. Follow-up care with Dr. Groblewski (2/15/00) resulted in impression of right probable cerebellar infarct, right rotator cuff tear, diabetes, and headaches. Dr. Groblewski initiated care and scheduled other evaluative studies. Carotid ultrasound (4/05/00) failed to reveal any thermodynamically significant clot or lesion. As of 4/18/00, Dr. Groblewski's impression was one of right cerebellar CVA, probable thromboembolic or directly/indirectly related to injection. He anticipated that Mr. Chavis would improve over the course of the next six months. He provided opinions regarding Mr. Chavis' difficulties to inquires posed by attorneys representing Mr. Chavis' Workers' Compensation case. Mr. Chavis continued to experience right upper extremity discomfort affecting the forearm and hand, though was reassured that the cerebellar stroke "should not cause the discomfort." He was to undergo EMG nerve conduction studies and was encouraged to advance his Neurontin as tolerated to 2-3 times a day. Nerve conduction studies (6/16/00) failed to reveal any evidence of radiculopathy or carpal tunnel syndrome...

Mr. Chavis was referred to the Pain Management Program at Palmetto Health Facility. This was conducted while he was under the care of Dr. Wilkins. Dr. Metcalf's assessment was one of peripheral neuropathy and he noted that imaging studies of the shoulder failed to demonstrate

any abnormality of the rotator cuff. Recommendation was to wean Mr. Chavis down off Oxycodone and initiate use of Gavatril. He also recommended conduction of a functional capacities evaluation. Dr. Metcalf also recommended neuropsychological testing for assessment of Mr. Chavis' memory post-CVA. Clay Drummond, Ph.D. conducted psychological testing revealing moderate depression as well as a diagnosis of a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition.

In interview, I reviewed with Mr. Chavis the series of treatments and operative procedures he has undergone since suffering injury at his place of employment on 12/01/98. Subsequently, the series of interventions led up to the nerve block that was conducted resulting in the cerebellar infarct. I reviewed with him the acute difficulties following the procedure, as he has improved significantly since that period of time. I reviewed with him how he did not want to stay in the East Cooper facility and subsequently sought care with his family physician leading to the referral to Dr. Groblewski, neurologist.

With regard to current complaints, Mr. Chavis reported continuing pain in the left shoulder, offering that pain occurs in both extremities. He reported an impingement of the right upper extremity and muscle spasms affecting the left arm. He reported that headaches persist, though they have significantly improved since acutely following the procedure that led to cerebellar stroke. Headaches continue to be somewhat frequent with migrainous type symptomatology. He reported that his wife complains that he is very forgetful with decreased concentration. As he reported, "I can tell you about ten years ago, but I have trouble remembering things from yesterday."...

In separate interview on 5/20/02, I interviewed Mr. Chavis' wife. In interview, I reviewed the series of events that led to her husband's acute confusion and subsequent hospitalization at the East Cooper facility. She acknowledged that her husband has "been though a lot" since the work related injury. Currently, she views her husband as irritable and "ill a lot." She described him as emotional with crying spells. There is also an easy fatiguability. She stated that "he is not the same since the stroke," but also reported that he has improved significantly since acutely following the incident. Mr. [sic] Chavis reported some continuing language difficulties, stating "he still stutters if he gets excited." There was complaint of decreased capacity for attention and concentration. Ms. Chavis reported that her husband continues to experience pain in the shoulder region. She also stated,"he has aged so much." She further stated, "he hurts all the time." Of particular disappointment for Mr. Chavis was his loss of job at AVX as he could only return to light duty and "they didn't accept that." Ms. Chavis stated that her husband is "depressed about not working" and it has limited the couples ability "to do the things we want to do." Ms. Chavis remains employed with the Horry County Finance Office...

With regard to motor functioning, there was no evidence of paralysis, though Mr. Chavis complained of general weakness affecting his upper extremities. Acutely following the "stroke"

there were significant balance problems, but he describes them as "minor now." He reported numbness in the 4th and 5th digits of the left and right hand. There was also report of paresthesias affecting his feet.

Mr. Chavis' primary complaint is of pain in the left arm as well as the right shoulder region. He reported burning pain in his feet likely related to peripheral neuropathy. Pain is aggravated by any physical exertion and particularly reaching over head. He obtains relief via use of medication.

Acutely following the injection and subsequent stroke, Mr. Chavis reported experiencing intense headache activity. Currently, headaches have significantly improved.

There was report of occasional dizziness, but no report of vertigo, blackout spells, or seizure activity.

With regard to cognitive processes, there were complaints of decreased capacity for concentration, easy distractibility, and an inability to think as quickly as before (bradyphrenia). Mr. Chavis reported that his wife specifically believes that he is having memory problems.

With regard to psychological functioning, Mr. Chavis admitted to problems with sadness/depression. Sleep was characterized as disturbed with difficulty falling asleep and middle of the night awakenings. There was no report of nightmare activity or specific symptomatology associated with the Posttraumatic Stress Disorder, Mr. Chavis did not currently view himself as disruptively anxious aor tense. Nor did he repot episodes of anger dyscontrol. There was report of excessive fatigue. There is concern regarding a potential to lose his wife, but no other evidence of paranoid ideation or delusional thinking. There was no report of phobic symptomatology. Mr. Chavis denied hallucinatory activity. He was without report of appetite disturbance. He was significantly concerned regarding erectile dysfunction, stating "my sex life is gone" and further stating "Viagra doesn't even work."...

Medical History: Significant for positive loss of consciousness in a motor vehicle accident in 1979. Mr. Chavis denied any serious after effects following his involvement in the motor vehicle accident. Mr. Chavis underwent a tracheotomy at age 10 months. Reportedly, he suffered an injury to his back while employed at AVX in 1996. He underwent shoulder surgery in 1999.

Other than diabetes, Mr. Chavis denied history of medical problems such as hypertension, serious infections, or cardiovascular difficulties. Mr. Chavis denied a history of migraine or tension headaches prior to the stroke...

Family History: Significant for a father who had alcohol problems but has been recovering during the past 19 years. Mr. Chavis is unaware of any other family history for psychiatric illness or substance abuse.

Psychosocial Review: Mr. Chavis reported attending formal education through the 10th grade and subsequently attained his GED. Reportedly, there were three attempts to obtain his GED, and he passed it six to seven months after the cerebellar stroke. Reportedly, there was repetition of the 6th grade. Reportedly, he underwent evaluation at South Carolina Vocational Rehabilitation Department and received a report that he had a reading disorder. Reportedly, Vocational Rehabilitation Services assisted him with attaining the GED.

Mr. Chavis reported being employed with AVX for approximately 13 years. Reportedly, he was employed as a paste processor for ten year period.

Mr. Chavis has been married to his current wife sine 1988. Reportedly, he has been married on three previous occasions. Reportedly, there is one child in the home setting. Mr. Chavis reported being saved and converting to Christianity approximately 2 ½ years ago...

Examination Results:

Neurobehavioral Status: ...There was no evidence of psychomotor retardation or excitation. Mr. Chavis had no difficulty with test instructions and worked in a straight forward, diligent fashion. He was observed to put forth good effort throughout the evaluative process. Specific assessment of effort was undertaken via administration of the Test of Memory Malingering (TOMM). Mr. Chavis' performance on the TOMM including his errorless performance on trial 2 was consistent with our observation of providing good effort. The obtained test results are viewed as a valid depiction of his current functioning.

Language Functions: There was no aphasic or agnostic symptomatology. Conversational speech was prosodic, fluent, of normal rate and tone without evidence of dysarthria. Mr. Chavis did not demonstrate any word finding difficulties in conversational speech. His performance on a formal test of verbal fluency was well within the average range (87th percentile). There was no evidence of receptive language dysfunction.

Intellectual/Academic Achievement: Mr. Chavis' performance on the Wechsler Adult Intelligence Scale-III (WAIS-III) classified his intellectual functioning to be in the average range with a Full Scale I.Q. of 91, a Verbal I.Q. of 88, and performance I.Q. of 99. Mr. Chavis' Full Scale I.Q. places him at the 27th percentile compared to age related peers. There was a significant discrepancy in his performance on verbal, educationally oriented tasks (21st percentile) compared to visual spatial integration tasks (47th percentile), a finding likely reflective of his lack of full educational attainment.

WAIS-III analysis revealed Mr. Chavis to score in the average range on tasks assessing working memory (66th percentile) and perceptual organizational skills (58th percentile). He was also in the average range on tasks assessing processing speed (39th percentile). He demonstrated significant weakness on verbal comprehension tests (9th percentile), again a finding likely related to his lack of profiting from formal educational experiences.

Analysis of separate WAIS-III scale performance was consistent with his lack of formal educational attainment as he was deficient with regard to his performance on tests assessing vocabulary skills (9th percentile) and general fund of information (5th percentile). In contrast, Mr. Chavis demonstrated strength on tests assessing letter/number sequencing (84th percentile) and matrix reasoning (84th percentile).

Mr. Chavis' academic achievement skills were assessed via administration of the Wide Range Achievement Test-Revision 3 (WRAT-3). He demonstrated deficient performance across the assessed tasks. Below are the standard scores, percentiles, and grade scores for each of the assessed academic areas:

	Standard Score	Percentile	Grade Score
Reading/Word Recognition	81	10	08
Spelling	70	02	05
Arithmetic	91	27	08

Mr. Chavis' performance on the Wechsler Test of Adult Reading provided a prediction of intellectual functioning that was consistent with that obtained in the current evaluation.

Attention/Memory Functioning: In addition to suffering from chronic pain, Mr. Chavis' primary complaint as the result of a cerebellar stroke was one of decreased capacity for attention/ concentration and memory functioning.

In the current evaluation, Mr. Chavis demonstrated mildly slowed processing speed for word (T = 42) and color (T = 44) stimuli. He remained mildly slow but without added decrement on a divided attentional task (T = 41). Mr Chavis scored in the average range on an attentional task demanding discrimination of rhythmic sounds (T = 57). In contrast, he was impaired on a task demanding discrimination of speech sounds and matching them to their phonemes (T = 39). Mr. Chavis was able to meet the demands of the Paced Auditory Serial Addition Test (PASAT), a measure of information processing speed, attention/concentration, and immediate learning. He demonstrated a good initial trial performance with expected decrements in his performance as the trials became more rapid and demanding. His total recall performance on the PASAT was within average limits (T = 46).

Mr. Chavis was administered the Wechsler Memory Scale-III (WMS-III) to assess different components of anterograde memory functioning. Mr. Chavis demonstrated significant impairment in his performance across WMS-III tasks, attaining a general memory index score of 78 placing him at the 7th percentile. Mr. Chavis was deficient in his performance on WMS-III tasks assessing immediate auditory memory (6th percentile) as well as immediate visual memory (7th percentile). Mr. Chavis' performance on delayed auditory memory tasks fell at the 9th percentile with performance on delayed visual memory tasks falling at the 14th percentile. Mr. Chavis performed efficiently on WMS-III tasks assessing working memory (88th percentile).

Analysis of separate WMS-III scale performance revealed Mr. Chavis to be below average across a variety of immediate learning tasks including recall of orally presented story material and free recall of family pictorial stimuli. Mr. Chavis had difficulties retaining and recalling orally presented story material after a period of delay (percent retention = 50). Immediate learning and reproduction of visual designs placed him at the 63rd percentile. Yet, Mr. Chavis had difficulties retaining and reproducing visual designs after a period of delay (16th percentile).

Mr. Chavis was administered the California Verbal Learning Test-II (CVLT-II), a repetitive word list learning task. Mr. Chavis' total recall score after five administrations of the word list placed him at the 48th percentile compared to age related peers. Observation of test performance revealed mild impairment in his initial learning trial, but a good ability to profit from repetitive administrations as he demonstrated the expected learning curve. Mr. Chavis showed a generally good ability to remain and recall word list information in a short and long delay, free and cued recall process. There was evidence of mildly excessive intrusive errors. Mr. Chavis performed efficiently on a recognition task demanding that he discriminate target from non-target words.

Visual Spatial/Visual Constructional Functions: There was no evidence of visual inattention or neglect processes. Nor was there evidence of constructional difficulties. Mr. Chavis' performance on WAIS-III tasks assessing perceptual organizational skills placed him at the 58th percentile. Mr. Chavis was less efficient in his performance on a task demanding fine discriminations of lines in space (9th percentile). On a visuographic sequencing test involving the serial processing of numbers, he was within average limits (T = 59). When the task became more demanding, involving alternations between numbers and letters in sequential fashion, he remained within average limits (T = 61).

Executive/Higher Reasoning Skills: Mr. Chavis had no difficulties inhibiting and sequencing fine motor movements on go-no go types of tasks. He was able to meet the demands of a word genertivity test as well as the set shifting skills associated with Trail Making Test-Part B.

On the WAIS-III, Mr. Chavis was variable in his performance but generally scored in the average range on tasks demanding higher reasoning and problem solving skills.

Mr. Chavis was efficient in his performance on the Wisconsin Card Sorting Test. He showed a good ability to methodically generate hypotheses, to discern the correct hypotheses, as well as to shift the basis of his responding when the externally imposed demands of the task necessitated this. He attained the expected categories on this test with a low rate of perseverative errors and one failure to maintain set.

Sensory/Motor Functioning: Evaluation failed to reveal any evidence of imperceptions or suppressions affecting tactile, auditory, or visual modalities during unilateral or bilateral stimulation paradigms. Mr. Chavis performed errorlessly on a tactile finger recognition test. He had no difficulty recognizing tactile forms in his extremities.

Mr. Chavis reports being right hand dominant. There has been obvious pain and physical limitations affecting his upper extremities, particularly with regard to physical exertion and reaching overhead. On a test demanding fine motor speed (Finger Tapping Test), Mr. Chavis performed within average limits. He was less efficient, scoring in the impaired range bilaterally, on a test demanding fine motor speed and dexterity (Grooved Pegboard Test). Mr. Chavis was noted to ambulate without difficulty or complaint.

Emotional/Mood State Functioning: This has obviously been a very difficult course of events for Mr. Chavis since he sustained his work related injury in December of 1998. It appears that while undergoing a nerve block, he suffered a cerebellar stroke with acute difficulties that have significantly cleared with the passage of time. Multiple medical problems as well as stressors associated with unemployment and financial concerns have certainly impacted significantly on Mr. Chavis as well as his wife. He remains suffering from chronic pain and has experienced episodes of depression and continuing sleep disturbance (difficulty falling asleep and middle of the night awakenings). Mr. Chavis remains quite fragile and vulnerable with concerns that his wife will leave him due to his failure to be a full partner both financially and sexually. There have been difficulties getting along with his spouse, and he has experienced a significant decline in his ability to pursue social and recreational activities. Previous evaluations have confirmed depression as well as chronic pain associated with psychological factors and a general medical condition.

In the current evaluation, Mr. Chavis' responses to psychological testing revealed him to have a negative view of himself and a tendency to view his current situation in a negative manner. The response set is indicative of a "cry for help."

The corresponding clinical profile is consistent with clinical interview in revealing an individual who views his life as being severely disrupted by a variety of medical/physical problems. There is complaint of chronic pain, somatic difficulties, and physical problems that have left him unhappy, with little energy or enthusiasm with which to concentrate on important life tasks, and little hope for improvement in the future.

Separate scale elevations are consistent with ongoing pain and somatic difficulties in a person who is depressed, anxious, and somewhat wary and sensitive with regard to interpersonal relations.

Mr. Chavis denied being disturbed by thoughts of self harm. He reported his temper as being within the normal range.

On the Multi Dimensional Pain Inventory, Mr. Chavis reported experiencing intense pain on a daily basis that extremely interferes with his ability to work and to attain satisfaction and enjoyment from participation in social and recreational activities.

Mrs. Chavis completed a Symptom Checklist regarding her husband's current functioning. She viewed her husband as having severe difficulties with headaches, nausea, numbness or tingling on parts of his body, forgetfulness, fatigue, sleep disturbance, feeling depressed or sad, irritability/easily annoyed, and poor frustration tolerance/feeling easily overwhelmed by things.

Summary/Integration: I had the opportunity to provide Mr. Chavis feedback regarding the neuropsychological evaluation. The course of his medical difficulties as well as the manifestation of a cerebellar infarct have been well documented in the medical records. Acutely after sustaining the stroke, he experienced confusion and other neurocognitive difficulties that would be expected. He has shown significant improvement with the passage of time.

Neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected considering the location of the stroke. Attention/ concentration appears to be intact, though there was notable variability in his performance on memory/learning tasks. Indeed, there is compelling evidence of reduced capacity for immediate learning/memory, but no evidence of rapid forgetting or amnestic syndrome. There is no compelling evidence for impairment affecting visual spatial skills, receptive or expressive language functions, or sensory perceptual functions. Mr. Chavis was generally efficient and commensurate with his intellectual/educational level in his performance on tasks assessing executive/higher reasoning skills.

Assessment of emotional functioning reveals an individual who continues to suffer from chronic pain and comorbid depressive and anxious difficulties. This has been a highly stressful period for Mr. Chavis and his wife, and it certainly has affected the quality their life.

In summary, there is neuroradiographic evidence of the sustainment of a cerebellar stroke as well as some residual impairments affecting Mr. Chavis' capacity for learning/memory functioning. A great obstacle for Mr. Chavis' return to life pursuits is continuing pain and physical limitations. I would agree with previous diagnoses of Pain Disorder Associated with Both Psychological Factors and a General Medical Condition (307.89) as well as Depressive Disorder, NOS (311). Mr. Chavis likely experiences a mild reduction in overall neurocognitive functioning consistent with the location of stroke. There is no extreme interference in his overall cognitive processing...

11/18/02
Michael McCaffrey, M.D.
Strand Regional Specialty Associates
Worker's Compensation Evaluation

...PAST MEDICAL HISTORY: Non-insulin dependent diabetes mellitus and migraine headaches.

PAST SURGICAL HISTORY: Tracheostomy at age 10 months old, skin tag removed off his scrotum in 1967, right shoulder surgery in 1999, left ulnar transposition in 2002.

PREVIOUS HOSPITALIZATIONS OTHER THAN SURGERY: Kidney stones in 2001 and 2002...

PREVIOUS ACCIDENTS, OUTCOMES OR DISABILITY RATINGS: The patient had 2 separate Worker's Comp injuries in the past, regarding his back in 1996 and shoulder in 1998...

SOCIAL HISTORY: He is a nonsmoker, nondrinker. He denies recreational drug use or history of addiction. He has been married to his 4th wife 16 years. He has 2 children and 2 dependents. His wife works for Horry County in finance...

HIGHEST EDUCATIONAL LEVEL: GED...

FAMILY HISTORY: His mother died at age 62 from cancer. His father died at age 65 from unknown reasons. He has 5 sisters and 4 brothers. One of his brothers is 56 years old and recently had cataracts removed. He has a son who is 26 and a daughter 17 alive and well. He has 1 grandson who is 2 years old alive and well.

OCCUPATIONAL HISTORY: He has been disabled since 2000 secondary to left side weakens from his previous CVA...

HISTORY OF PRESENT ILLNESS: This 47 year old right handed white male states that on 01/25/00 while at Disk Imaging in Mount Pleasant, SC at the approximate time of 1:15 p.m.

bodily injury occurred in the following manner. The patient was undergoing a selective nerve root block by Dr. David Goltra at Disk Imaging in Mount Pleasant, SC. He had an episode of loss of consciousness during this injection and woke with left sided weakness and dysarthria. He was taken to Cooper River Medical Center and admitted at that time. He stayed over night but requested to go home the following day. He was seen by Dr. Groblewski approximately 2 days later for continued left sided weakness and dysarthria. Symptoms lasted for the next 6 to 8 months and he has been disabled since then secondary to left sided weakness.

PRIOR LAWSUITS: The patient has had a previous lawsuit in 1996 from his first Worker's Com injury and in 1998 with his second Worker's Comp injury. His lawyer is Bruce Dew out of Columbia, SC.

NEGATIVE IMPACT TO THE INJURY: The patient has chronic pain his left shoulder with weakness of his left side and is unable to work at present secondary to this...

NEUROLOGICAL EVALUATION:
MENTAL STAT: Oriented to person, place and time. No difficulty with short or long term memory. Good attention span and concentration. Patient able to repeat phrases and identify objects. Patient had difficulty in discussing current events...

IMPRESSION & PLAN:
1. Previous right CVA with left sided weakness. The patient has no definable weakness in his left lower extremity on examination today. I think some of his weakness if not all of his weakness, in his left upper extremity si secondary to left shoulder pain. I recommended starting the patient on aspirin 81 mg p.o. q.d. He is on no stroke prophylactic medication at present. He may need a repeat MRI of the brain in the near future to reevaluate for any reoccurrence of his right subcortical CVA verus new CVA's...

09/22/03
Michael McCaffrey, M.D.
Strand Regional Specialty Associates
Follow-up Visit

...IMPRESSION & PLAN:
1. Previous right CVA with left-sided weakness. Patient had no weakness on examination today except for his left ABV. He will need to undergo left carpal tunnel syndrome release by Dr. Chamber.
2. Intermittent migraine headaches. These appear to be stable at present.

12/16/03
Steven Epstein, M.D.
Open MRI & CT of Myrtle Beach
Radiology Report

MRI OF THE BRAIN AND PITUITARY WITH AND WITHOUT CONTRAST...

IMPRESSION:
1. THERE IS NO ADENOMA IDENTIFIED WITHIN THE PITUITARY GLAND.
2. THERE IS A SMALL OLD INFARCT IN THE RIGHT CEREBELLAR HEMISPHERE WITHIN THE PICA DISTRIBUTION.

06/01/04
Charles S. Jervey, M.D.
Carolina Neurological Clinic, LLP
Independent Medical Evaluation

HISTORY: ...According to Dr. Goltra's procedure report he had a needle directed toward the right C5-6 neural foramen, and a neurogram was performed using a small amount of Omnipaque, and this documented opacification of the nerve root shealth [sic]. Following that a mixture of 1 cc Xylocaine and 80 mg Depo-Medrol were injected in the perineural space. Upon removing the needle a small amount of blood return was obtained. Direct compression was applied to the lateral neck. At approximately the time when the needle was removed the patient had an episode of syncope.

According to Dr. Wenzel's history and physical the patient had persistent nausea as well as an episode of vomiting at the hospital, but no further episodes of confusion. He also was reporting a headache and feeling tired. He had no visual complaints nor focal weakness or focal numbness. Dr. Wenzel did not observe any further episodes of confusion although the patient did later have complaints of difficulty with his memory.

When I spoke with Mr. Chavis today he indicates that his primary complaints at this time are pain and numbness in his left shoulder area which is exacerbated by raising his left upper extremity into the air. His back pain is another source of major complaint and a burning pain which he has in the distal lower extremities and upper extremities bilaterally. He also has been experiencing erectile dysfunction, and that is another of his major complaints.

He later had an EMG/nerve conduction study conducted by Dr. Hodge, who is a neurologist. This was done of the right upper extremity and right supraparaspinal region and was a normal study. This was dated 6/16/2000. He had another EMG/nerve conduction study dated 7/31/02,

and that was done by Dr. Gregory Kang, who is a physiatrist. According to his study the median sensory nerve distal latencies were delayed bilaterally, and the left ulnar sensory nerve response was absent. Bilateral median motor distal latencies were slightly delayed, and the left ulnar motor nerve had slowing of the conduction velocity across the elbow and an amplitude drop across the elbow, but was otherwise normal. There were denervation changes in the left first distal interosseous muscle which is ulnar nerve territory.

He has also been undergoing orthopaedic evaluation and treatment. He had an MRI dated 6/07/99 which showed probable partial tear in the rotator cuff on the right.

Following his syncopal episode and hospital admission he had MRI of the brain dated 2/07/00. which showed evidence of a stroke in the right cerebellar hemisphere and right mid brain immediately above the cerebellar peduncle on the right side measuring 2-3 mm. The stroke in the right cerebellar hemisphere measured 1 x 2 cm, and these appeared subacute. He had a follow up scan done in approximately April of 2000 which showed almost complete resolution of the stroke. Mr. Chavis had neuropsychological testing done by Randolph Waid in May and June of 2002. This showed notable variability in his performance on memory/learning tasks with evidence of reduced capacity for immediate learning/memory but no evidence of rapid forgetting or amnestic syndrome. On his assessment he indicated that Mr. Chavis was generally efficient commensurate with his intellectual/education level on tasks of assessing executive/higher reasoning skills. He also was found to have chronic pain and comorbid depression and difficulty with anxiety.

PAST MEDICAL HISTORY: Significant for diabetes, which is controlled with oral medications...

IMPRESSION: Mr. Chavis had a stroke in 2000 involving the cerebellum and right brainstem although relatively small size. He did experience nausea, vomiting, and vertigo, which have resolved. He has ongoing complaints of burning pain in both hands and both feet. This would not be expected from a cerebellar stroke, and the bilateral nature of his symptoms suggest this is a systemic disorder and not related to this stroke. The most common cause of symptoms such as that is diabetic neuropathy. He does have diabetes and in between his first nerve conduction study and his second nerve conduction study he had developed some abnormalities in his peripheral nerve testing indicating that he has likely developed peripheral neuropathy. That would be the most probable explanation for those symptoms.

He also has complaints in his left shoulder which I do not think are related to this strike either.

In addition he has ongoing complaints of memory difficulty. I would not expect permanent memory impairment related to cerebellar stoke. Even large strokes of the cerebellum are usually

not associated with any memory impairment. He does have problems with depression, and depression is a well known contributing factor to problems with memory.

In addition he also mentions having problems with erectile dysfunction. I do not think that is related to his stroke. Erectile dysfunction is a common problem in diabetics and is caused by the development of peripheral neuropathy. Depression and use of narcotic medications can also contribute to that type of problem.

At this point in time the only neurologic impairment that may be related to his stroke is that he has some difficulty with heel to toe walking. That can also be caused by peripheral neuropathy, however. In my experience patients with small cerebellar hemisphere strokes usually get complete resolution of all of their symptoms from their stroke and for those that don't, I would expect no more than minor residual deficits related to the stroke.

06/19/03
James R. Merikangas, M.D.
Georgetown University Hospital Neuropsychiatry Program
Addressed to J. Edward Bell, III

Mr. Chavis is an unfortunate gentleman who suffered a stroke as the result of an improperly performed cervical spine injection. A misplace needle injured a vertebral artery, causing a cerebrovascular accident involving his cerebellum and brainstem. As a result he is left with permanent neurological and psychological impairments. Mr. Chavis had sustained various work related injuries to his back and shoulder and was in chronic pain. He had been treated in a number of places including: Primary Medical Associates from September 8, 1994 to January 24, 2000; Strand Regional Specialty Associates from May 5, 1998 to June 1, 1998; Disc Imaging from January 5, 1999 to April 13, 2000; Atlantic Physical Therapy and Rehab from August 30, 1999 to December 3, 1999 and from March 19, 2002 to April 25, 20003 [sic]; Pee Dee Orthopedic Associates from December 29, 1999 to June 2, 2000; East Cooper Regional Medical Center from January 25, 2000 to January 26, 2000; Doctors Care Conway from January 28, 2000 to May 18, 2002; Eastern Carolina Neurosurgical Associates of Conway from January 31, 2000 to February 21, 2001; Coastal Orthopedic Associates from February 7, 2000; Conway Hospital February 7, 2000; Palmetto Health from February 7, 2000 to September 28, 2000; Midlands Orthopedic on August 7, 2001; and by L. Randolph Waid, Ph.D., from December 5, 2002 to June 12, 2002. As part of my evaluation I reviewed all these medical records.

Mr. Chavis had lifted a heavy pot at work and had pain in his right shoulder down to his elbow. An x-ray taken on December 8, 1998, showed mild spurring of the right acromioclavicular joint. He was noted to have chronic back pain, which resulted in him being sent to Dr. Holgate for an L5-S1 facet block on the right. A note of January 11, 1999, reveals that he had a marked improvement in his pain as a consequence of that procedure.

Richard C. Holgate, M.D. on January 5, 1999, under fluoroscopic control, performed this successful block of the right S1-S2 joint. An MRI of the right shoulder performed on June 7, 1999, by Beverly M. Genez, M.D., Ph.D., revealed abnormal signal of the rotator cuff, representing a partial tear on the undersurface and a possible tendinosis. Another MRI on October 23, 1999, for his chronic right shoulder pain revealed "Heterogeneous fluid within the subacromial subdeltoid bursa most likely resulting from prior decompression. Abnormal signal intensity within the distal rotator cuff may represent tendinosis. No focal full thickness of the rotator cuff is identified on the current examination".

An MRI scan of the cervical spine on January 8, 2000, showed a large number of osteophytes with neural foraminal stenosis at C3-4. At C4-5 there was also seen a small shallow central disc protrusion and at C5-6 there is a parasagittal disc protrusion, which "Contacts and flattens the spinal cord" and "This is superimposed on a diffuse disc bulge which narrows both neural foramina, slightly more so on the right than on the left, but there is moderate right neural foraminal stenosis. At C6-7 and C7-T1 the MRI showed normal discs and normal foramina.

Dr. Goltra then performed a lateral selective epidural block in the cervical area on January 25, 2000. It was noted "Upon removing the needles a small amount of blood returned (sic) was obtained and direct compression was applied to the lateral neck. At approximately the time that the needle was removed the patient had an episode of syncope, which lasted for approximately one minute. When he awakened, he was nauseated and mildly disoriented. When he recovered from this he stated that his right shoulder pain was gone." Following that, a CT scan of the brain was performed with axial images showing no hemorrhage, edema or other abnormality. Unfortunately, subsequent MRI scans revealed the patient had a stroke. With reference to a prior examination of February 7, 2000 and an MRI of April 13, 2000, "There is a subtle area of signal abnormality in the right cerebellar hemisphere. Relative to the prior study the area of signal abnormality in the right cerebellar hemisphere is diminished in size, markedly. The lesion is not apparent on flair images and there is no abnormal enhancement, retrained or increased diffusion in this area. Small high signal focus in the right pons is again seen and is unchanged." This was also read by David D. Goltra, Jr., M.D.

...The doctor was reluctant to recommend surgery "Given his previous history of a 'stroke' from an epidural steroid injection done back in January". Furthermore, "He was cautioned, however, that some of his radicular symptoms conceivably could come from this (i.e., his cervical disc) and that he could not expect complete resolution of all of his symptoms from whatever type of shoulder surgery Dr. Elvington feels is required". It was further noted on June 2, 2000, by Robert E. Elvington, Jr., M.D. that "Gilbert is still having significant pain" and furthermore, "I think that this is related to the stroke and/or the injection."

Following the episode of syncope with his cervical injection, he was admitted to East Cooper Regional Medical Center under the care of David Wenzel, M.D., "For 23 hour observation

following a complication related to a nerve block procedure". Dr. Wenzel noted "He was undergoing selective nerve root injection this afternoon for pain relief with a combination of Lidocaine and Depo-Medrol. Immediately after one of the injections was performed, he abruptly stopped talking, exhibited flexor posturing of both upper extremities and staring for perhaps two minutes, after which he became violently nauseated and vomited several times and was somewhat confused, reporting that he did not know where he was, why he was there, etc.". The impression was "Brief episode of unresponsiveness, followed by confusion and persistent nausea, likely due to inadvertent intra-arterial injection of Lidocaine".

He was subsequently seen on February 15, 2000, by Daniel B. Groblewski, M.D., who noted that he was complaining of imbalance and episodic diplopia and he had three days of bad headache. The MRI showed a right cerebellar stroke. Dr. Groblewski's note of April 18, 2000, states the impression "Right cerebellar cerebrovascular accident, probably thromboembolic or directly/indirectly related to injection". In his letter to Bruce G. Dew, Attorney at Law, dated April 18, 2000, Dr. Groblewski gives the opinion "Because of the association of his symptoms to the epidural injection, it is very possible that his stroke could have resulted from the epidural injection. This has been documented in previous literature as well. Also, I believe this could have caused his syncopal spell". He went on to state further "It is very unlikely that this represented a pre-existing condition and certainly could be a direct/indirect cause of the injection (sic)".

I subsequently personally examined Mr. Chavis at Georgetown University Medical Center. I also interviewed his wife on the same date.

Mr. Chavis was complaining of imbalance, neck and shoulder pain, headaches and depression.

A review of systems, physical examination and his history are all consistent with a cerebellar and brain stem stroke occurring from interference with the vertebral arterial system in the course of a cervical injection for pain relief as described in the previous reports.

The cervical segment of the vertebral artery courses through the intervertebral foramina. According to Frank H. Netter, MD., writing on page 62 of Volume I of the Nervous System published by Ciba, West Caldwell, New Jersey, 1986, "The second (cervical) segment of the vertebral artery courses through the intervertebral foramina and is seldom the site of serious atherosclerosis. Minor ridges and plaques may develop at sites of indentation by the osteophytic spurs of cervical arthritis, but occlusion of this portion of the vertebral artery is rare".

As the vertebral arteries supply the pons and the posterior fossa through the basilar artery with its penetrating branches and the cerebellar branches, the symptoms of pain and ataxia and nausea can easily explained by the misplaced injection striking the vertebral artery. Again, according to Netter on page 62 of the cited volume "The artery is easily dissected or torn, which may cause

clot formation within one or both vertebral arteries. Ischemia most often occurs at the time of injury and is limited to the ipsilateral cerebellum and lateral brainstem". The illustration on this page of Netter's book very clearly illustrates the anatomy of the region and how a misplaced needle could cause a stroke of this type.

In summary then, there was a deviation from the standard of care in the attempted nerve blood [sic], which injured a vertebral artery. Mr. Chavis will continue to suffer the impairments caused by this stroke for the rest of his life. He will remain in chronic pain. He is depressed and suffers from dizziness and unsteadiness.

The above is based upon my review of the medical records cited, my personal interview of Mr. Chavis and his wife and the relevant medical literature, as well as my experience and training as a board certified neurologist...

06/21/04
Brian L. West, Ph.D.
Charleston Psychiatry, LLC
Letter addressed to Roy A. Howell, III

...RE: Gilbert Chavis vs. AVX Corporation
Worker's Compensation Carrier File No. 9826170, Date of accident: 12/07/98
Worker's Compensation Carrier File No. 9927964, Date of Accident: 12/27/99

Dear Mr. Howell,
As per your request, I saw Mr. Chavis on 06/01/04. As you know, he is a 49-year-old male who reports a work-related accident on 12/07/98 while employed by the AVX company in Myrtle Beach, S.C. Details regarding that injury and its effect on his shoulder are outlined elsewhere. With regards to the current request of neurocognitive dysfunctions, the patient underwent a procedure by Dr. Goltra for his right shoulder pain. In that procedure, an epidural block was placed in the cervical area on 01/25/00 and the patient experienced an episode of syncope and reportedly a loss of consciousness. Upon arousing, he was nauseated and disoriented. A CT scan of the brain was performed without evidence of hemorrhage or edema. He was seen by neurology (Dr. Wenzel) and observed for 23 hours. Although Dr. Wenzel had requested an extended time of observation the patient chose to go home. Subsequently, an MRI revealed evidence of probable cerebrovascular accidents in the right cerebellar hemisphere and in the pons.

In sequelae, the patient has had continued pain-related issues including the initial injury of the right shoulder and cervical spondylosis. He was followed by Dr. Hartsock and more detailed information of these concerns is in his findings. The patient was referred to a pain management program at Palmetto Health facility. He was evaluated by Dr. Metcalf who diagnosed peripheral

neuropathy. At this point, Mr. Chavis had reported memory deficits perhaps secondary to the CVA and was seen by Dr. Drummond (psychologist) who diagnosed a moderate depression as well as a pain disorder associated with psychological and medical conditions.

The patient was then referred for a neuropsychological evaluation conducted by Dr. Randy Waid in May and June of 2002. In that study, Mr. Chavis' Wechsler Adult Intelligence Scale, III Revision had a full-scale IQ of 91 and in low end of average range. This placed him at the 27th percentile. There was significant differential between verbal and performance measures and his verbal IQ is 88 and performance IQ is 99. Mr. Chavis' working memory as assessed through the Wechsler was at the 66th percentile and perceptual organizational skills at the 58th percentile while processing speed was at the 39th percentile. Verbal comprehension was at the 9th percentile and does suggest limited verbal skills.

His achievement scores suggest impoverished educational development with standard scores of 81 for reading, 70 for spelling, and 91 for arithmetic.

In the neuropsychological portion of the exam, Dr. Waid provided the Stroop which was in average ranges. Seashore Rhythm Test was also in average ranges. He was also in average ranges on the PASAT.

The patient was then provided the Wechsler Memory Scale, III Edition with above-average working memory results. However, his General Memory Index score was a 78 and at the 7th percentile. In interesting contrast., Mr. Chavis was then administered the California Verbal Learning Test, II Edition and his five-trial learning procedure is in average ranges. Although he had some excessiveness for intrusive errors apparently his recalls were within average ranges.

On remaining tasks, such as visuospatial and executive functions apparently Mr. Chavis was in average ranges with the exception of the Judgment of Line Orientation Test.

In emotional and psychiatric measures, the patient apparently indicted significant psychological distress with probable depression. The Multi-Dimensional Pain Inventory was also administered and the patient is reporting intense pain interfering with daily activities.

Dr. Waid concludes that Mr. Chavis' neurocognitive, evaluation while there is some evidence of immediate learning and memory concerns, there is not support for rapid forgetting or amnestic syndrome and, in general, Mr. Chavis is intact for neurocognitive functions.

In reviewing these test results, it would appear that while there are some inconsistencies and variabilities there is not a consistent pattern that would suggest short-term memory loss. Instead, Mr. Chavis's inconsistencies in test performance may well be due to psychological interferences related to a depression and effects from pain. Frequently these will cause variability in

performance depending on intensity of pain and psychological distress at the time of testing. It is important to note that the neurocognitive test battery was apparently administered over multiple test dates and over the course of approximately a month. Therefore, depending on time of administration there may have been some variability due to the patient's ongoing psychological condition. It may be prudent to have this patient re-evaluated given that the former assessment was greater than two years ago. A current assessment would allow for addressing such questions as whether he has reached maximum medical improvement and whether there is any evidence of any sustained psychological impairments...

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August 11, 2005

Roy A. Howell, III, Esquire
Trask & Howell, L.L.C.
763 Johnnie Dodds Boulevard
PO Box 2167
Mt. Pleasant, South Carolina 29465

RE: Gilbert Chavis vs. AVX Corporation
WCC File Nos.: 9826170 and 9927964
Carrier File Nos.: WC550-441515 and WC550-448871

Dear Mr. Howell:

Thank you for sending me additional information on the above-referenced matter to me for review. I have reviewed the following records:

Radiology Reports:
01/25/00 - David D. Goltra, Jr., M.D.
02/07/00 - William Weadock, M.D., Conway Hospital
04/05/00 - Ashley D. Kent, M.D., Eastern Carolina Neurological Associates of Conway, Carotid Ultrasound
04/13/00 - David D. Goltra, Jr., M.D., Disc Imaging
12/16/03 - Steven Epstein, M.D., Open MRI & CT of Myrtle Beach

Daniel B. Groblewski, M.D.
(Eastern Carolina Neurological Association of Conway)
01/31/00 - Letter addressed to Lewis Lawson, M.D.
02/15/00 - Follow-up Note
04/18/00 - Follow-up Note
04/18/00 - Handwritten Note
04/18/00 - Letter addressed to Bruce G. Dew, Attorney-At-Law
06/09/00 - Re Evaluation Note

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Records reviewed (cont)

Richard W. Ward, M.D.
(Strand Orthopaedic Consultants)
__/11/00 - Handwritten Note
03/30/00 - Office Note

L. Randolph Waid, Ph.D.
Undated Report - Neuropsychological Consultation/Evaluation of May 2nd, 15th, 29th, and June 12th, 2002

Michael McCaffrey, M.D.
(Strand Regional Specialty Associates)
11/18/02 - Worker's Compensation Evaluation
09/22/03 - Follow-up Visit

Charles S. Jervey, M.D.
(Carolina Neurological Clinic, LLP)
06/01/04 - Independent Medical Evaluation

James R. Merikangas, M.D.
(Georgetown University Hospital Neuropsychiatry Program)
06/19/03 - Addressed to J. Edward Bell, III

Brian L. West, Ph.D.
(Charleston Psychiatry, LLC)
06/21/04 - Letter addressed to Roy A. Howell, III

Domenic J. DeMichele, M.D., Ph.D.
(Eastern Carolina Medicine)
03/28/05 - Report addressed to Mr. Preston McDaniel
06/07/05 - Nerve conduction study
06/07/05 - F-Wave latency examination
06/07/05 - Letter addressed to Mr. Preston McDaniel
06/20/05 - Nerve conduction study

As reflected in my initial report of 07/27/05, these records indicate to me that relative to the infarct, Mr. Chavis has made an excellent recovery. He has little, if any, cognitive deficits related to this injury as indicated by Dr. Waid's neuropsychological evaluation, which was

Roy A. Howell, III, Esquire
August 11, 2005
re: Gilbert Chavis
Page 3

entirely consistent with Mr. Chavis' pre-existing history of a 10th grade education, obtaining a GED on the third attempt, a Reading Learning Disability, and the possibility of depression. Given the location of Mr. Chavis' stroke, involving the cerebellum and right brain stem, he is likely to have a complete resolution of any related symptoms. Given the location of that CVA, you would not expect any impairment in memory or any other neurocognitive functioning. This opinion is entirely consistent with the opinion expressed by Charles S. Jervey, M.D. on 06/01/04, Brian L. West, Ph.D. on 06/21/04, and Dr. Waid's undated evaluation. Those evaluations reported the following:

> *Undated*
> *L. Randolph Waid, Ph.D.*
> *Neuropsychological Consultation/Evaluation*
>
> *...Summary/Integration: ...Acutely after sustaining the stroke, he experienced confusion and other neurocognitive difficulties that would be expected. He has shown significant improvement with the passage of time.*
>
> *Neurocognitive evaluation reveals Mr. Chavis to be functioning in the average range of intellectual abilities with weakness in verbal comprehension skills likely related to his educational deficiency. Academic achievement testing confirmed his lack of formal educational attainment and deficiency with regard to academic skills. Neurocognitive evaluation revealed Mr. Chavis to have made a good recovery from acute difficulties suffered as the result of a cerebellar stroke. This would be expected considering the location of the stroke. Attention/ concentration appears to be intact, though there was notable variability in his performance on memory/learning tasks. Indeed, there is compelling evidence of reduced capacity for immediate learning/memory, but no evidence of rapid forgetting or amnestic syndrome. There is no compelling evidence for impairment affecting visual spatial skills, receptive or expressive language functions, or sensory perceptual functions. Mr. Chavis was generally efficient and commensurate with his intellectual/educational level in his performance on tasks assessing executive/higher reasoning skills...*
>
> *There is no extreme interference in his overall cognitive processing...*

06/01/04
Charles S. Jervey, M.D.
Carolina Neurological Clinic, LLP
Independent Medical Evaluation

...IMPRESSION: Mr. Chavis had a stroke in 2000 involving the cerebellum and right brainstem although relatively small size. He did experience nausea, vomiting, and vertigo, which have resolved. He has ongoing complaints of burning pain in both hands and both feet. This would not be expected from a cerebellar stroke, and the bilateral nature of his symptoms suggest this is a systemic disorder and not related to this stroke. The most common cause of symptoms such as that is diabetic neuropathy. He does have diabetes and in between his first nerve conduction study and his second nerve conduction study he had developed some abnormalities in his peripheral nerve testing indicating that he has likely developed peripheral neuropathy. That would be the most probable explanation for those symptoms...

...In my experience patients with small cerebellar hemisphere strokes usually get complete resolution of all of their symptoms from their stroke and for those that don't, I would expect no more than minor residual deficits related to the stroke.

06/21/04
Brian L. West, Ph.D.
Charleston Psychiatry, LLC
Letter addressed to Roy A. Howell, III

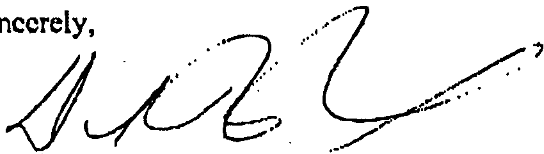
...Dr. Waid concludes that Mr. Chavis' neurocognitive, evaluation while there is some evidence of immediate learning and memory concerns, there is not support for rapid forgetting or amnestic syndrome and, in general, Mr. Chavis is intact for neurocognitive functions...

If one looked at the effects of the infarct upon Mr. Chavis, apart from his shoulder injury, his diabetes, his hypertension, his reported sleep apnea, and his possible depression, there would be no restriction on his return to work. This stroke would have little impact on his neurocognitive functioning in general, and on his ability to be gainfully employed and perform substantial gainful activity. The neuropsychological test data found in this case would not restrict his employment.

Mr. Chavis' diabetes, hypertension and sleep apnea are unrelated to his shoulder injury and infarct. It is possible that his depression is, but it is more likely attributable to his diabetes and is a pre-existing condition.

Should you have any questions or comments, please don't hesitate to call upon me.

Sincerely,



David R. Price, Ph.D.
Licensed Clinical Psychologist
Adjunct Associate Professor
Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina
Adjunct Associate Professor
Department of Social and Behavioral Sciences, University of South Carolina-Spartanburg

PAUL B. PRITCHARD, III, M.D.
939 Scottland Drive, Mount Pleasant, SC 29464
ppritchard@gmail.com
843-367-8122

March 18, 2006

Mr. Roy A. Howell, III
Trask & Howell, L.L.C.
P.O. Box 2167
Mount Pleasant, SC 29465

Re: Gilbert Chavis v. AVX Corporation
W.C.C. File No.: 9826170 & 9927964
Carrier File No.: WC550-441515 & WC550-448871
Date of Accident: December 7, 1998 & December 27, 1999

MEDICAL RECORD ANALYSIS
Gilbert R. Chavis
D.O.B.: 12/7/1954
Social Security No.: 248-04-2224

Performed by Paul B. Pritchard, III, M.D., 939 Scottland Drive, Mount Pleasant, SC 29464.
South Carolina Medical License #5721
Board Certified in Neurology (1975) and
Clinical Neurophysiology (1984).
Fellow, American Academy of Neurology

This medical record analysis was done at the request of Mr. Roy A. Howell, III of Trask & Howell, L.L.C., 763 Johnnie Dodds Boulevard, Mount Pleasant, SC 29465, who supplied the following records for review:

1. Records from Asbury H. Williams, M.D.
2. Records from Strand Orthopaedic Consultants (Thomas P. Harden, M.D.).
3. Records from Coastal Orthopaedic Associates (William L. Mills, M.D.) re: complaints of neck and low back pain which Mr. Chavis related to an injury on the job on 4/8/1996. Mr Chavis was awarded 5% permanent impairment to his lumbar spine on 9/23/1996 in relation to the injury on the job which occurred on 4/8/1996.
4. Records from Coastal Orthopaedic Associates (Jeffrey C. Wilkins, M.D.) re: complaint of low back and right shoulder pain – first visit 3/18/1997. Rated as DRE category II injury to the cervical spine with a 5% whole person impairment rating on December 2, 1997.
5. Records from Pee Dee Orthopaedic Associates (Robert E. Elvington, Jr., M.D.).

6. Records from Coastal Orthopaedic Associates, P.A. (A. Jay Presler, III, M.D.).
7. Records from Eastern Carolina Neurological Associates of Conway (Daniel B. Groblewski, M.D.).
8. Records from Eastern Carolina Neurological Associates of Conway (Michael L. Hodge, M.D.).: right upper extremity nerve conduction study, electromyography (normal).
9. Records from Strand Orthopaedic Consultants (Richard W. Ward, M.D.).
10. Records from MUSC Bone and Joint Center (Langdon A. Hartsock, M.D., F.A.C.S.).
11. Records from Midlands Orthopaedics, P.A. (Michael S. Green, M.D.).
12. Records from The Center for Pain Management, Palmetto Health (Matthew E. Midcap, M.D., Clay Drummond, Ph.D., and Kimberly Shull-Massey, P.T.).
13. Records from L. Randolph Waid, Ph.D. (neuropsychology evaluation).
14. Records from Pain, Spine & Sports Medicine (C. Gregory Kang, M.D.), including nerve conduction studies, electromyography.
15. Records from Strand Regional Specialty Associates (Michael McCaffrey, M.D.).
16. Records from Strand Regional Specialty Associates (Thomas J. Chambers, M.D.).
17. Records from James R. Merikangas, M.D., L.L.C.
18. Records from Brian L. West, Ph.D. (neuropsychology evaluation).
19. Records from Carolina Neurological Clinic, L.L.P. (Charles S. Jervey, M.D.).
20. David R. Price, Ph.D. (comprehensive record review).
21. Radiologic study reports, including the following:
    a. MRI right shoulder, 6/7/1999.
    b. MRI right shoulder, 10/23/1999.
    c. CT brain scan, 1/25/2000.
    d. MRI brain scan, 2/7/2000.
    e. MRI brain scan, 4/13/2000.
    f. MRI cervical spine, 2/28/2001.
    g. MRI left shoulder, 3/12/2002.
    h. MRI left shoulder, 3/31/2003.
    i. Lumbar spine xrays, 9/18/2003.
    j. MRI brain, 12/16/2003.
    k. Hip xrays, 2/6/2004.
    l. Lumbar spine xrays, 2/6/2004.
22. Functional Capacity Evalution (Ian W. McClure, COTA/L, Murray Cooper, LPT).
23. Nerve conduction studies, electromyography, right arm and cervical paraspinous muscles, 3/29/2001 (Jeffrey C. Wilkins, M.D.).
24. Nerve conduction studies, electromyography, both upper extremities, 12/11/2002 (C. Gregory Kang, M.D.).

Facts of the case:

I will confine my comments to neurological issues in the case, and I will not offer an opinion with regard to problems he has encountered with his shoulders. Records from Asbury H. Williams, M.D. indicate that on 6/7/1996 Mr. Chavis was being treated with Flexeril (a muscle

relaxant), Ultram (pain medication), and physical therapy for lumbosacral strain. In his note of 12/27/1996, Dr. Thomas Harden of Strand Orthopaedic Consultants reported that Mr. Chavis had sustained an injury while on the job in May 1996. Dr. Harden detailed Mr. Chavis' complaints of low back pain, neck pain, and right shoulder pain at the evaluation of 12/27/1996. Contemporaneously, Mr. Chavis was also under the care of other orthopaedic specialists, Dr. William L. Mills (Coastal Orthopaedic Associates) and Dr. Jeffrey C. Wilkins (Strand Orthopaedic Consultants) for similar complaints, which continued at the time of Dr. Wilkins' impairment rating letter of December 2, 1997 and as further documented in subsequent notes during 1998.

Mr. Chavis suffered ischemic cerebral infarcts (strokes) in his cerebellum and brainstem in close proximity to a selective nerve root block performed on January 25, 2000. The strokes were demonstrated by an MRI brain scan of 2/7/2000 and were shown to have improved in a follow up MRI of 4/13/2000. A third MRI brain scan of 12/16/2003 no longer showed the brainstem infarct, demonstrating only "...a small area of previous infarction within the right cerebellar hemi-sphere...," (line 5, findings in Dr. Steven Epstein's report). A neurological independent medical examination performed by Dr. Charles Jervey on June 1, 2004 showed no residual deficit which could be attributed to the stroke.

Although initial nerve conduction studies and electromyography were normal, Mr. Chavis has developed polyneuropathy, as evidenced by the study performed by C. Gregory Kang on 7/31/2002.

Mr. Chavis has had MRI scans of his cervical and lumbar spine, each of which has demonstrated degenerative disc and degenerative joint changes. It should be noted that Mr. Chavis had been awarded a 5% impairment rating to his lumbar spine on 9/23/1996 and a 5% impairment rating to his cervical spine on 12/2/1997, which dates precede December 7, 1998 and December 27, 1999, the dates specified for job-related injuries under present consideration.

Opinion:

It is my professional opinion that Mr. Chavis had neck, right shoulder, and low back pain prior to the incidents of job-related injury on December 7, 1998 and December 27, 1999. In fact, he had been awarded impairment ratings for cervical and lumbar spine prior to these dates. The neurological injuries of December 7, 1998 and December 27, 1999 were limited to lumbar and cervical muscle strain. It should be noted that Mr. Chavis was taking muscle relaxants and pain medications on an ongoing basis prior to the job-related injuries of December 7, 1998 and December 27, 1999.

It is clear from the medical records that Mr. Chavis suffered strokes of his brain stem and cerebellum on January 25, 2000 as a complication of treatment of his job-related injury consequent to the selective cervical nerve root block which was performed that day. Fortunately, Dr. Jervey's evaluation on June 1, 2004 showed no physical exam residual from the strokes.

Mr. Chavis also underwent neuropsychology evaluations through L. Randolph Waid, Ph.D. and Brian West, Ph.D. Neither of them found evidence of any cognitive impairment either as a consequence of the strokes or as sequelae to any injuries which he incurred on a job-related basis.

Although Mr. Chavis has developed polyneuropathy since the job-related accidents in question, the polyneuropathy has no relationship to his job-related injuries. The polyneuropathy is a complication of his diabetes.

I offer all of the above within a reasonable degree of medical certainty.

Respectfully submitted,

Paul B. Pritchard, III, M.D., F.A.A.N.

149-073-0007-0 | N | FINAL | PG | 03 N 01

LabCorp

ADDITIONAL INFORMATION

1C Gawith

DOB: 12/07/54

LD: 31064074789

CLINICAL INFORMATION

05-30-97 08:1

PHYSICIAN ID.	PATIENT ID.	
GAWITT	60235	TVO

PATIENT NAME	SEX	AGE (YR./MOS.)
L ,VIS, GILBERT	N	042/05

PATIENT ADD.

ACCOUNT

COASTAL UROLOGY CENTER PA 390961
DRS. QUILLEN, GAWITH & SASSER
394 SINGLETON RIDGE RD.
CONWAY , SC 29526-
803-347-8765 SCF

DATE OF COLLECTION	DATE ENTERED	DATE REPORTED	
05/29/97	05/29/97	05/30/97	0049

TEST	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Testosterone	268		ng/dL		B
			Adult Male	241 - 827	
			Adult Female	14 - 76	

LAB: BN LABCORP HOLDINGS DIRECTOR: FRANK HANCOCK MD DIR
1447 YORK COURT BURLINGTON, NC 27215-2230

FRANK HANCOCK MD DIR
FOR INQUIRIES, THE PHYSICIAN MAY CONTACT THE MEDICAL DIRECTOR AT:
BRANCH: 803-679-0687 LAB: 800-762-4344

Will Be in 6/4/97

Low normal
will need LH/Prolactin

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LabCorp

ADDITIONAL INFORMATION

CLINICAL INFORMATION

PHYSICIAN ID. | PATIENT ID.

PATIENT NAME: ...VIS, G.LBERT | SEX: M | AGE (YR./MOS.): 042/..

ACCOUNT

603-347-8765

DATE OF COLLECTION	DATE ENTERED	DATE REPORTED
06/04/..	06/05/..	06/06/..

TEST	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
... PLASMA		121 H	ng/dL	65 - 415	B
LH	3.6		mIU/mL		B
			Male		
			20 - 70 years	1.5 - 9.3	
			>70 years	3.1 - 34.6	
			Children	<6.0	
Prolactin	10.3		ng/mL	2.1 - 17.7	B

LAB: BN LABCORP HOLDINGS DIRECTOR: FRANK HANCOCK MD DIR
1447 YORK COURT BURLINGTON, NC 27215-2230

FRANK HANCOCK MD DIR
FOR INQUIRIES, THE PHYSICIAN MAY CONTACT THE MEDICAL DIRECTOR AT:
BRANCH: 603-673-0657 LAB: 800-762-4344
LAST PAGE OF REPORT

G0235

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PATIENT'S NAME: Gilbert Chavis AGE: 42 DATE: May 29, 1997

HISTORY OF UROLOGIC ILLNESS: 42 y/o WM c̄ c/o erectile dysfunction noted several months ago. Has progressively worsened.

Referring M.D. Wilkens. A. Williams

****

UROLOGIC HISTORY:

Ø	Infection
	Stones
	Hematuria
	Nocturia
	Frequency
	Urgency
	Force of stream
	Post void dribbling
	Incontinence
	Dysuria
	Incomplete emptying

MEDICAL HISTORY:

Cardiac
Pulmonary
Digestive
Gynecologic

lumbar back strain (Apr 96)
NIDDM -

SURGICAL HISTORY:

Excision growth age 13
Tracheostomy 10 months (2° to strangulation).

Ø Smoke

****

ALLERGIES:

NKDA

MEDICATIONS:

glipizide 5 mg -

****

EXAMINATION:

GEN: WNWD wm in NAD.

HEENT: Nml.

CV:

PULM:

ABD:

EXT: Nml.

NEURO: good rectal tone.

GENITO-URINARY: Testes nml bilat - Nml penis. DRE: Nml prostate.

****

IMPRESSION:

Erectile dysfunction.
No evidence of lumbar etiology.

PLAN: ① ✓ Testosterone

② Consider confidence [illegible] if Testosterone is nml.

URINE:
Leuko: —
Nitrite: —
Urobil: 4
Protein: tr
pH: 5
Blood: —
Sp. Gravity: 1.015
Ketones: —
Glucose: 250

MICRO:

[signature]

COASTAL UROLOGY CENTER

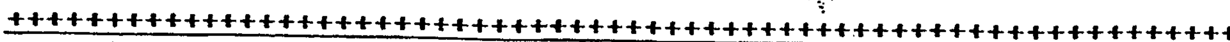
PROGRESS NOTE

	URINALYSIS	
June 4, 1997 LH, Prolactin drawn		
6.10.97 Pt informed of Test results & confidence	Leuko:	Micro
ring suggested – per Dr Jawitt – L Meyer	Nitrite:	
	Urobili:	
	Protein:	
	pH:	
	Blood:	
	Sp.Grav:	
	Ketones:	
	Bilirub:	
	Glucose:	

June 13, 1997 C/R

JUN 20 1997 no show

	Leuko:	Micro
	Nitrite:	
	Urobili:	
	Protein:	
	pH:	
	Blood:	
	Sp.Grav:	
	Ketones:	
	Bilirub:	
	Glucose:	



F 20

#1

is correct

NO.446 P.2/11

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

File

WCC File #
Carrier File # C510-192314
Carrier Code # 55-4
Employer FEIN

Gilbert Chavis — Claimant's Name
248-04-2224 — SSN
AVX. — Employer's Name
616 McKinley Way Conway S.C. 29526 — Address, City, State, Zip
P.O. Box 867 M.B. S.C. 29578 — Address, City, State, Zip
(843) 347-0812 — Home Phone #
843-448-9411 — Work Phone #
Liberty Mutual Ins — Insurance Carrier
Cheryl A. Keel — Preparer's Name
(843) 946-0240 — Phone #

Total Wages Paid

Check Applicable Method:

Date of Injury: 12/1/98 (month day year)

- [x] Report of earnings of injured employee based on four completed quarters.
- [ ] Report of earnings of injured employee who did not complete four quarters based on actual time worked.
- [ ] Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: 12-3-87
- [ ] Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)

List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	12-22-97	$6412.56
2nd	3-22-98	$4978.07
3rd	6-21-98	$5067.61
4th	9-20-98	$3317.15

Total Paid 2. $19776.39

List total value of other allowances of any character made in lieu of wages during four quarters above. 3. -

Add lines 2 and 3. TOTAL WAGES PAID: 4. $19775.39

5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 50

Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

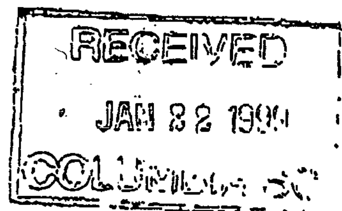
AVERAGE WEEKLY WAGE: 6. $395.51

Compensation Rate

The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667.
Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $263.69

The compensation rate is as follows (choose one):

- [ ] When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
- [ ] When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
- [ ] When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
- [ ] Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8: ______
- [x] The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.



WEEKLY COMPENSATION RATE: 8. $263.69

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See 1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. IF THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

TO: WCC 8/3/99 mw

WCC FORM # 20 REV. DATE 3/97
CSF-17 R1

20

STATEMENT OF INJURE

F20

#5

is correct.

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

WCC File # ______
Carrier File # ______
Carrier Code # ______
Employer FEIN ______

Claimant's Name: Gilbert Chavis
SSN: 249-04-2224
Employer's Name: AVX Corporation
Address: 616 McKinley Way City: Conway State: SC Zip: 2902[illegible]
Address: P.O. Box 867 City: M.B. State: S.C. Zip: 29578
Home Phone #: 843-347-0812 Work Phone #: 448-9411
Insurance Carrier: Liberty Mutual
Preparer's Name: Cheryl Keel
Phone #: 843-946-0240 CORRECTED COPY

A. Total Wages Paid

Date of injury: 12 - 27 - 99 (month day year)

1. Check Applicable Method:
   - [x] Report of earnings of injured employee based on four completed quarters.
   - [ ] Report of earnings of injured employee who did not complete four quarters based on actual time worked.
   - [ ] Report of earnings of similar employee. Injured employee did not work sufficient time before alleged injury. Hire Date: ______
   - [ ] Report of earnings of injured employee based on alternative method because Form 20 results in a compensation rate that is not fair and just. (Attach documentation to show how average weekly wage and compensation rate were calculated.)

2. List total wages paid as reported to Employment Security Commission on the Employer Quarterly Contribution and Wage Reports during the four quarters immediately preceding the quarter in which the injury occurred. Do not include the quarter during which the injury occurred.

Quarter	Ending Date	Total Wages Paid
1st	12-26-98	$3903.46
2nd	3-21-99	$6028.61
3rd	6-20-99	$7177.20
4th	9-19-99	$3502.18

Total Paid 2. $20611.45

3. List total value of other allowances of any character made in lieu of wages during four quarters above. 3. –
4. Add lines 2 and 3. TOTAL WAGES PAID: 4. $20611.45
5. List total number of weeks paid to employee during the four quarters immediately preceding the quarter in which the injury occurred. 5. 47

B. Average Weekly Wage

6. To calculate average weekly wage, divide total wages (line 4) by total weeks paid (line 5).

AVERAGE WEEKLY WAGE: 6. $438.54

C. Compensation Rate

7. The general rule for calculating the compensation rate is to multiply average weekly wage (line 6) by .6667. Estimate compensation rate by multiplying average weekly wage (line 6) by .6667. See part 8 below to determine the actual compensation rate. 7. $292.37

8. The compensation rate is as follows (choose one):
   - [ ] When average weekly wage (line 6) is less than $75.00, the compensation rate is the average weekly wage. Enter average weekly wage on line 8.
   - [ ] When the estimated compensation rate (line 7) is less than $75.00 and average weekly wage (line 6) is more than $75.00, the compensation rate is $75.00. Enter $75.00 on line 8.
   - [ ] When the estimated compensation rate (line 7) is more than the maximum compensation rate for the year in which the injury occurred, enter the maximum compensation rate for the year in which the injury occurred on line 8.
   - [ ] Employee is within the exceptions listed in S.C. Code Ann. Section 42-7-65. List applicable exception here and enter appropriate compensation rate on line 8: ______
   - [x] The calculated compensation rate (line 7) applies. Enter amount from line 7 on line 8.

WEEKLY COMPENSATION RATE: 8. $292.37

Employer's representative shall prepare a Form 20 and serve per R.67-211 a copy on the claimant within thirty days of beginning temporary compensation. See R.67-1603 when no temporary compensation is paid. NOTE: Average weekly wage represents average gross pay before taxes and other deductions. WHEN THE CLAIMANT DOES NOT AGREE WITH THE COMPENSATION RATE ON LINE 8, HE OR SHE SHOULD CONTACT THE EMPLOYER'S REPRESENTATIVE TO TRY TO REACH AN AGREEMENT AS TO THE COMPENSATION RATE. IF NO AGREEMENT CAN BE REACHED THE CLAIMANT SHOULD CONTACT THE CLAIMS DEPARTMENT AT (803)737-5723.

WCC FORM # 20 REV. DATE 3/97
39-CSF-17 R1

20

STATEMENT OF EARNINGS OF

387

AVX CORPORATION - MYRTLE BEACH,S.C.

TIME = 15.14.51
W E E K L Y EARNING HISTORY REPORT RHR717-1
RUN DATE = 20020514

AXMF 0248042224 CHAVIS, GILBERT R. WK

L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES: FEDERAL	TAXES: STATE	TAXES: CITY / COUNTY	DED/NET/CK AMT
METL 2929	16.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	9.69 TOTDED
M1 C-1	.00 OT	.00 OT	9.70 FIC	.00 SDI	.00 CTY	134.82 NETPAY
785470	.00 OTH	156.48 OTH	2.27 MED	.00 SUI	.00	134.82 CK AMT
1996/12/29	16.00 TOT	156.48 TOT	11.97 TOT	.00 TOT	.00 TOT	9.78 RATE
METL 2929	32.00 REG	156.48 REG	.00 FED	2.46 STA	.00 CNT	14.39 TOTDED
M1 C-1	.00 OT	.00 OT	19.41 FIC	.00 SDI	.00 CTY	272.16 NETPAY
787042	.00 OTH	156.48 OTH	4.54 MED	.00 SUI	.00	272.16 CK AMT
1997/01/05	32.00 TOT	312.96 TOT	23.95 TOT	2.46 TOT	.00 TOT	9.78 RATE
METL 2929	32.00 REG	312.96 REG	.00 FED	2.46 STA	.00 CNT	14.39 TOTDED
M1 C-1	.00 OT	.00 OT	19.40 FIC	.00 SDI	.00 CTY	272.18 NETPAY
788708	.00 OTH	.00 OTH	4.53 MED	.00 SUI	.00	272.18 CK AMT
1997/01/12	32.00 TOT	312.96 TOT	23.93 TOT	2.46 TOT	.00 TOT	9.78 RATE
METL 2929	36.98 REG	361.66 REG	34.01 FED	18.78 STA	.00 CNT	25.18 TOTDED
M1 C-1	.00 OT	.00 OT	22.42 FIC	.00 SDI	.00 CTY	256.02 NETPAY
790184	.00 OTH	.00 OTH	5.25 MED	.00 SUI	.00	256.02 CK AMT
1997/01/19	36.98 TOT	361.66 TOT	61.68 TOT	18.78 TOT	.00 TOT	9.78 RATE
METL 2929	42.50 REG	415.65 REG	49.34 FED	25.94 STA	.00 CNT	28.34 TOTDED
M1 C-1	5.25 OT	51.35 OT	28.96 FIC	.00 SDI	.00 CTY	327.65 NETPAY
791636	.00 OTH	.00 OTH	6.77 MED	.00 SUI	.00	327.65 CK AMT
1997/01/26	47.75 TOT	467.00 TOT	85.07 TOT	25.94 TOT	.00 TOT	9.78 RATE
METL 2929	54.93 REG	537.22 REG	74.45 FED	37.65 STA	.00 CNT	33.52 TOTDED
M1 C-1	14.93 OT	102.35 OT	39.65 FIC	.00 SDI	.00 CTY	445.03 NETPAY
793488	.00 OTH	.00 OTH	9.27 MED	.00 SUI	.00	445.03 CK AMT
1997/02/02	69.86 TOT	639.57 TOT	123.37 TOT	37.65 TOT	.00 TOT	9.78 RATE
METL 2929	39.47 REG	386.01 REG	37.55 FED	20.44 STA	.00 CNT	25.91 TOTDED
M1 C-1	.00 OT	.00 OT	23.93 FIC	.00 SDI	.00 CTY	272.58 NETPAY
802840	.00 OTH	.00 OTH	5.60 MED	.00 SUI	.00	272.58 CK AMT
1997/02/09	39.47 TOT	386.01 TOT	67.08 TOT	20.44 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	38.31 FED	20.79 STA	.00 CNT	26.07 TOTDED
M1 C-1	.00 OT	.00 OT	24.26 FIC	.00 SDI	.00 CTY	276.10 NETPAY
804324	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	276.10 CK AMT
1997/02/16	40.00 TOT	391.20 TOT	68.24 TOT	20.79 TOT	.00 TOT	9.78 RATE
METL 2929	32.00 REG	312.97 REG	14.96 FED	5.97 STA	.00 CNT	23.72 TOTDED
M1 C-1	.00 OT	.00 OT	19.40 FIC	.00 SDI	.00 CTY	244.38 NETPAY
805974	.00 OTH	.00 OTH	4.54 MED	.00 SUI	.00	244.38 CK AMT
1997/02/23	32.00 TOT	312.97 TOT	38.90 TOT	5.97 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	26.07 TOTDED
M1 C-1	.00 OT	.00 OT	24.25 FIC	.00 SDI	.00 CTY	298.41 NETPAY
807445	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	298.41 CK AMT
1997/03/02	40.00 TOT	391.20 TOT	56.26 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	26.07 TOTDED
M1 C-1	.00 OT	.00 OT	24.26 FIC	.00 SDI	.00 CTY	298.39 NETPAY
809082	.00 OTH	.00 OTH	5.68 MED	.00 SUI	.00	298.39 CK AMT
1997/03/09	40.00 TOT	391.20 TOT	56.28 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	51.25 REG	501.24 REG	54.80 FED	23.54 STA	.00 CNT	81.93 TOTDED
M1 C-1	11.25 OT	85.58 OT	36.38 FIC	.00 SDI	.00 CTY	381.66 NETPAY
810550	.00 OTH	.00 OTH	8.51 MED	.00 SUI	.00	381.66 CK AMT
1997/03/16	62.50 TOT	586.82 TOT	99.69 TOT	23.54 TOT	.00 TOT	9.78 RATE
METL 2929	44.50 REG	435.22 REG	42.89 FED	17.98 STA	.00 CNT	65.15 TOTDED
M1 C-1	4.50 OT	22.00 OT	31.31 FIC	.00 SDI	.00 CTY	340.30 NETPAY
811979	.00 OTH	47.73 OTH	7.32 MED	.00 SUI	.00	340.30 CK AMT
1997/03/23	49.00 TOT	504.95 TOT	81.52 TOT	17.98 TOT	.00 TOT	9.78 RATE
METL 2929	32.00 REG	234.72 REG	14.95 FED	5.96 STA	.00 CNT	73.72 TOTDED

714

AVX CORPORATION - MYRTLE BEACH,S.C.

TIME = 15.14.51
W E E K L Y EARNING HISTORY REPORT RHR717-1
RUN DATE = 20020514

AXMF 0248042224 CHAVIS, GILBERT R. WK

L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES: FEDERAL	TAXES: STATE	TAXES: CITY / COUNTY	DED/NET/CK AMT
M1 C-1	.00 OT	.00 OT	19.40 FIC	.00 SDI	.00 CTY	194.39 NETPAY
813687	.00 OTH	78.24 OTH	4.54 MED	.00 SUI	.00	194.39 CK AMT
1997/03/30	32.00 TOT	312.96 TOT	38.89 TOT	5.96 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.93 FIC	.00 SDI	.00 CTY	248.40 NETPAY
815318	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	248.40 CK AMT
1997/04/06	40.00 TOT	391.20 TOT	61.94 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.92 FIC	.00 SDI	.00 CTY	248.41 NETPAY
816752	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	248.41 CK AMT
1997/04/13	40.00 TOT	391.20 TOT	61.93 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.93 FIC	.00 SDI	.00 CTY	248.40 NETPAY
817920	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	248.40 CK AMT
1997/04/20	40.00 TOT	391.20 TOT	61.94 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	22.58 REG	220.83 REG	1.55 FED	2.17 STA	.00 CNT	70.95 TOTDED
M1 C-1	.00 OT	.00 OT	16.89 FIC	.00 SDI	.00 CTY	129.27 NETPAY
819506	.00 OTH	.00 OTH	3.20 MED	.00 SUI	.00	129.27 CK AMT
1997/04/27	22.58 TOT	220.83 TOT	21.64 TOT	2.17 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.93 FIC	.00 SDI	.00 CTY	248.40 NETPAY
821083	.00 OTH	.00 OTH	5.68 MED	.00 SUI	.00	248.40 CK AMT
1997/05/04	40.00 TOT	391.20 TOT	61.95 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	33.00 REG	322.74 REG	16.38 FED	6.48 STA	.00 CNT	74.01 TOTDED
M1 C-1	.00 OT	.00 OT	24.69 FIC	.00 SDI	.00 CTY	201.18 NETPAY
822676	.00 OTH	.00 OTH	4.68 MED	.00 SUI	.00	201.18 CK AMT
1997/05/11	33.00 TOT	322.74 TOT	45.75 TOT	6.48 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	30.61 FED	12.25 STA	.00 CNT	76.95 TOTDED
M1 C-1	.00 OT	.00 OT	32.16 FIC	.00 SDI	.00 CTY	268.57 NETPAY
824275	.00 OTH	29.34 OTH	6.09 MED	.00 SUI	.00	268.57 CK AMT
1997/05/18	40.00 TOT	420.54 TOT	68.86 TOT	12.25 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.94 FIC	.00 SDI	.00 CTY	248.39 NETPAY
826015	.00 OTH	.00 OTH	5.68 MED	.00 SUI	.00	248.39 CK AMT
1997/05/25	40.00 TOT	391.20 TOT	61.96 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	46.67 REG	378.19 REG	40.58 FED	16.90 STA	.00 CNT	79.00 TOTDED
M1 C-1	6.67 OT	32.62 OT	37.41 FIC	.00 SDI	.00 CTY	315.16 NETPAY
827887	.00 OTH	78.24 OTH	7.09 MED	.00 SUI	.00	315.16 CK AMT
1997/06/01	53.34 TOT	489.05 TOT	85.08 TOT	16.90 TOT	.00 TOT	9.78 RATE
METL 2929	.00 REG	.00 REG	25.74 FED	10.49 STA	.00 CNT	17.92 TOTDED
M1 C-1	.00 OT	.00 OT	45.69 FIC	.00 SDI	.00 CTY	497.43 NETPAY
829426	.00 OTH	597.27 OTH	8.66 MED	.00 SUI	.00	497.43 CK AMT
1997/06/01	.00 TOT	597.27 TOT	80.09 TOT	10.49 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.93 FIC	.00 SDI	.00 CTY	248.40 NETPAY
830883	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	248.40 CK AMT
1997/06/08	40.00 TOT	391.20 TOT	61.94 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	38.00 REG	371.64 REG	23.49 FED	9.26 STA	.00 CNT	75.48 TOTDED
M1 C-1	.00 OT	.00 OT	28.43 FIC	.00 SDI	.00 CTY	234.98 NETPAY
832329	.00 OTH	.00 OTH	5.39 MED	.00 SUI	.00	234.98 CK AMT
1997/06/15	38.00 TOT	371.64 TOT	57.31 TOT	9.26 TOT	.00 TOT	9.78 RATE
METL 2929	46.00 REG	449.89 REG	39.15 FED	16.23 STA	.00 CNT	64.38 TOTDED
M1 C-1	6.00 OT	29.34 OT	36.66 FIC	.00 SDI	.00 CTY	322.81 NETPAY

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L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
833922	.00 OTH	.00 OTH	6.95 MED	.00 SUI	.00	322.81 CK AMT
1997/06/22	52.00 TOT	479.23 TOT	82.76 TOT	16.23 TOT	.00 TOT	9.78 RATE
METL 2929	57.75 REG	564.80 REG	69.11 FED	29.93 STA	.00 CNT	84.76 TOTDED
M1 C-1	17.75 OT	116.14 OT	52.09 FIC	.00 SDI	.00 CTY	445.05 NETPAY
835383	.00 OTH	.00 OTH	9.87 MED	.00 SUI	.00	445.05 CK AMT
1997/06/29	75.50 TOT	680.94 TOT	131.07 TOT	29.93 TOT	.00 TOT	9.78 RATE
METL 2929	47.50 REG	386.31 REG	46.26 FED	19.55 STA	.00 CNT	80.17 TOTDED
M1 C-1	7.50 OT	63.57 OT	40.40 FIC	.00 SDI	.00 CTY	341.74 NETPAY
836986	.00 OTH	78.24 OTH	7.66 MED	.00 SUI	.00	341.74 CK AMT
1997/07/06	55.00 TOT	528.12 TOT	94.32 TOT	19.55 TOT	.00 TOT	9.78 RATE
METL 2929	43.02 REG	420.74 REG	51.27 FED	21.89 STA	.00 CNT	81.21 TOTDED
M1 C-1	8.00 OT	68.46 OT	43.04 FIC	.00 SDI	.00 CTY	365.14 NETPAY
838426	.00 OTH	73.35 OTH	8.16 MED	.00 SUI	.00	365.14 CK AMT
1997/07/13	51.02 TOT	562.55 TOT	102.47 TOT	21.89 TOT	.00 TOT	9.78 RATE
METL 2929	64.25 REG	628.37 REG	95.01 FED	36.40 STA	.00 CNT	87.62 TOTDED
M1 C-1	24.25 OT	147.93 OT	59.38 FIC	.00 SDI	.00 CTY	497.89 NETPAY
839874	.00 OTH	.00 OTH	11.25 MED	.00 SUI	.00	497.89 CK AMT
1997/07/20	88.50 TOT	776.30 TOT	165.64 TOT	36.40 TOT	.00 TOT	9.78 RATE
METL 2929	51.02 REG	498.99 REG	55.55 FED	23.89 STA	.00 CNT	82.09 TOTDED
M1 C-1	12.77 OT	93.01 OT	45.29 FIC	.00 SDI	.00 CTY	385.18 NETPAY
841472	.00 OTH	.00 OTH	8.59 MED	.00 SUI	.00	385.18 CK AMT
1997/07/27	63.79 TOT	592.00 TOT	109.43 TOT	23.89 TOT	.00 TOT	9.78 RATE
METL 2929	63.23 REG	618.39 REG	90.95 FED	35.39 STA	.00 CNT	87.17 TOTDED
M1 C-1	23.23 OT	142.94 OT	58.25 FIC	.00 SDI	.00 CTY	489.57 NETPAY
842932	.00 OTH	.00 OTH	11.04 MED	.00 SUI	.00	489.57 CK AMT
1997/08/03	86.46 TOT	761.33 TOT	160.24 TOT	35.39 TOT	.00 TOT	9.78 RATE
METL 2929	59.50 REG	581.92 REG	76.08 FED	31.67 STA	.00 CNT	85.53 TOTDED
M1 C-1	19.50 OT	124.69 OT	54.05 FIC	.00 SDI	.00 CTY	459.28 NETPAY
844550	.00 OTH	.00 OTH	10.24 MED	.00 SUI	.00	459.28 CK AMT
1997/08/10	79.00 TOT	706.61 TOT	140.37 TOT	31.67 TOT	.00 TOT	9.78 RATE
METL 2929	46.25 REG	452.33 REG	39.68 FED	16.48 STA	.00 CNT	78.82 TOTDED
M1 C-1	6.25 OT	30.57 OT	36.94 FIC	.00 SDI	.00 CTY	310.98 NETPAY
845993	.00 OTH	.00 OTH	7.00 MED	.00 SUI	.00	310.98 CK AMT
1997/08/17	52.50 TOT	482.90 TOT	83.62 TOT	16.48 TOT	.00 TOT	9.78 RATE
METL 2929	42.33 REG	414.00 REG	33.78 FED	13.73 STA	.00 CNT	77.60 TOTDED
M1 C-1	5.80 OT	28.36 OT	33.84 FIC	.00 SDI	.00 CTY	283.41 NETPAY
847592	.00 OTH	.00 OTH	6.42 MED	.00 SUI	.00	283.41 CK AMT
1997/08/24	48.13 TOT	442.36 TOT	74.04 TOT	13.73 TOT	.00 TOT	9.78 RATE
METL 2929	50.30 REG	491.94 REG	48.32 FED	20.51 STA	.00 CNT	80.60 TOTDED
M1 C-1	10.30 OT	50.36 OT	41.48 FIC	.00 SDI	.00 CTY	351.39 NETPAY
849060	.00 OTH	.00 OTH	7.86 MED	.00 SUI	.00	351.39 CK AMT
1997/08/31	60.60 TOT	542.30 TOT	97.66 TOT	20.51 TOT	.00 TOT	9.78 RATE
METL 2929	43.75 REG	349.64 REG	34.34 FED	13.99 STA	.00 CNT	77.72 TOTDED
M1 C-1	3.75 OT	18.34 OT	34.14 FIC	.00 SDI	.00 CTY	286.03 NETPAY
850703	.00 OTH	78.24 OTH	6.47 MED	.00 SUI	.00	286.03 CK AMT
1997/09/07	47.50 TOT	446.22 TOT	74.95 TOT	13.99 TOT	.00 TOT	9.78 RATE
METL 2929	51.52 REG	503.87 REG	55.38 FED	23.81 STA	.00 CNT	82.05 TOTDED
M1 C-1	11.52 OT	86.91 OT	45.20 FIC	.00 SDI	.00 CTY	384.34 NETPAY
852180	.00 OTH	.00 OTH	8.57 MED	.00 SUI	.00	384.34 CK AMT
1997/09/14	63.04 TOT	590.78 TOT	109.15 TOT	23.81 TOT	.00 TOT	9.78 RATE
METL 2929	60.25 REG	589.25 REG	79.07 FED	32.42 STA	.00 CNT	71.53 TOTDED
M1 C-1	20.25 OT	128.36 OT	54.89 FIC	.00 SDI	.00 CTY	479.70 NETPAY
853823	.00 OTH	.00 OTH	10.40 MED	.00 SUI	.00	479.70 CK AMT

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1997/09/21	80.50 TOT	717.61 TOT	144.36 TOT	32.42 TOT	.00 TOT	9.78 RATE
METL 2929	49.00 REG	479.22 REG	51.24 FED	21.88 STA	.00 CNT	81.20 TOTDED
M1 C-1	13.00 OT	83.13 OT	43.03 FIC	.00 SDI	.00 CTY	365.00 NETPAY
855305	.00 OTH	.00 OTH	8.16 MED	.00 SUI	.00	365.00 CK AMT
1997/09/28	62.00 TOT	562.35 TOT	102.43 TOT	21.88 TOT	.00 TOT	9.78 RATE
METL 2929	55.18 REG	539.67 REG	58.74 FED	25.38 STA	.00 CNT	82.75 TOTDED
M1 C-1	15.18 OT	74.24 OT	46.96 FIC	.00 SDI	.00 CTY	400.08 NETPAY
856947	.00 OTH	.00 OTH	8.90 MED	.00 SUI	.00	400.08 CK AMT
1997/10/05	70.36 TOT	613.91 TOT	114.60 TOT	25.38 TOT	.00 TOT	9.78 RATE
METL 2929	64.00 REG	625.93 REG	93.35 FED	35.99 STA	.00 CNT	87.44 TOTDED
M1 C-1	24.00 OT	144.27 OT	58.92 FIC	.00 SDI	.00 CTY	494.50 NETPAY
858434	.00 OTH	.00 OTH	11.17 MED	.00 SUI	.00	494.50 CK AMT
1997/10/12	88.00 TOT	770.20 TOT	163.44 TOT	35.99 TOT	.00 TOT	9.78 RATE
METL 2929	54.68 REG	534.77 REG	61.94 FED	26.87 STA	.00 CNT	83.61 TOTDED
M1 C-1	14.68 OT	101.12 OT	48.65 FIC	.00 SDI	.00 CTY	415.02 NETPAY
859935	.00 OTH	.00 OTH	9.22 MED	.00 SUI	.00	415.02 CK AMT
1997/10/19	69.36 TOT	635.89 TOT	119.81 TOT	26.87 TOT	.00 TOT	9.78 RATE
METL 2929	50.02 REG	489.21 REG	47.73 FED	20.24 STA	.00 CNT	80.48 TOTDED
M1 C-1	10.02 OT	49.01 OT	41.17 FIC	.00 SDI	.00 CTY	348.60 NETPAY
861616	.00 OTH	.00 OTH	7.80 MED	.00 SUI	.00	348.60 CK AMT
1997/10/26	60.04 TOT	538.22 TOT	96.70 TOT	20.24 TOT	.00 TOT	9.78 RATE
METL 2929	48.25 REG	471.89 REG	43.95 FED	18.47 STA	.00 CNT	79.70 TOTDED
M1 C-1	8.25 OT	40.34 OT	39.18 FIC	.00 SDI	.00 CTY	330.93 NETPAY
863097	.00 OTH	.00 OTH	7.43 MED	.00 SUI	.00	330.93 CK AMT
1997/11/02	56.50 TOT	512.23 TOT	90.56 TOT	18.47 TOT	.00 TOT	9.78 RATE
METL 2929	48.02 REG	469.64 REG	44.15 FED	18.57 STA	.00 CNT	79.74 TOTDED
M1 C-1	9.00 OT	44.01 OT	39.30 FIC	.00 SDI	.00 CTY	331.89 NETPAY
864799	.00 OTH	.00 OTH	7.45 MED	.00 SUI	.00	331.89 CK AMT
1997/11/09	57.02 TOT	513.65 TOT	90.90 TOT	18.57 TOT	.00 TOT	9.78 RATE
METL 2929	39.60 REG	387.29 REG	25.77 FED	10.22 STA	.00 CNT	75.95 TOTDED
M1 C-1	.00 OT	.00 OT	29.62 FIC	.00 SDI	.00 CTY	245.73 NETPAY
866360	.00 OTH	.00 OTH	5.61 MED	.00 SUI	.00	245.73 CK AMT
1997/11/16	39.60 TOT	387.29 TOT	61.00 TOT	10.22 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.94 FIC	.00 SDI	.00 CTY	248.39 NETPAY
868069	.00 OTH	.00 OTH	5.68 MED	.00 SUI	.00	248.39 CK AMT
1997/11/23	40.00 TOT	391.20 TOT	61.96 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	234.72 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.92 FIC	.00 SDI	.00 CTY	248.41 NETPAY
869621	.00 OTH	156.48 OTH	5.67 MED	.00 SUI	.00	248.41 CK AMT
1997/11/30	40.00 TOT	391.20 TOT	61.93 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	40.00 REG	391.20 REG	26.34 FED	10.46 STA	.00 CNT	76.07 TOTDED
M1 C-1	.00 OT	.00 OT	29.93 FIC	.00 SDI	.00 CTY	248.40 NETPAY
871358	.00 OTH	.00 OTH	5.67 MED	.00 SUI	.00	248.40 CK AMT
1997/12/07	40.00 TOT	391.20 TOT	61.94 TOT	10.46 TOT	.00 TOT	9.78 RATE
METL 2929	37.65 REG	382.90 REG	25.13 FED	9.95 STA	.00 CNT	75.82 TOTDED
M1 C-1	.00 OT	.00 OT	29.29 FIC	.00 SDI	.00 CTY	242.71 NETPAY
873087	.00 OTH	.00 OTH	5.55 MED	.00 SUI	.00	242.71 CK AMT
1997/12/14	37.65 TOT	382.90 TOT	59.97 TOT	9.95 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	322.32 REG	16.32 FED	6.46 STA	.00 CNT	59.67 TOTDED
M1 C-1	.00 OT	.00 OT	24.66 FIC	.00 SDI	.00 CTY	215.21 NETPAY
874643	.00 OTH	.00 OTH	4.68 MED	.00 SUI	.00	215.21 CK AMT
1997/12/21	32.00 TOT	322.32 TOT	45.66 TOT	6.46 TOT	.00 TOT	10.17 RATE

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METL 2929	16.00	REG	.00	REG	.00	FED	.64	STA	.00	CNT	69.21	TOTDED
M1 C-1	.00	OT	.00	OT	12.45	FIC	.00	SDI	.00	CTY	80.42	NETPAY
876174	.00	OTH	162.72	OTH	2.36	MED	.00	SUI	.00		80.42	CK AMT
1997/12/28	16.00	TOT	162.72	TOT	14.81	TOT	.64	TOT	.00	TOT	10.17	RATE

	HOURS	EARNINGS	FEDERAL	STATE	CITY / COUNTY	DED/NET/CK AMT
	2,294.95	21,529.93	2,071.62	885.14	.00	3,529.71
	313.60	1,959.00	1,846.25	.00	.00	16,768.86
	.00	1,692.81	365.14	.00	.00	16,768.86
	2,608.55	25,181.74	4,283.01	885.14	.00	529.29

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METL 2929	16.00 REG	.00 REG	.00 FED	.15 STA	.00 CNT	69.21 TOTDED
M1 C-1	.00 OT	.00 OT	12.29 FIC	.00 SDI	.00 CTY	81.07 NETPAY
877619	.00 OTH	162.72 OTH	2.33 MED	.00 SUI	.00	81.07 CK AMT
1998/01/04	16.00 TOT	162.72 TOT	14.62 TOT	.15 TOT	.00 TOT	10.17 RATE
METL 2929	46.67 REG	459.96 REG	40.79 FED	15.09 STA	.00 CNT	79.20 TOTDED
M1 C-1	7.00 OT	35.60 OT	37.77 FIC	.00 SDI	.00 CTY	322.71 NETPAY
879328	.00 OTH	.00 OTH	7.16 MED	.00 SUI	.00	322.71 CK AMT
1998/01/11	53.67 TOT	495.56 TOT	85.72 TOT	15.09 TOT	.00 TOT	10.17 RATE
METL 2929	42.00 REG	427.15 REG	35.21 FED	12.75 STA	.00 CNT	77.98 TOTDED
M1 C-1	5.50 OT	27.97 OT	34.81 FIC	.00 SDI	.00 CTY	294.37 NETPAY
880865	.00 OTH	.00 OTH	6.60 MED	.00 SUI	.00	294.37 CK AMT
1998/01/18	47.50 TOT	455.12 TOT	76.62 TOT	12.75 TOT	.00 TOT	10.17 RATE
METL 2929	39.00 REG	396.64 REG	31.88 FED	11.35 STA	.00 CNT	97.30 TOTDED
M1 C-1	7.00 OT	35.60 OT	33.06 FIC	.00 SDI	.00 CTY	258.65 NETPAY
882572	.00 OTH	.00 OTH	6.26 MED	.00 SUI	.00	258.65 CK AMT
1998/01/25	46.00 TOT	432.24 TOT	71.20 TOT	11.35 TOT	.00 TOT	10.17 RATE
METL 2929	39.00 REG	396.64 REG	31.88 FED	11.35 STA	.00 CNT	97.30 TOTDED
M1 C-1	7.00 OT	35.60 OT	33.38 FIC	.00 SDI	.00 CTY	258.33 NETPAY
884224	.00 OTH	.00 OTH	6.33 MED	.00 SUI	.00	258.33 CK AMT
1998/02/01	46.00 TOT	432.24 TOT	71.59 TOT	11.35 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	28.18 FED	9.80 STA	.00 CNT	96.53 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	241.17 NETPAY
885698	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	241.17 CK AMT
1998/02/08	40.00 TOT	406.80 TOT	65.20 TOT	9.80 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	16.34 FED	5.26 STA	.00 CNT	94.09 TOTDED
M1 C-1	.00 OT	.00 OT	24.90 FIC	.00 SDI	.00 CTY	184.85 NETPAY
887117	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	184.85 CK AMT
1998/02/15	32.00 TOT	325.44 TOT	45.96 TOT	5.26 TOT	.00 TOT	10.17 RATE
METL 2929	46.50 REG	472.91 REG	8.28 FED	6.73 STA	.00 CNT	99.51 TOTDED
M1 C-1	6.50 OT	33.06 OT	38.70 FIC	.00 SDI	.00 CTY	352.75 NETPAY
888673	.00 OTH	.00 OTH	7.33 MED	.00 SUI	.00	352.75 CK AMT
1998/02/22	53.00 TOT	505.97 TOT	54.31 TOT	6.73 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	.00 FED	.37 STA	.00 CNT	94.09 TOTDED
M1 C-1	.00 OT	.00 OT	24.89 FIC	.00 SDI	.00 CTY	206.09 NETPAY
890074	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	206.09 CK AMT
1998/03/01	32.00 TOT	325.44 TOT	29.61 TOT	.37 TOT	.00 TOT	10.17 RATE
METL 2929	43.50 REG	442.41 REG	1.62 FED	4.51 STA	.00 CNT	98.14 TOTDED
M1 C-1	3.50 OT	17.80 OT	35.22 FIC	.00 SDI	.00 CTY	320.72 NETPAY
891594	.00 OTH	.00 OTH	6.68 MED	.00 SUI	.00	320.72 CK AMT
1998/03/08	47.00 TOT	460.21 TOT	43.52 TOT	4.51 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.81 REG	.00 FED	2.43 STA	.00 CNT	96.53 TOTDED
M1 C-1	.00 OT	.00 OT	31.11 FIC	.00 SDI	.00 CTY	276.74 NETPAY
892952	.00 OTH	.00 OTH	5.89 MED	.00 SUI	.00	276.74 CK AMT
1998/03/15	40.00 TOT	406.81 TOT	37.00 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	82.20 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	291.05 NETPAY
894500	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	291.05 CK AMT
1998/03/22	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	.00 FED	.37 STA	.00 CNT	94.09 TOTDED
M1 C-1	.00 OT	.00 OT	24.90 FIC	.00 SDI	.00 CTY	206.08 NETPAY
895907	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	206.08 CK AMT
1998/03/29	32.00 TOT	325.44 TOT	29.62 TOT	.37 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	97.91 TOTDED

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M1 C-1 987400 1998/04/05	.00 OT .00 OTH 40.00 TOT	.00 OT .00 OTH 406.80 TOT	31.12 FIC 5.90 MED 37.02 TOT	.00 SDI .00 SUI 2.43 TOT	.00 CTY .00 .00 TOT	275.34 NETPAY 275.34 CK AMT 10.17 RATE
METL 2929 M1 C-1 988786 1998/04/12	40.00 REG .00 OT .00 OTH 40.00 TOT	325.44 REG .00 OT 81.36 OTH 406.80 TOT	.00 FED 31.12 FIC 5.90 MED 37.02 TOT	2.43 STA .00 SDI .00 SUI 2.43 TOT	.00 CNT .00 CTY .00 .00 TOT	97.91 TOTDED 275.34 NETPAY 275.34 CK AMT 10.17 RATE
METL 2929 M1 C-1 990335 1998/04/19	39.22 REG .00 OT .00 OTH 39.22 TOT	398.87 REG .00 OT .00 OTH 398.87 TOT	.00 FED 30.51 FIC 5.78 MED 36.29 TOT	2.15 STA .00 SDI .00 SUI 2.15 TOT	.00 CNT .00 CTY .00 .00 TOT	97.68 TOTDED 268.53 NETPAY 268.53 CK AMT 10.17 RATE
METL 2929 M1 C-1 991798 1998/04/26	36.02 REG .00 OT .00 OTH 36.02 TOT	366.32 REG .00 OT .00 OTH 366.32 TOT	.00 FED 28.02 FIC 5.31 MED 33.33 TOT	1.24 STA .00 SDI .00 SUI 1.24 TOT	.00 CNT .00 CTY .00 .00 TOT	46.70 TOTDED 290.36 NETPAY 290.36 CK AMT 10.17 RATE
METL 2929 M1 C-1 993066 1998/05/03	40.00 REG .00 OT .00 OTH 40.00 TOT	406.80 REG .00 OT .00 OTH 406.80 TOT	.00 FED 31.13 FIC 5.90 MED 37.03 TOT	2.43 STA .00 SDI .00 SUI 2.43 TOT	.00 CNT .00 CTY .00 .00 TOT	47.91 TOTDED 325.33 NETPAY 325.33 CK AMT 10.17 RATE
METL 2929 M1 C-1 994490 1998/05/10	38.48 REG .00 OT .00 OTH 38.48 TOT	391.34 REG .00 OT .00 OTH 391.34 TOT	.00 FED 29.94 FIC 5.68 MED 35.62 TOT	1.90 STA .00 SDI .00 SUI 1.90 TOT	.00 CNT .00 CTY .00 .00 TOT	27.45 TOTDED 332.05 NETPAY 332.05 CK AMT 10.17 RATE
METL 2929 M1 C-1 1998/05/17	.00 REG .00 OT .00 OTH .00 TOT	.00 REG .00 OT .00 OTH .00 TOT	.00 FED .00 FIC .00 MED .00 TOT	.00 STA .00 SDI .00 SUI .00 TOT	.00 CNT .00 CTY .00 .00 TOT	.00 TOTDED .00 NETPAY .00 CK AMT 10.17 RATE
METL 2929 M1 C-1 997321 1998/05/24	39.57 REG .00 OT .00 OTH 39.57 TOT	402.43 REG .00 OT .00 OTH 402.43 TOT	.00 FED 30.78 FIC 5.83 MED 36.61 TOT	2.28 STA .00 SDI .00 SUI 2.28 TOT	.00 CNT .00 CTY .00 .00 TOT	83.49 TOTDED 285.88 NETPAY 285.88 CK AMT 10.17 RATE
METL 2929 M1 C-1 999200 1998/05/31	32.00 REG .00 OT .00 OTH 32.00 TOT	325.44 REG .00 OT .00 OTH 325.44 TOT	.00 FED 24.90 FIC 4.72 MED 29.62 TOT	.37 STA .00 SDI .00 SUI .37 TOT	.00 CNT .00 CTY .00 .00 TOT	45.47 TOTDED 254.70 NETPAY 254.70 CK AMT 10.17 RATE
METL 2929 M1 C-1 1000330 1998/05/31	.00 REG .00 OT .00 OTH .00 TOT	.00 REG .00 OT 1,443.39 OTH 1,443.39 TOT	14.00 FED 110.42 FIC 20.93 MED 145.35 TOT	16.29 STA .00 SDI .00 SUI 16.29 TOT	.00 CNT .00 CTY .00 .00 TOT	43.30 TOTDED 1,259.38 NETPAY 1,259.38 CK AMT 10.17 RATE
METL 2929 M1 C-1 1001981 1998/06/07	46.00 REG 6.00 OT .00 OTH 52.00 TOT	467.82 REG 30.51 OT .00 OTH 498.33 TOT	7.17 FED 38.12 FIC 7.23 MED 52.52 TOT	6.33 STA .00 SDI .00 SUI 6.33 TOT	.00 CNT .00 CTY .00 .00 TOT	50.66 TOTDED 396.05 NETPAY 396.05 CK AMT 10.17 RATE
METL 2929 M1 C-1 1003245 1998/06/14	40.00 REG .00 OT .00 OTH 40.00 TOT	406.80 REG .00 OT .00 OTH 406.80 TOT	.00 FED 31.11 FIC 5.89 MED 37.00 TOT	2.43 STA .00 SDI .00 SUI 2.43 TOT	.00 CNT .00 CTY .00 .00 TOT	47.91 TOTDED 325.35 NETPAY 325.35 CK AMT 10.17 RATE
METL 2929 M1 C-1 1004655 1998/06/21	32.00 REG .00 OT .00 OTH 32.00 TOT	325.44 REG .00 OT .00 OTH 325.44 TOT	.00 FED 24.90 FIC 4.72 MED 29.62 TOT	.37 STA .00 SDI .00 SUI .37 TOT	.00 CNT .00 CTY .00 .00 TOT	29.76 TOTDED 270.41 NETPAY 270.41 CK AMT 10.17 RATE
METL 2929 M1 C-1	40.00 REG .00 OT	406.80 REG .00 OT	.00 FED 31.12 FIC	2.43 STA .00 SDI	.00 CNT .00 CTY	47.91 TOTDED 325.34 NETPAY

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L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
1005898	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	325.34 CK AMT
1998/06/28	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	8.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	38.15 TOTDED
M1 C-1	.00 OT	.00 OT	6.23 FIC	.00 SDI	.00 CTY	36.98 NETPAY
1007166	.00 OTH	81.36 OTH	1.18 MED	.00 SUI	.00	36.98 CK AMT
1998/07/05	8.00 TOT	81.36 TOT	7.41 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	47.91 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	325.34 NETPAY
1008571	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	325.34 CK AMT
1998/07/12	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	47.91 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	325.34 NETPAY
1009784	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	325.34 CK AMT
1998/07/19	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	.00 FED	.37 STA	.00 CNT	45.47 TOTDED
M1 C-1	.00 OT	.00 OT	24.90 FIC	.00 SDI	.00 CTY	254.70 NETPAY
1011148	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	254.70 CK AMT
1998/07/26	32.00 TOT	325.44 TOT	29.62 TOT	.37 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	47.91 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	325.34 NETPAY
1012343	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	325.34 CK AMT
1998/08/02	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	28.02 REG	284.96 REG	.00 FED	.00 STA	.00 CNT	44.26 TOTDED
M1 C-1	.00 OT	.00 OT	21.80 FIC	.00 SDI	.00 CTY	218.90 NETPAY
1013695	.00 OTH	.00 OTH	4.13 MED	.00 SUI	.00	218.90 CK AMT
1998/08/09	28.02 TOT	284.96 TOT	25.93 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	38.28 REG	389.31 REG	.00 FED	1.84 STA	.00 CNT	47.39 TOTDED
M1 C-1	.00 OT	.00 OT	29.77 FIC	.00 SDI	.00 CTY	310.31 NETPAY
1014895	.00 OTH	.00 OTH	5.64 MED	.00 SUI	.00	310.31 CK AMT
1998/08/16	38.28 TOT	389.31 TOT	35.41 TOT	1.84 TOT	.00 TOT	10.17 RATE
METL 2929	39.87 REG	405.48 REG	.00 FED	2.39 STA	.00 CNT	47.87 TOTDED
M1 C-1	.00 OT	.00 OT	31.02 FIC	.00 SDI	.00 CTY	324.20 NETPAY
1016237	.00 OTH	.00 OTH	5.88 MED	.00 SUI	.00	324.20 CK AMT
1998/08/23	39.87 TOT	405.48 TOT	36.90 TOT	2.39 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1998/08/30	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	12.00 REG	122.04 REG	.00 FED	.00 STA	.00 CNT	35.08 TOTDED
M1 C-1	.00 OT	.00 OT	9.34 FIC	.00 SDI	.00 CTY	77.62 NETPAY
1018754	.00 OTH	.00 OTH	1.77 MED	.00 SUI	.00	77.62 CK AMT
1998/09/06	12.00 TOT	122.04 TOT	11.11 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	8.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	5.44 TOTDED
M1 C-1	.00 OT	.00 OT	6.23 FIC	.00 SDI	.00 CTY	69.69 NETPAY
1019955	.00 OTH	81.36 OTH	1.18 MED	.00 SUI	.00	69.69 CK AMT
1998/09/13	8.00 TOT	81.36 TOT	7.41 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1998/09/20	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT

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L3 L4 L5 TYPE CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
1998/09/27	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1998/10/04	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1998/10/11	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-M	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1998/10/18	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.81 REG	.00 FED	2.43 STA	.00 CNT	21.20 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	352.06 NETPAY
1026037	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	352.06 CK AMT
1998/10/18	40.00 TOT	406.81 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	16.00 REG	162.72 REG	.00 FED	.00 STA	.00 CNT	9.88 TOTDED
M1 C-1	.00 OT	.00 OT	12.45 FIC	.00 SDI	.00 CTY	140.39 NETPAY
1027320	.00 OTH	.00 OTH	2.36 MED	.00 SUI	.00	140.39 CK AMT
1998/10/25	16.00 TOT	162.72 TOT	14.81 TOT	.00 TOT	.00 TOT	10.17 RATE
METL 2929	40.53 REG	412.19 REG	.00 FED	2.71 STA	.00 CNT	17.45 TOTDED
M1 C-1	.53 OT	2.70 OT	31.74 FIC	.00 SDI	.00 CTY	362.99 NETPAY
1028437	.00 OTH	.00 OTH	6.02 MED	.00 SUI	.00	362.99 CK AMT
1998/11/01	41.06 TOT	414.89 TOT	37.76 TOT	2.71 TOT	.00 TOT	10.17 RATE
METL 2929	36.02 REG	366.32 REG	.00 FED	1.24 STA	.00 CNT	15.99 TOTDED
M1 C-1	.00 OT	.00 OT	28.02 FIC	.00 SDI	.00 CTY	321.07 NETPAY
1029709	.00 OTH	.00 OTH	5.31 MED	.00 SUI	.00	321.07 CK AMT
1998/11/08	36.02 TOT	366.32 TOT	33.33 TOT	1.24 TOT	.00 TOT	10.17 RATE
METL 2929	38.00 REG	386.46 REG	.00 FED	1.77 STA	.00 CNT	16.59 TOTDED
M1 C-1	.00 OT	.00 OT	29.56 FIC	.00 SDI	.00 CTY	338.54 NETPAY
1030841	.00 OTH	.00 OTH	5.60 MED	.00 SUI	.00	338.54 CK AMT
1998/11/15	38.00 TOT	386.46 TOT	35.16 TOT	1.77 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	17.20 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	356.05 NETPAY
1032121	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	356.05 CK AMT
1998/11/22	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	46.25 REG	307.64 REG	7.72 FED	6.53 STA	.00 CNT	20.06 TOTDED
M1 C-1	6.25 OT	31.78 OT	38.42 FIC	.00 SDI	.00 CTY	429.41 NETPAY
1033289	.00 OTH	162.72 OTH	7.28 MED	.00 SUI	.00	429.41 CK AMT
1998/11/29	52.50 TOT	502.14 TOT	53.42 TOT	6.53 TOT	.00 TOT	10.17 RATE
METL 2929	40.00 REG	406.80 REG	.00 FED	2.43 STA	.00 CNT	17.20 TOTDED
M1 C-1	.00 OT	.00 OT	31.12 FIC	.00 SDI	.00 CTY	356.05 NETPAY
1034611	.00 OTH	.00 OTH	5.90 MED	.00 SUI	.00	356.05 CK AMT
1998/12/06	40.00 TOT	406.80 TOT	37.02 TOT	2.43 TOT	.00 TOT	10.17 RATE
METL 2929	37.00 REG	376.29 REG	.00 FED	1.50 STA	.00 CNT	16.29 TOTDED
M1 C-1	.00 OT	.00 OT	28.79 FIC	.00 SDI	.00 CTY	329.71 NETPAY
1035910	.00 OTH	.00 OTH	5.46 MED	.00 SUI	.00	329.71 CK AMT
1998/12/13	37.00 TOT	376.29 TOT	34.25 TOT	1.50 TOT	.00 TOT	10.17 RATE
METL 2929	30.63 REG	311.51 REG	.00 FED	.13 STA	.00 CNT	9.35 TOTDED
M1 C-1	.00 OT	.00 OT	23.82 FIC	.00 SDI	.00 CTY	278.21 NETPAY
1037059	.00 OTH	.00 OTH	4.51 MED	.00 SUI	.00	278.21 CK AMT
1998/12/20	30.63 TOT	311.51 TOT	28.33 TOT	.13 TOT	.00 TOT	10.17 RATE

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L3 L4 L5 TYPE CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
METL 2929 M1 C-1 1038237 1998/12/27	16.00 REG .00 OT .00 OTH 16.00 TOT	.00 REG .00 OT 162.72 OTH 162.72 TOT	.00 FED 12.45 FIC 2.36 MED 14.81 TOT	.00 STA .00 SDI .00 SUI .00 TOT	.00 CNT .00 CTY .00 .00 TOT	9.88 TOTDED 140.39 NETPAY 140.39 CK AMT 10.17 RATE
	1,618.56 49.28 .00 1,667.84	15,713.91 250.62 2,175.63 18,140.16	223.07 1,387.72 263.03 1,873.82	158.73 .00 .00 158.73	.00 .00 .00 .00	2,518.71 13,851.93 13,851.93 549.18

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L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES: FEDERAL	TAXES: STATE	TAXES: CITY / COUNTY	DED/NET/CK AMT
METL 2929	41.50 REG	259.34 REG	.00 FED	3.23 STA	.00 CNT	17.89 TOTDED
M1 C-1	1.50 OT	7.63 OT	32.87 FIC	.00 SDI	.00 CTY	375.70 NETPAY
1039404	.00 OTH	162.72 OTH	6.23 MED	.00 SUI	.00	375.70 CK AMT
1999/01/03	43.00 TOT	429.69 TOT	39.10 TOT	3.23 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	.00 FED	.37 STA	.00 CNT	14.76 TOTDED
M1 C-1	.00 OT	.00 OT	24.90 FIC	.00 SDI	.00 CTY	285.41 NETPAY
1040684	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	285.41 CK AMT
1999/01/10	32.00 TOT	325.44 TOT	29.62 TOT	.37 TOT	.00 TOT	10.17 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.59 STA	.00 CNT	37.50 TOTDED
M1 C-1	.00 OT	.00 OT	95.62 FIC	.00 SDI	.00 CTY	1,116.29 NETPAY
1041655	.00 OTH	1,250.00 OTH	18.12 MED	.00 SUI	.00	1,116.29 CK AMT
1999/01/10	.00 TOT	1,250.00 TOT	113.74 TOT	.59 TOT	.00 TOT	10.17 RATE
METL 2929	32.00 REG	325.44 REG	.00 FED	.37 STA	.00 CNT	14.76 TOTDED
M1 C-1	.00 OT	.00 OT	24.90 FIC	.00 SDI	.00 CTY	285.41 NETPAY
1042795	.00 OTH	.00 OTH	4.72 MED	.00 SUI	.00	285.41 CK AMT
1999/01/17	32.00 TOT	325.44 TOT	29.62 TOT	.37 TOT	.00 TOT	10.17 RATE
METL 2929	36.50 REG	374.85 REG	.00 FED	1.47 STA	.00 CNT	16.25 TOTDED
M1 C-1	.00 OT	.00 OT	28.68 FIC	.00 SDI	.00 CTY	328.45 NETPAY
1044056	.00 OTH	.00 OTH	5.44 MED	.00 SUI	.00	328.45 CK AMT
1999/01/24	36.50 TOT	374.85 TOT	34.12 TOT	1.47 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	3.05 STA	.00 CNT	17.73 TOTDED
M1 C-1	.00 OT	.00 OT	32.46 FIC	.00 SDI	.00 CTY	371.24 NETPAY
1045351	.00 OTH	13.68 OTH	6.15 MED	.00 SUI	.00	371.24 CK AMT
1999/01/31	40.00 TOT	424.48 TOT	38.61 TOT	3.05 TOT	.00 TOT	10.27 RATE
METL 2929	38.15 REG	391.80 REG	.00 FED	1.91 STA	.00 CNT	16.75 TOTDED
M1 C-1	.00 OT	.00 OT	29.98 FIC	.00 SDI	.00 CTY	343.16 NETPAY
1046524	.00 OTH	.00 OTH	5.68 MED	.00 SUI	.00	343.16 CK AMT
1999/02/07	38.15 TOT	391.80 TOT	35.66 TOT	1.91 TOT	.00 TOT	10.27 RATE
METL 2929	39.42 REG	404.84 REG	.00 FED	2.36 STA	.00 CNT	17.15 TOTDED
M1 C-1	.00 OT	.00 OT	30.97 FIC	.00 SDI	.00 CTY	354.36 NETPAY
1047666	.00 OTH	.00 OTH	5.87 MED	.00 SUI	.00	354.36 CK AMT
1999/02/14	39.42 TOT	404.84 TOT	36.84 TOT	2.36 TOT	.00 TOT	10.27 RATE
METL 2929	35.98 REG	369.51 REG	.00 FED	1.33 STA	.00 CNT	16.09 TOTDED
M1 C-1	.00 OT	.00 OT	28.27 FIC	.00 SDI	.00 CTY	323.82 NETPAY
1048955	.00 OTH	.00 OTH	5.36 MED	.00 SUI	.00	323.82 CK AMT
1999/02/21	35.98 TOT	369.51 TOT	33.63 TOT	1.33 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.42 FIC	.00 SDI	.00 CTY	359.49 NETPAY
1050120	.00 OTH	.00 OTH	5.96 MED	.00 SUI	.00	359.49 CK AMT
1999/02/28	40.00 TOT	410.80 TOT	37.38 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	42.50 REG	436.48 REG	.00 FED	4.03 STA	.00 CNT	18.48 TOTDED
M1 C-1	2.50 OT	12.84 OT	34.37 FIC	.00 SDI	.00 CTY	392.44 NETPAY
1051425	.00 OTH	.00 OTH	6.51 MED	.00 SUI	.00	392.44 CK AMT
1999/03/07	45.00 TOT	449.32 TOT	40.88 TOT	4.03 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.43 FIC	.00 SDI	.00 CTY	359.48 NETPAY
1052604	.00 OTH	.00 OTH	5.96 MED	.00 SUI	.00	359.48 CK AMT
1999/03/14	40.00 TOT	410.80 TOT	37.39 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	43.20 REG	443.67 REG	.96 FED	4.57 STA	.00 CNT	13.85 TOTDED
M1 C-1	3.50 OT	17.97 OT	35.31 FIC	.00 SDI	.00 CTY	406.95 NETPAY
1053925	.00 OTH	.00 OTH	6.69 MED	.00 SUI	.00	406.95 CK AMT
1999/03/21	46.70 TOT	461.64 TOT	42.96 TOT	4.57 TOT	.00 TOT	10.27 RATE
METL 2929	43.75 REG	449.32 REG	1.97 FED	4.87 STA	.00 CNT	19.06 TOTDED

AVX CORPORATION - MYRTLE BEACH,S.C.

TIME = 15.14.51
W E E K L Y EARNING HISTORY REPORT RHR717-1
RUN DATE = 20020514

AXMF 0248042224 CHAVIS, GILBERT R. WK

L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES: FEDERAL	TAXES: STATE	TAXES: CITY / COUNTY	DED/NET/CK AMT
M1 C-1	3.75 OT	19.25 OT	35.86 FIC	.00 SDI	.00 CTY	406.81 NETPAY
1055137	.00 OTH	.00 OTH	6.80 MED	.00 SUI	.00	406.81 CK AMT
1999/03/28	47.50 TOT	468.57 TOT	44.63 TOT	4.87 TOT	.00 TOT	10.27 RATE
METL 2929	51.50 REG	446.76 REG	20.09 FED	12.42 STA	.00 CNT	22.79 TOTDED
M1 C-1	12.50 OT	64.18 OT	45.37 FIC	.00 SDI	.00 CTY	492.43 NETPAY
1056349	.00 OTH	82.16 OTH	8.60 MED	.00 SUI	.00	492.43 CK AMT
1999/04/04	64.00 TOT	593.10 TOT	74.06 TOT	12.42 TOT	.00 TOT	10.27 RATE
METL 2929	57.75 REG	593.10 REG	40.82 FED	22.10 STA	.00 CNT	27.07 TOTDED
M1 C-1	17.75 OT	142.49 OT	56.27 FIC	.00 SDI	.00 CTY	589.33 NETPAY
1057688	.00 OTH	.00 OTH	10.67 MED	.00 SUI	.00	589.33 CK AMT
1999/04/11	75.50 TOT	735.59 TOT	107.76 TOT	22.10 TOT	.00 TOT	10.27 RATE
METL 2929	35.50 REG	364.59 REG	.00 FED	1.67 STA	.00 CNT	16.48 TOTDED
M1 C-1	3.50 OT	17.97 OT	29.26 FIC	.00 SDI	.00 CTY	335.15 NETPAY
1058907	.00 OTH	.00 OTH	5.54 MED	.00 SUI	.00	335.15 CK AMT
1999/04/18	39.00 TOT	382.56 TOT	34.80 TOT	1.67 TOT	.00 TOT	10.27 RATE
METL 2929	45.25 REG	464.72 REG	5.33 FED	5.98 STA	.00 CNT	19.75 TOTDED
M1 C-1	5.25 OT	26.96 OT	37.62 FIC	.00 SDI	.00 CTY	423.00 NETPAY
1060265	.00 OTH	.00 OTH	7.13 MED	.00 SUI	.00	423.00 CK AMT
1999/04/25	50.50 TOT	491.68 TOT	50.08 TOT	5.98 TOT	.00 TOT	10.27 RATE
METL 2929	51.50 REG	528.91 REG	19.34 FED	12.07 STA	.00 CNT	22.64 TOTDED
M1 C-1	11.50 OT	59.06 OT	44.98 FIC	.00 SDI	.00 CTY	488.94 NETPAY
1061479	.00 OTH	.00 OTH	8.53 MED	.00 SUI	.00	488.94 CK AMT
1999/05/02	63.00 TOT	587.97 TOT	72.85 TOT	12.07 TOT	.00 TOT	10.27 RATE
METL 2929	39.50 REG	405.67 REG	.00 FED	2.39 STA	.00 CNT	17.17 TOTDED
M1 C-1	.00 OT	.00 OT	31.03 FIC	.00 SDI	.00 CTY	355.08 NETPAY
1062814	.00 OTH	.00 OTH	5.88 MED	.00 SUI	.00	355.08 CK AMT
1999/05/09	39.50 TOT	405.67 TOT	36.91 TOT	2.39 TOT	.00 TOT	10.27 RATE
METL 2929	40.62 REG	417.17 REG	.00 FED	3.08 STA	.00 CNT	17.76 TOTDED
M1 C-1	.62 OT	3.18 OT	32.55 FIC	.00 SDI	.00 CTY	372.10 NETPAY
1064078	.00 OTH	5.14 OTH	6.17 MED	.00 SUI	.00	372.10 CK AMT
1999/05/16	41.24 TOT	425.49 TOT	38.72 TOT	3.08 TOT	.00 TOT	10.27 RATE
METL 2929	39.00 REG	400.53 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	2.00 OT	10.27 OT	31.43 FIC	.00 SDI	.00 CTY	359.48 NETPAY
1065638	.00 OTH	.00 OTH	5.96 MED	.00 SUI	.00	359.48 CK AMT
1999/05/23	41.00 TOT	410.80 TOT	37.39 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	45.25 REG	464.72 REG	5.33 FED	5.98 STA	.00 CNT	19.75 TOTDED
M1 C-1	5.25 OT	26.96 OT	37.61 FIC	.00 SDI	.00 CTY	423.01 NETPAY
1067086	.00 OTH	.00 OTH	7.12 MED	.00 SUI	.00	423.01 CK AMT
1999/05/30	50.50 TOT	491.68 TOT	50.06 TOT	5.98 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	6.17 STA	.00 CNT	35.64 TOTDED
M1 C-1	.00 OT	.00 OT	90.87 FIC	.00 SDI	.00 CTY	1,055.22 NETPAY
1069798	.00 OTH	1,187.90 OTH	17.22 MED	.00 SUI	.00	1,055.22 CK AMT
1999/05/31	.00 TOT	1,187.90 TOT	108.09 TOT	6.17 TOT	.00 TOT	10.27 RATE
METL 2929	42.00 REG	349.18 REG	.00 FED	3.69 STA	.00 CNT	18.25 TOTDED
M1 C-1	2.00 OT	10.27 OT	33.79 FIC	.00 SDI	.00 CTY	385.88 NETPAY
1068586	.00 OTH	82.16 OTH	6.41 MED	.00 SUI	.00	385.88 CK AMT
1999/06/06	44.00 TOT	441.61 TOT	40.20 TOT	3.69 TOT	.00 TOT	10.27 RATE
METL 2929	14.00 REG	143.78 REG	.00 FED	.00 STA	.00 CNT	9.31 TOTDED
M1 C-1	.00 OT	.00 OT	11.00 FIC	.00 SDI	.00 CTY	123.47 NETPAY
1070879	.00 OTH	.00 OTH	2.09 MED	.00 SUI	.00	123.47 CK AMT
1999/06/13	14.00 TOT	143.78 TOT	13.09 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	2.57 STA	.00 CNT	12.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.42 FIC	.00 SDI	.00 CTY	364.49 NETPAY

AVX CORPORATION - MYRTLE BEACH,S.C.

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AXMF 0248042224 CHAVIS, GILBERT R. WK

L3 L4 / L5 TYPE / CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
1072130	.00 OTH	.00 OTH	5.95 MED	.00 SUI	.00	364.49 CK AMT
1999/06/20	40.00 TOT	410.80 TOT	37.37 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	33.77 REG	346.82 REG	.00 FED	.74 STA	.00 CNT	15.40 TOTDED
M1 C-1	.00 OT	.00 OT	26.53 FIC	.00 SDI	.00 CTY	304.15 NETPAY
1073249	.00 OTH	.00 OTH	5.03 MED	.00 SUI	.00	304.15 CK AMT
1999/06/27	33.77 TOT	346.82 TOT	31.56 TOT	.74 TOT	.00 TOT	10.27 RATE
METL 2929	37.50 REG	385.13 REG	.00 FED	1.74 STA	.00 CNT	16.55 TOTDED
M1 C-1	.00 OT	.00 OT	29.47 FIC	.00 SDI	.00 CTY	337.37 NETPAY
1074368	.00 OTH	.00 OTH	5.59 MED	.00 SUI	.00	337.37 CK AMT
1999/07/04	37.50 TOT	385.13 TOT	35.06 TOT	1.74 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	328.64 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.42 FIC	.00 SDI	.00 CTY	359.49 NETPAY
1075628	.00 OTH	82.16 OTH	5.95 MED	.00 SUI	.00	359.49 CK AMT
1999/07/11	40.00 TOT	410.80 TOT	37.37 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	39.72 REG	407.92 REG	.00 FED	2.47 STA	.00 CNT	17.24 TOTDED
M1 C-1	.00 OT	.00 OT	31.21 FIC	.00 SDI	.00 CTY	357.00 NETPAY
1076737	.00 OTH	.00 OTH	5.92 MED	.00 SUI	.00	357.00 CK AMT
1999/07/18	39.72 TOT	407.92 TOT	37.13 TOT	2.47 TOT	.00 TOT	10.27 RATE
METL 2929	38.50 REG	395.40 REG	.00 FED	2.03 STA	.00 CNT	16.86 TOTDED
M1 C-1	.00 OT	.00 OT	30.25 FIC	.00 SDI	.00 CTY	346.26 NETPAY
1077964	.00 OTH	.00 OTH	5.73 MED	.00 SUI	.00	346.26 CK AMT
1999/07/25	38.50 TOT	395.40 TOT	35.98 TOT	2.03 TOT	.00 TOT	10.27 RATE
METL 2929	39.52 REG	405.87 REG	.00 FED	2.40 STA	.00 CNT	17.18 TOTDED
M1 C-1	.00 OT	.00 OT	31.05 FIC	.00 SDI	.00 CTY	355.24 NETPAY
1079082	.00 OTH	.00 OTH	5.89 MED	.00 SUI	.00	355.24 CK AMT
1999/08/01	39.52 TOT	405.87 TOT	36.94 TOT	2.40 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.42 FIC	.00 SDI	.00 CTY	359.49 NETPAY
1080358	.00 OTH	.00 OTH	5.95 MED	.00 SUI	.00	359.49 CK AMT
1999/08/08	40.00 TOT	410.80 TOT	37.37 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	32.00 REG	328.64 REG	.00 FED	.43 STA	.00 CNT	14.86 TOTDED
M1 C-1	.00 OT	.00 OT	25.15 FIC	.00 SDI	.00 CTY	288.20 NETPAY
1081496	.00 OTH	.00 OTH	4.77 MED	.00 SUI	.00	288.20 CK AMT
1999/08/15	32.00 TOT	328.64 TOT	29.92 TOT	.43 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1999/08/22	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	.00 REG	.00 FED	2.57 STA	.00 CNT	22.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.43 FIC	.00 SDI	.00 CTY	354.48 NETPAY
1083937	.00 OTH	410.80 OTH	5.96 MED	.00 SUI	.00	354.48 CK AMT
1999/08/29	40.00 TOT	410.80 TOT	37.39 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1999/09/05	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1999/09/12	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT

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AVX CORPORATION - MYRTLE BEACH,S.C.

TIME = 15.14.51
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AXMF 0248042224 CHAVIS, GILBERT R. WK

L3 L4 L5 TYPE CHECK NUMBER	HOURS	EARNINGS	TAXES FEDERAL	TAXES STATE	TAXES CITY / COUNTY	DED/NET/CK AMT
1999/09/19	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-1	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1999/09/26	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	.00 REG	.00 REG	.00 FED	.00 STA	.00 CNT	.00 TOTDED
M1 C-M	.00 OT	.00 OT	.00 FIC	.00 SDI	.00 CTY	.00 NETPAY
	.00 OTH	.00 OTH	.00 MED	.00 SUI	.00	.00 CK AMT
1999/10/03	.00 TOT	.00 TOT	.00 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	44.25 REG	454.45 REG	8.88 FED	7.26 STA	.00 CNT	32.48 TOTDED
M1 C-1	6.00 OT	61.62 OT	39.47 FIC	.00 SDI	.00 CTY	427.98 NETPAY
1090206	.00 OTH	.00 OTH	7.48 MED	.00 SUI	.00	427.98 CK AMT
1999/10/03	50.25 TOT	516.07 TOT	55.83 TOT	7.26 TOT	.00 TOT	10.27 RATE
METL 2929	44.98 REG	461.95 REG	4.73 FED	5.76 STA	.00 CNT	19.63 TOTDED
M1 C-1	4.98 OT	25.57 OT	37.30 FIC	.00 SDI	.00 CTY	420.10 NETPAY
1091566	.00 OTH	.00 OTH	7.07 MED	.00 SUI	.00	420.10 CK AMT
1999/10/10	49.96 TOT	487.52 TOT	49.10 TOT	5.76 TOT	.00 TOT	10.27 RATE
METL 2929	48.78 REG	500.98 REG	13.25 FED	9.23 STA	.00 CNT	21.38 TOTDED
M1 C-1	8.78 OT	45.08 OT	41.77 FIC	.00 SDI	.00 CTY	460.43 NETPAY
1092814	.00 OTH	.00 OTH	7.92 MED	.00 SUI	.00	460.43 CK AMT
1999/10/17	57.56 TOT	546.06 TOT	62.94 TOT	9.23 TOT	.00 TOT	10.27 RATE
METL 2929	40.00 REG	410.80 REG	.00 FED	2.57 STA	.00 CNT	17.32 TOTDED
M1 C-1	.00 OT	.00 OT	31.42 FIC	.00 SDI	.00 CTY	359.49 NETPAY
1094198	.00 OTH	.00 OTH	5.95 MED	.00 SUI	.00	359.49 CK AMT
1999/10/24	40.00 TOT	410.80 TOT	37.37 TOT	2.57 TOT	.00 TOT	10.27 RATE
METL 2929	13.92 REG	142.96 REG	.00 FED	.00 STA	.00 CNT	9.29 TOTDED
M1 C-1	.00 OT	.00 OT	10.95 FIC	.00 SDI	.00 CTY	122.72 NETPAY
1095457	.00 OTH	.00 OTH	2.08 MED	.00 SUI	.00	122.72 CK AMT
1999/10/31	13.92 TOT	142.96 TOT	13.03 TOT	.00 TOT	.00 TOT	10.27 RATE
METL 2929	51.82 REG	532.19 REG	20.06 FED	12.41 STA	.00 CNT	22.79 TOTDED
M1 C-1	11.82 OT	60.69 OT	45.35 FIC	.00 SDI	.00 CTY	492.27 NETPAY
1096826	.00 OTH	.00 OTH	8.59 MED	.00 SUI	.00	492.27 CK AMT
1999/11/07	63.64 TOT	592.88 TOT	74.00 TOT	12.41 TOT	.00 TOT	10.27 RATE
METL 2929	66.25 REG	680.40 REG	52.40 FED	27.50 STA	.00 CNT	29.46 TOTDED
M1 C-1	26.25 OT	134.79 OT	62.36 FIC	.00 SDI	.00 CTY	643.47 NETPAY
1097927	.00 OTH	.00 OTH	11.82 MED	.00 SUI	.00	643.47 CK AMT
1999/11/14	92.50 TOT	815.19 TOT	126.58 TOT	27.50 TOT	.00 TOT	10.27 RATE
METL 2929	34.85 REG	357.91 REG	.00 FED	1.41 STA	.00 CNT	16.18 TOTDED
M1 C-1	2.85 OT	14.63 OT	28.49 FIC	.00 SDI	.00 CTY	326.46 NETPAY
1099445	.00 OTH	.00 OTH	5.40 MED	.00 SUI	.00	326.46 CK AMT
1999/11/21	37.70 TOT	372.54 TOT	33.89 TOT	1.41 TOT	.00 TOT	10.27 RATE
METL 2929	61.75 REG	469.85 REG	42.32 FED	22.79 STA	.00 CNT	27.38 TOTDED
M1 C-1	21.75 OT	111.70 OT	57.07 FIC	.00 SDI	.00 CTY	596.31 NETPAY
1100705	.00 OTH	164.32 OTH	10.82 MED	.00 SUI	.00	596.31 CK AMT
1999/11/28	83.50 TOT	745.87 TOT	110.21 TOT	22.79 TOT	.00 TOT	10.27 RATE
METL 2929	56.50 REG	580.26 REG	30.55 FED	17.30 STA	.00 CNT	24.95 TOTDED
M1 C-1	16.50 OT	84.73 OT	50.87 FIC	.00 SDI	.00 CTY	541.32 NETPAY
1102110	.00 OTH	.00 OTH	9.64 MED	.00 SUI	.00	541.32 CK AMT
1999/12/05	73.00 TOT	664.99 TOT	91.06 TOT	17.30 TOT	.00 TOT	10.27 RATE
METL 2929	43.00 REG	441.61 REG	.29 FED	4.37 STA	.00 CNT	18.71 TOTDED
M1 C-1	3.00 OT	15.41 OT	34.96 FIC	.00 SDI	.00 CTY	398.69 NETPAY
1113333	.00 OTH	.00 OTH	6.63 MED	.00 SUI	.00	398.69 CK AMT
1999/12/12	46.00 TOT	457.02 TOT	41.88 TOT	4.37 TOT	.00 TOT	10.27 RATE

727

Re: Gilbert Chavis vs. AVX
S.C. W.C.C. # 9826170; D/A: 12/1/98
S.C. W.C.C. # 9927964; D/A: 12/27/99

1) Your diagnosis of the injuries most likely sustained by Mr. Chavis as a result of his work accident of 12/1/98 (neck/shoulder)? Was this a direct injury, or an injury, or an injury most likely caused by aggravation of a Pre-existent condition?

yes direct injury

2) Your diagnosis of the injuries likely sustained by Mr. Chavis as a result of his work accident of 12/27/99 to his low back? Was this a direct injury, or an injury most likely caused by aggravation of a Pre-existent condition?

~~1) [illegible]~~ - aggravation of LBP
~~2) [illegible]~~ - [illegible]

3) Has he reached maximum medical improvement from the 12/1/98 injury? If so, what degree of impairment did he sustain and to what body part? If not, what further treatment does he need?

NO

4) Has he reached MMI from the 12/27/99 injury? If so, what degree of impairment did he sustain and to what body part? If not, what further treatment does he need?

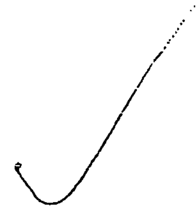
NO

5) If he has reached MMI, what, if any, permanent restrictions would you place on his ability to work?

N/A

Date: 2/20/01

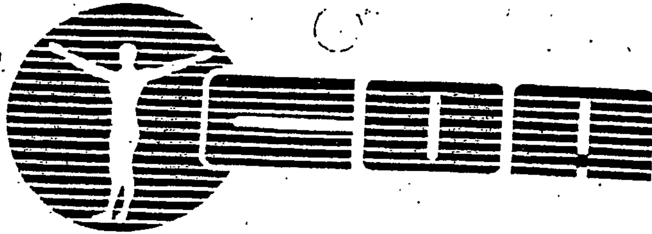
Jeffrey C. Wilkins, M.D.



GILBERT CHAVIS
20347
07/08/2002

We request Mr. Chavis see Dr. Kang in second opinion. He continues to show very high rates of narcotic usage without corresponding severity of degenerative deficits. I would like Dr. Kang's opinion and assistance in management of this difficult case.

Jeffrey C. Wilkins, M.D. /pmc
33780



COASTAL ORTHOPAEDIC ASSOCIATES, P.A.

James W. Yates, Jr., M.D.
Orthopaedic Surgery
Sports Medicine

. Stewart Haskin, Jr., M.D.
Orthopaedic Surgery
Surgery of the Hand

A. Jay Preslar III, M.D.
Orthopaedic Surgery
Shoulder Surgery

William L. Mills, M.D.
Orthopaedic Surgery
Spinal Surgery

ɛffrey C. Wilkins, M.D.
al Medicine and Rehabilitation
Electrodiagnosis

Ross Taylor, M.D.
Orthopaedic Surgery
ery of the Foot and Ankle

Curtis Elliott, M.D.
rthopaedic Surgery
Sports Medicine

May 31, 2005

Preston F. McDaniel
McDaniel Law Firm
1315 Elmwood Avenue
Columbia, SC 29201

RE: GILBERT CHAVIS
DOB: 12/07/1954
Our Case No. 120347

Dear Mr. McDaniel:

I am writing in response to your letter of April 15, 2005, regarding Gilbert Chavis. I have reviewed the records available to me regarding Mr. Chavis. Based on the third MRI of that right shoulder done at Conway Hospital on 6/29/01 and including an arthrogram. I do not think there is any evidence that he re-injured his shoulder in his workman's comp accident of December 27, 1999.

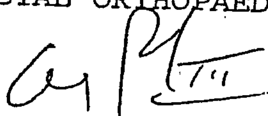
With regard to the cervical spine, he had had some previous cervical spine complaints and had received a 5% whole person impairment rating related to the cervical spine by Dr. Wilkins on December 2, 1997. It is not clear to me if he had a preceding cervical MRI. We did order a cervical MRI which was done in January, 2000, showed multilevel disease with moderate central and right sided bulge at C5-6. This certainly could have been due to his work injury of December 27, 1999.

RE: GILBERT CHAVIS

I hope this information is helpful in your evaluation of his case.

Sincerely,

COASTAL ORTHOPAEDIC ASSOCIATES, P.A.



A. Jay Preslar, III, MD

AJP/dsh
142146

STATEMENT

To whom it may concern:

I evaluated Gilbert Chavis for injuries he sustained in a work-related accident on December 7, 1998.

Prior to 1998, I had treated the Claimant for lower back and right shoulder injuries. The Claimant injured his lower back and right shoulder in an accident on April 8, 1996. The injuries the Claimant sustained in the 1996 accident resulted in permanent physical impairment. Additionally, the Claimant suffered from problems related to his preexisting diabetes, depression, and impotence prior to 1998.

It is my opinion within a reasonable degree of medical certainty that the accident of December 7, 1998 aggravated and combined with Mr. Chavis' preexisting permanent impairment to the lumbar spine and right shoulder, as well as his preexisting diabetes, impotence, and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 7, 1998 injury alone.

Also, it is my opinion, within a reasonable degree of medical certainty that Mr. Chavis' December 1998 accident aggravated these preexisting conditions and were a hindrance or obstacle to his reemployment.

Sincerely,

Jeffrey C. Wilkins, M.D.

Dated: 5/20/7

<u>**STATEMENT**</u>

To whom it may concern:

I evaluated Gilbert Chavis for injuries he sustained in a work-related accident on December 7, 1998. I evaluated Mr. Chavis on May 2, May 15, May 29, and June 12, 2002. As a result of extensive records review, neuropsychological testing, examination and interviews of the Claimant, I concluded that the Claimant sustained a physical injury to the brain due to a stroke he sustained while undergoing a nerve block to treat his work-related injuries.

It is my opinion within a reasonable degree of medical certainty that the injuries Mr. Chavis sustained on December 7, 1998 aggravated and combined with Mr. Chavis' preexisting diabetes and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 7, 1998 injury alone.

In the course of my 2002 evaluation, the Claimant specifically reported that he had been diagnosed with diabetes "approximately nine years ago." He further reported episodic blurred vision associated with his diabetes, which he stated "has been worse since the stroke." While Mr. Chavis denied a history of depression during the course of my evaluations, medical records in this case show that the Claimant was treated with anti-depressant medications, including Zoloft and Prozac, in the year prior to his 1998 work-related accident.

It is my opinion, within a reasonable degree of neuropsychological certainty, that Mr. Chavis' December 1998 work-related accident aggravated his pre-existing depression and diabetes, resulting in his need for ongoing treatment and medication. His pre-existing diabetes and depression, combined with his pain and physical limitations which resulted from his work-related injuries to his shoulder, neck, and back, resulted in a hindrance or obstacle in Mr. Chavis' reemployment.

Sincerely,

L. Randolph Waid, Ph.D
Licensed Clinical Psychologist

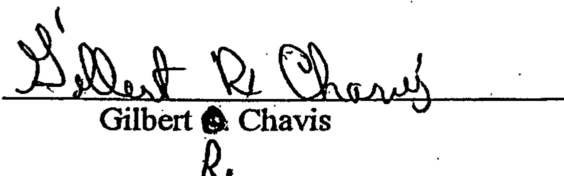
Dated: 4/8/2010

STATEMENT

To Whom It May Concern:

I, Gilbert C. Chavis, was involved in a work-related accident on December 7, 1998 and injured my right shoulder. Prior to December 1st, 1998, I was treated by an orthopaedist for right shoulder pain on multiple visits beginning in 1996 which continued until December 7, 1998. I also was treated for impotence, depression, and diabetes prior to the 1998 accident. As a result of ongoing problems with my right shoulder, a cervical injection was recommended. As a result of a reaction to the cervical injection I suffered a cerebellar stroke. The injection was recommended because of ongoing problems with my right shoulder related to the December 7, 1998 accident.

My employer, AVX Corporation, was aware of my prior right shoulder injury, as it occurred while working for AVX. AVX was also aware of my prior treatment for impotence, depression, and diabetes.



Gilbert R. Chavis

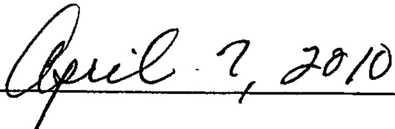
Dated: 5-20-09

STATEMENT

To Whom It May Concern:

I am employed as the Medical Services Coordinator/ Employee Relations for AVX Corporation and have been with the company for thirty-three (33) years. Throughout Mr. Chavis' employment with the company, he had several work-related accidents. On December 7, 1998, the Claimant sustained an injury to his right shoulder in a work-related accident. Prior to that time, the Claimant had sustained an injury to the right shoulder while working for AVX in 1996. As a result of the 1996 injury, the Claimant continued receiving medical treatment for his right shoulder until the time of his December 7, 1998, work-related accident. AVX was also aware of the Claimant's prior medical treatment for impotence, depression, and diabetes.

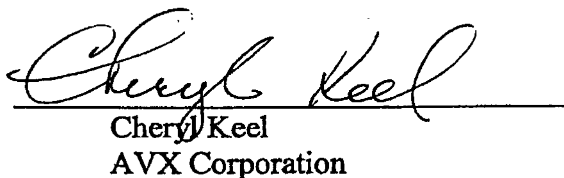
Cheryl Keel

Dated: 

STATEMENT

To Whom It May Concern:

I am employed as the Medical Services Coordinator/ Employee Relations for AVX Corporation and have been with the company for thirty-three (33) years. Throughout Mr. Chavis' employment with the company, he had several work-related accidents. Prior to his December 27, 1999, work-related injury to his lower back, Mr. Chavis sustained injuries to his lower back while working for AVX in 1996. AVX was also aware of Mr. Chavis' prior treatment for the right shoulder, neck, impotence, depression, and diabetes.



Cheryl Keel
AVX Corporation

Dated: April 7, 2010

Gilbert Chavis v. AVX Corp. 3019/1625 & 1626

Impairment Ratings and Restrictions

Dr. Thomas Chambers	11/6/03 – 24% left upper extremity, patient reports shoulder 50-70% better with surgery; did not address work restrictions.
Dr. Gregory Kang	4/23/03 – 12% left upper extremity, given before shoulder surgery; 8% cervical spine; unable to work due to chronic pain.
Dr. Michael Green	8/7/01 – 5% right upper extremity; no lifting over 50-60lbs below chest level, 20-30lb above chest level, lifting above chest level on infrequent basis.
Dr. Daniel Groblewski	2/12/01 – 5% right cerebella CVA, stroke and cerebella CVA likely directly/indirectly related to C6 nerve block; did not address work restrictions.
Dr. Tucker Weston	1/20/98 – 5% whole person (low back claim); did not address any work restrictions.
Dr. Jeffrey Wilkins	12/2/97 – 5% whole person (cervical spine); no impairment from lumbar spine complaints; did not address work restrictions.
	6/20/97 – 5% right upper extremity; no impairment for the lumbar spine; did not address work restrictions.
Dr. Asbury Williams	12/4/96 – 5% residual impairment to back due to subjective ongoing problems in lumbar spine; able to continue working.

STATEMENT

TO WHOM IT MAY CONCERN:

I evaluated Gilbert Chavis for injuries he sustained in a work-related accident on December 27, 1999.

Prior to 1999, I had treated the Claimant for lower back and right shoulder injuries he sustained in a work-related accident on December 7, 1998. Between 1998 and 1999, the Claimant required ongoing medical treatment for his lower back. The Claimant had been receiving treatment for these injuries since an accident on April 8, 1996. The injuries the Claimant sustained in the 1996 and 1998 accidents resulted in permanent physical impairment. Additionally, the Claimant suffered from problems related to his preexisting diabetes, depression, and impotence prior to 1998.

It is my opinion within a reasonable degree of medical certainty that the accident of December 27, 1999 aggravated and combined with Mr. Chavis' preexisting permanent impairment to lower back, as well as his preexisting diabetes, impotence, and depression, resulting in substantially greater disability and medical expenses than would have resulted from the December 27, 1999 injury alone.

Also, it is my opinion, within a reasonable degree of medical certainty that Mr. Chavis' subsequent December 1999 accident aggravated these preexisting conditions and were a hindrance or obstacle to his reemployment.

Sincerely,

Jeffrey C. Wilkins, M.D.

Dated: 7/9/10

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM HORRY COUNTY
Court of Commons Pleas

Benjamin H. Culbertson, Circuit Court Judge

Case No.: 2012-213175

Gilbert Chavis, ... Employee,

v.

AVX Corporation, Employer, and Liberty Mutual Insurance, ... Carrier,

In Re: AVX Corporation and Liberty Mutual Insurance Company, ... Respondents,

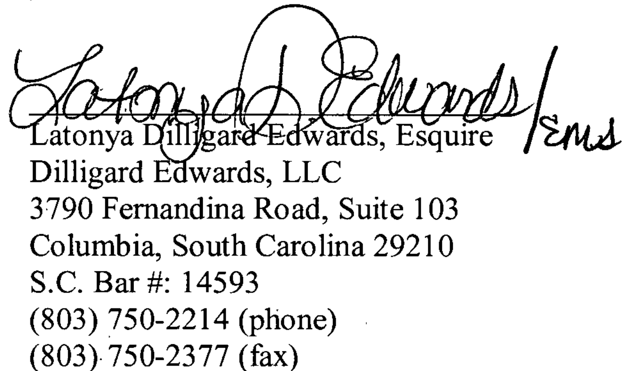
v.

South Carolina Second Injury Fund,...Appellant.

CERTIFICATE OF COUNSEL

The undersigned certified that this Record on Appeal complies with Rule 210(c), SCACR.

July 17, 2013



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ATTORNEY FOR APPELLANT

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SC Court of Appeals