

20638

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM CHESTERFIELD COUNTY
Court of Common Pleas

The Honorable Paul M. Burch, Circuit Court Judge

Case No.: 2012-213511

South Carolina Second Injury Fund,..... Appellant,

v.

American Home Assurance Co., ...Respondent.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

RECORD ON APPEAL

Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
(803) 750-2214
ATTORNEY FOR APPELLANT

AND

Jared M. Pretulak, Esquire
Robert C. Rogers, Esquire
Gallivan, White & Boyd, P.A.
Post Office Box 10589
Greenville, South Carolina 29603
(864) 271-9580
ATTORNEYS FOR RESPONDENT

RECEIVED

JUL 08 2013

SC Court of Appeals

INDEX

American Home Assurance v. South Carolina Second Injury Fund

1. Single Commissioner's Decision and Order (September 5, 2008)	1
2. Appellate Panel Decision and Order (May 1, 2009)	12
3. Single Commissioner's Decision and Order (October 20, 2011)	19
4. Appellate Panel Decision and Order (May 22, 2012)	46
5. Notice of Intent to Appeal to Chesterfield County Circuit Court (June 20, 2012)	67
6. Chesterfield County Circuit Court Order (October 11, 2012)	72
7. Single Commission Hearing Transcript (September 21, 2011)	78
8. Full Commission Hearing Transcript (March 19, 2012)	100
9. Circuit Court Hearing Transcript (September 17, 2012)	119
10. S.C. Second Injury Fund's Request for Commission Review (Form 30) & Questions (October 31, 2011)	143
11. Employee/Carrier's Pre-Hearing Brief (September 6, 2011)	146
12. Medical Records of Dr. John F. McLeod, III (July 14, 1992-December 30, 2005)	152
13. Medical Records of Dr. G. Simpson (July 15, 2004)	170
14. Medical Records of Dr. Lenwood P. Smith, Jr, Dr. Eddie G. Richmond and Dr. James E. Morrison (July 15, 2004-July 19, 2004)	184
15. Medical Records of Dr. Patrick Connor (April 10, 2005)	192
16. Medical Records from Carolinas Healthcare System (April 10, 2005-June 8, 2005)	193
17. Medical Records from Carolinas Healthcare System – Radiological Services (April 10, 2005-April 5, 2006)	243
18. Medical Records of Dr. Abdul Garuba (May 18, 2005-June 2, 2005)	280

19. Medical Records of Dr. Michael J. Bosse (June 3, 2005-April 5, 2006)	286
20. Medical Records of Dr. Sonya G. Rissmiller and Dr. Sharon K. Kanelos (September 8, 2005-November 12, 2007).....	293
21. Medical Records of Jeff Haskett, M.S. (September 13, 2005-November 12, 2007)	301
22. Medical Records of Dr. Sharon K. Kanelos (May 22, 2007-November 25, 2008)	307
23. Medical Records of Dr. John Barkenbus (May 7, 2008).....	316
24. Notice of Possible Second Injury Fund Claim Form (June 8, 2011)	342
25. Letter from Dr. Glenn L. Scott (May 11, 2011).....	343
26. Letter from L. Randolph Waid, Ph.D. re: diabetes (June 1, 2011)	344
27. Medical Certificate of Glenn L. Scott re: diabetes (May 11, 2011).....	346
28. Medical Certificate of L. Randolph Waid, Ph.D re: diabetes (May 31, 2011).....	347
29. Centers for Disease Control and Prevention (Internet Article re: Traumatic Brain Injury) (August 29, 2011).....	348

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 0504228

JOHN STROUD, EMPLOYEE, CLAIMANT,

versus

JOHN F. STROUD AND SON
AND AIG CLAIM SERVICES, INC., CARRIER, DEFENDANTS

HEARING:

Held in Florence, South Carolina on the 5th day of August,
2008

APPEARANCES:

Claimant was represented by Vincent Sheheen, of Savage,
Royall & Sheheen, L.L.P., 1111 Church Street, Post Office
Drawer 10, Camden, South Carolina, 29020.

Defendants were represented by J. Stuart Moore, Esquire,
PO Box 12519, Capitol Station Columbia SC 29211

PURPOSED OF HEARING:

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

DECISION AND ORDER:

B. Bryan Lyndon, Commissioner

FILED:

September 5, 2008.

The hearing in this matter was held in Florence, South Carolina on August 5, 2008,
pursuant to notices timely and properly served. All parties and their representatives were present.

RECEIVED

SEP 08 2008

2094. 0736

APA SUBMISSIONS

The following records were submitted into evidence by Claimant and Employer without

objection:

	<u>Dates</u>	<u>Pages</u>
1. North Carolina Neuropsychiatry	05/07/08	1-26
2. Academy Eye Associates	12/29/05-02/24/06	27-31
3. Carolina Vision Center	11/21/05-01/21-08	32-41
4. Anson-Union Prosthetic-Orthotic Services	09/13/05-05/22/07	42-50
5. Letter from Lundin and Brogdon CPA	8/23/07	51
6. Home remodeling Invoices and summary		52-61
7. Carolinas Healthcare	4/10/05-6/8/05	62-71
8. Dr. Boatright, MD	4/11/2006	

STIPULATIONS

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

1. That the purpose of the hearing was to determine the issues as set forth on Forms 50 and 51 and to determine the extent of the Claimant's permanent disability, brain damage, maximum medical improvement, compensation rate, and entitlement to benefits.
2. Notice of this hearing was timely and properly served upon all parties of interest.
3. The medical records in this case consisted of thousands of documents, but counsel for the parties have submitted only the most relevant for purposes of decision making.
4. Venue, set in Florence County, is proper as agreed by all parties.
5. The Claimant seeks benefits under the SC Workers' Compensation Act based upon an admitted accident occurring on or about April 10, 2005 while in the employment of the Defendant/Employer; and therefore, the S.C. Workers' Compensation Commission has jurisdiction of this case. Claimant further seeks lifetime benefits for brain injury, a partial lump

sum award from the back end of his benefits, Utica-Mohawk language included in the order, payment for improvements done to his home due to his handicap and medical needs, lifetime related medical care, and a determination of his average weekly wage. Claimant further seeks a lump sum for underpayment of his back temporary total benefits because Employer incorrectly calculated his compensation rate.

6. Employer disputes that Claimant suffered a brain injury and contests the average weekly wage asserted by Claimant. In the alternative, Employer argues that if Claimant suffered a physical brain injury he may not have reached maximum medical improvement.

Statement and Evidence of the Case

On April 10, 2005, the Claimant, Mr. Stroud, was employed by Employer. Employer is in the construction and land grading business. Employer is a sole proprietorship owned and operated by Claimant. Claimant worked as a covered employee of the business. On the day of the accident, Claimant was solo piloting his aircraft to view a work site. His aircraft crashed, severely injuring him in numerous ways. Claimant alleged injuries to his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, hearing loss, shoulders, and brain damage. Employer admitted in its pre-hearing brief that Claimant suffered injuries to his left eye, right leg, left hip, left leg, right arm, left hand, and ribs. At the hearing, Employer did not contest any of the injuries alleged by Claimant except for the physical brain injury. Alternatively, Employer took the position that if brain damage occurred, maximum medical improvement may not yet have occurred.

Because of the severe nature of Claimant's injuries and the limited issues in dispute, Claimant's wife Linda Stroud presented testimony at the hearing instead of Claimant. Claimant,

Mr. Stroud, was present during the hearing, and he was observed by the undersigned. At the hearing, the undersigned observed that Mr. Stroud had difficulty walking, needing a walker for mobility. Even with the walker he had difficulty, and he was guided by his wife in and out of the hearing room. Mr. Stroud seemed withdrawn from the proceedings. His left eye remained closed during the entire hearing.

Without objection, the Commission file was made a part of the record. Numerous documents were submitted pursuant to the Administrative Procedures Act, as set forth above.

Claimant is 65 years old and worked for John F. Stroud and Son at the time of his injury.

After the accident, Claimant's right leg was amputated below the knee. Claimant's vision in his left eye is totally lost. Claimant's vision in his right eye is severely restricted according to the testimony and medical records. Claimant's optic nerve was damaged in the accident. Claimant spent almost four months in the hospital as explained by Mrs. Stroud.

Mrs. Stroud testified that Claimant is unable to care for himself. Mrs. Stroud has to prepare all his food, provide for his daily hygiene care, and ensure that someone is present to help him. She stated that Claimant now has a very short attention span. She testified that he has severe short term memory loss and often cannot recall common, everyday words. For example, she stated that when Mr. Stroud wants a banana he cannot recall the word and will say "they're yellow." She testified that Claimant suffered from none of these impairments prior to the plane crash, and that he only experienced them after the severe head trauma sustained in the accident.

Mrs. Stroud explained that her husband uses a wheelchair to get around the house and uses a walker for short excursions outside of the home. Mr. Stroud underwent a hip replacement and repair, and he continues to have severe mobility problems.

Mr. Stroud was assigned a 50% impairment rating to his left hand by Dr. Boatright, who treated him for that specific injury. Mr. Stroud was treated by numerous other physicians for his multiple injuries.

Mr. Stroud was evaluated by Dr. John Barkenbus at North Carolina Neuropsychiatry. This evaluation was arranged by the Carrier with the consent of the Claimant. After reviewing the medical history, Dr. Barkenbus noted that Mr. Stroud had suffered a traumatic subarachnoid hemorrhage and subdural hematoma during the plane crash. Dr. Barkenbus noted that Mr. Stroud suffers from depression and severe mood swings.

Dr. Barkenbus found that Mr. Stroud's immediate recall was very impaired. He found that Mr. Stroud was oriented as to year, but not to month. The doctor found evidence of anatomical damage to the brain consistent with traumatic brain injury. Dr. Barkenbus found that Mr. Stroud's injuries had resulted in deficits in learning, processing speed, and strategic mental searches.

Claimant's optometrist, Dr. Greene, noted that Claimant suffered from cognitive problems associated with word recognition. Since the accident, Claimant has never been able to return to work or even perform his own personal care needs.

Mrs. Stroud testified that her husband needed continued medical care for all the injuries associated with his accident. Mrs. Stroud testified that Mr. Stroud's current medical regimen kept him stable, but that no treatments had been offered to improve his condition. Mrs. Stroud testified that she had been given no prognosis for improvement in her husband's condition.

Mrs. Stroud testified that her husband made well over \$100,000 per year working for his company for several years prior to the accident. Claimant introduced an affidavit of his Certified

Public Accountant stating that Mr. Stroud earned \$106,430 from John F. Stroud and Son in the year prior to the accident. No contrary evidence was introduced.

Mrs. Stroud testified that Mr. Stroud must use his wheelchair to get around the house, using his walker on occasion. She stated that upon returning home from the hospital, Mr. Stroud could not move through the house with his wheelchair or walker because of the home's design. The bathrooms were not accessible, and the bedroom needed to be raised level with the rest of the home. After consulting with the Carrier, Mrs. Stroud got several estimates of the work that needed to be done to accommodate Mr. Stroud's medical needs. Mrs. Stroud used the lowest bid to perform the work. Mrs. Stroud testified that all the work performed was caused by and related directly to meeting Mr. Stroud's medical needs and physical limitations. The work totaled \$88,176.62. No contrary evidence was presented.

Mrs. Stroud further testified that Mr. Stroud had an outstanding mortgage balance of \$280,000 on his home and adjoining property. She testified that she believed it was in Mr. Stroud's best interest to receive a large partial lump sum payment if awarded life time benefits. She testified that she would assist him in managing the money for his benefit. Mrs. Stroud further testified about the need for money to continue to provide adequate living arrangements and care for Mr. Stroud, and she testified that the partial lump sum was needed to maintain financial stability. No contrary evidence was presented.

Findings of Fact

It is found as fact:

1. All of the parties of this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, to date with John F.

Stroud and Son as Employer and AIG Claim Services, Inc. as carrier.

2. The South Carolina Workers Compensation Commission has subject matter jurisdiction and personal jurisdiction over the parties and matters before this Commissioner, all parties having received proper notice of the hearing.

3. The Claimant was employed by John F. Stroud and Son at the time of his accident and was working within the scope of his employment. Based on the undisputed evidence, I find that Claimant earned more than \$100,000 for several years prior to his accident, including the year prior to his accident. This conclusion is supported by his wife's testimony and by the document provided by his certified public accountant. It is also noted that Claimant owned and maintained the airplane that crashed, tending to show that he maintained considerable earnings. I find that Claimant is entitled to the maximum compensation rate for 2005, which was \$592.56.

4. The Claimant was injured by accident on August 5, 2005 while performing duties arising out of and within the course of employment as admitted by Employer, and his claim is compensable.

5. Claimant met the reporting requirements for his accidental injuries.

6. As a result of the accident, Claimant suffered injuries to his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, hearing loss, and shoulders. Claimants' injuries include but are not limited to complete loss of vision in left eye and severe vision loss in the right eye. Claimant suffered amputation of his lower right leg, hip replacement, head trauma, torso injuries, hearing loss, and problems related to these injuries.

7. Based on the medical records and the testimony presented, I find that Claimant is permanently and totally disabled and unable to work or even care for himself. I find that

Claimant has reached maximum medical improvement.

8. Based on the undisputed testimony of Mrs. Stroud and the undisputed medical records, I find that Claimant also suffered permanent, physical brain damage affecting his ability to work and care for his own personal needs. I find that Mr. Stroud is permanently and totally disabled due to his permanent brain injury and the combined affects of all his injuries.

9. I find that the entire testimony of Mrs. Stroud was extremely credible and that she did not exaggerate the extent of Mr. Stroud's injuries and accurately stated the wages of her husband.

10. Claimant operated and worked for his own land grading and construction business.

11. Claimant has suffered severe permanent physical brain damage and is permanently disabled as a result. Claimants' numerous other physical injuries further contribute to making him permanently and totally disabled. Claimant's injuries prohibit him from returning to any form of gainful employment. Additionally, the medical evidence and testimony confirms he will most probably remain incapable of sustaining gainful employment. *See, McCollum v. Singer Company*, 386 S.E.2d 471, 474 (S.C. Ct. App. 1989).

12. Employer is to pay to the Claimant compensation at the rate of \$592.56 for the remainder of his life because of the permanent, physical brain injury and resulting disability. I find it is in the best interests of Claimant to receive compensation in partial lump sum equaling \$280,000 (in addition to any lump sum funds directed toward satisfaction of attorney fees and litigation expenses) from the back end of Claimant's lifetime benefits. I find that Claimant with the assistance of his wife can adequately handle these lump sum proceeds in a responsible fashion, primarily involving satisfaction of debt on the home and property. These intended uses are reasonable and appropriate and constitute important financial needs. No evidence was

presented against awarding a partial lump sum payment and no argument was made questioning the legitimate needs of Claimant for such a lump sum.

13. Employer is to pay lifetime, causally-related medical benefits. These benefits include all benefits available under the Workers' Compensation Act, including any causally related life care, nursing care, in home care, prosthesis care or replacement, or any other causally-related medical needs.

14. Employer is further required to pay an additional sum directly to Claimant equaling \$88,176.62. This money is paid for up-fitting and modification done to the home to meet Claimant's medical and physical needs. This sum equals the amounts paid already by Claimant to the contractors for work performed plus amounts Claimant still owes for the completed work.

15. Employer is further required to pay an additional lump sum to Claimant due to underpayment of past temporary total benefits. Employer shall pay Claimant a lump sum for past underpayment based on an average weekly wage of \$592.56.

Conclusions of Law

Accordingly, as provided by the South Carolina Code Section 42-17-40, it is the determination and finding of this Commissioner:

1. Under Section 42-1-120, the Claimant was a covered employee at the time in question and under Section 42-1-140, the Defendant was a covered Employer.

2. Under Section 42-1-160, the Claimant sustained an injury by accident arising out of and in the course of his employment.

3. Under Sections 42-9-10 and 42-1-120, the Claimant is entitled to compensation for general disability. Under Section 42-9-10 Claimant is entitled to lifetime compensation for

physical brain damage. Mr. Stroud's causally related physical brain damage has contributed to his permanent and total disability. Mr. Stroud has reached maximum medical improvement.

4. Under Section 42-15-60, the Claimant is entitled to adequate and proper medical care related to his injuries, including but not limited to nursing services, medicines, prosthetic treatment and replacement, travel reimbursement, hospital care, or any other related medical care, needed during his life. Claimant is entitled to lump sum payment for up fitting to his house in the amount of \$88,176.62.

5. Under Section 42-9-10, the Claimant is entitled to lifetime compensation for total and permanently disability resulting from physical brain damage. Furthermore, while Section 42-9-10 precludes the total lump sum payment of a lifetime disability compensation award, a partial lump sum payment is allowed. *Cox v. BellSouth Comm.* 589 S.E.2d 766 (S.C. Ct. App. 2003). I conclude that Mr. Stroud will likely experience substantial financial hardship absent provision of sufficient funds to meet his accrued obligations and needs stemming from his period of disability. I find that a partial lump sum award of \$280,000 (in addition to any lump sum funds for attorney fees and costs) satisfies the requirements of S.C. Code Section 42-9-301, as his best interests certainly warrant such an award.

6. Claimant's life expectancy is 14.04 years or 730.08 weeks, pursuant to Section 19-1-150 of the S.C. Code of Laws and Section 42-25-60 of the Workers Compensation Act. The Claimant has requested and the Commission approves the allocation of \$280,000 in partial lump sum payment designated as follows: \$216,357.30 in future disability benefits at the rate of \$296.40 per week commencing October 1, 2008 and continuing thereafter for 730.08 weeks, which is his life expectancy pursuant to the S.C. Code as interpreted by the South Carolina

Supreme Court decision of *Utica-Mohawk Mills v. Orr*, 87 S.E.2d 589 (1955); and \$63,642.70 of the partial lump sum is designated as attorneys fees.

7. Claimant is further entitled to a payment of back temporary total based on the compensation rate of \$592.56 because of Defendant's underpayment since the date of injury.

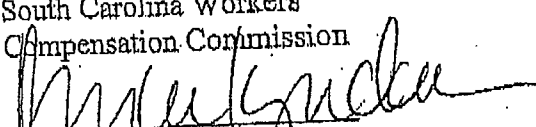
ORDERED

IT IS THEREFORE ORDERED, That the Findings of Fact and Conclusions of Law are incorporated herein as if set forth verbatim, and Defendants shall pay the Claimant total and permanent disability payments for the remainder of his life based on the Compensation Rate of \$592.56. A payment of \$280,000 shall be made as a partial lump sum off of the back end of Claimant's benefits. In addition, Defendants shall pay \$88,176.62 directly to Claimant for up-fitting and improvements done to the home because of Claimant's medical and physical needs. In addition, Defendants shall pay a lump sum for back temporary total based on the compensation rate of \$592.56 because of underpayment since the date of injury. Defendants are also ordered to provide adequate and appropriate causally related medical care during the lifetime of the Claimant and are responsible for all such medical care already performed. It is further ordered that Claimant's counsel upon submission of a duly executed Form 61 shall be entitled to a separate lump sum payment in satisfaction of attorneys fees and litigation expenses not recouped from Claimant's partial lump sum payment.

AND IT IS SO ORDERED.

September 3, 2008

South Carolina Workers'
Compensation Commission


The Honorable B. Bryan Lyndon,

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

This 5 day of September, 2008

APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO. 0504228

JOHN STROUD,

EMPLOYEE,
CLAIMANT/RESPONDENT,

- V -

JOHN F. STROUD & SONS,

EMPLOYER,

AND

AMERICAN HOME ASSURANCE CO.,

CARRIER,
DEFENDANTS/APPELLANTS.

Appellate Panel Review held in Columbia,
South Carolina on March 23, 2009 per notices
timely and properly served on all parties of
interest.

Appellate Panel Decision and Order filed

May 1, 2009.

APPEARANCES:

Claimant/Respondent represented by Vincent
A. Sheheen, Esquire, of Camden, South
Carolina.

Defendants/Appellants represented by J.
Stuart Moore, Esquire, of Columbia, South
Carolina.

RECEIVED

MAY 04 2009

2094.07303

STATEMENT OF CASE

The parties were heard by Commissioner G. Bryan Lyndon on August 5, 2008 in Florence, South Carolina. On September 5, 2008, he issued the following Order:

IT IS THEREFORE ORDERED, That the Findings of Fact and Conclusions of Law are incorporated herein as if set forth verbatim, and Defendants shall pay the Claimant total and permanent disability payments for the remainder of his life based on the Compensation Rate of \$592.56. A payment of \$280,000 shall be made as a partial sum off of the back end of Claimant's benefits. In addition, Defendants shall pay \$88,176.62 directly to Claimant for up-fitting and improvement done to the home because of Claimant's medical and physical needs. In addition, Defendants shall pay a lump sum for back temporary total based on the compensation rate of \$592.56 because of underpayment since the date of injury. Defendants are also ordered to provide adequate and appropriate causally related medical care during the lifetime of the Claimant and are responsible for all such medical care already performed. It is further ordered that Claimant's counsel upon submission of a duly executed Form 61 shall be entitled to a separate lump sum payment in satisfaction of attorneys fees and litigation expenses not recouped from Claimant's partial lump sum payment.

Within the statutory period, counsel for the Defendants filed an Application for Review in the case setting forth his reasons, copies of which were furnished to all interested parties, prior to oral argument presented before the Appellate Panel on March 23, 2009. All proffered testimony has been taken. Such, together with all documentary evidence, has been delivered by oral argument to the individual members of the Full Commission and has since been under study and consideration.

By appeal, Defendants respectfully submits the following:

1. The payment of a "partial" lump sum payment of \$280,000 is tantamount to a total lump sum payment, which is prohibited by the Workers' Compensation Act.

2. It is not in the best interests of Claimant and his dependents or the Carrier for Claimant to receive a partial lump sum payment of \$280,000.

3. It is inequitable to the Carrier to allow a lump sum payment to the Claimant off the back end of the Claimant's lifetime indemnity benefits. A "partial" lump sum payment should not exceed the amount Claimant is entitled to receive for permanent and total disability.

In an appellate review, the Panel shall, pursuant to S.C. Code Ann. §42-17-50 (1985), review the Award, weigh the evidence as presented at the initial hearing and, if good grounds be shown therefore, make its own Findings of Fact and reach its own Conclusions of Law consistent with or inconsistent with those of the Hearing Commissioner. Based upon a review of the foregoing, we affirm in part and reverse in part and enter the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. All of the parties to this proceeding are subject to and bound by the terms and provisions of the S. C. Workers' Compensation Act.

2. The S. C. Workers' Compensation Commission has subject matter jurisdiction and personal jurisdiction over the parties and matters before this Commission.

3. Claimant was employed by Employer at the time of his accident and was working within the scope of his employment. Based on the undisputed evidence, Claimant earned more than \$100,000 for several years prior to his accident, including the year prior to his accident. This conclusion is supported by his wife's testimony and by the documents provided by his certified public accountant. It is also noted Claimant owned and maintained the airplane that crashed, tending to show he maintained considerable earnings. Claimant is entitled to the maximum compensation rate for 2005 which was \$592.56.

4. Claimant was injured by accident on August 5, 2005 while performing duties arising out of and within the course of employment as admitted by Employer, and his claim is compensable.

5. Claimant met the reporting requirement for his accidental injuries.

6. As a result of the accident, Claimant suffered injuries to his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, hearing loss, and shoulders. Claimant's injuries include but are not limited to complete loss of vision in the left eye and severe vision loss in the right eye. Claimant suffered amputation of his lower right leg, hip replacement, head trauma, torso injuries, hearing loss, and problems related to these injuries.

7. Based on the medical records and the testimony presented, Claimant is permanently and totally disabled and unable to work or even care for himself. Claimant has reached maximum medical improvement.

8. Based on the undisputed testimony of Mrs. Stroud and the undisputed medical records, Claimant also suffered permanent, physical brain damage affecting his ability to work and care for his own personal needs. Claimant is permanently and totally disabled due to his permanent brain injury and the combined affects of all his injuries.

9. The hearing commissioner found the entire testimony of Mrs. Stroud extremely credible, that she did not exaggerate the extent of Claimant's injuries and accurately stated the wages of her husband.

10. Claimant operated and worked for his own land grading and construction business.

11. Claimant has suffered severe permanent physical brain damage and is permanently disabled as a result. Claimant's numerous other physical injuries further contribute to making him permanently and totally disabled. Claimant's injuries prohibit him from returning to any form of gainful employment. Additionally, the medical

evidence and testimony confirm he will most probably remain incapable of sustaining gainful employment. See *McCollum v. Singer Co.*, 386 S.E.2d 471, 474 (Ct. App. 1989).

12. Employer shall pay Claimant compensation at the rate of \$592.56 for the remainder of his life because of the permanent, physical brain injury and resulting disability. The award of a partial lump sum is reversed as it represents most of the balance of the life expectancy award and would leave Claimant with no compensation benefits in short order.

13. Defendants shall pay lifetime, causally related medical benefits. These benefits include all benefits available under the Workers' Compensation Act, including any causally related life care, nursing care, in home care, prosthesis care or replacement, or any other causally related medical needs.

14. Employer is further required to pay an additional sum directly to Claimant equaling \$88,176.62. This money is paid for up-fitting and modification done to the home to meet Claimant's medical and physical needs. This sum equals the amounts paid already by Claimant to the contractors for work performed plus amounts Claimant still owes for the completed work.

15. Employer is further required to pay an additional lump sum to Claimant due to underpayment of past temporary total benefits. Employer shall pay Claimant a lump sum for past underpayment based on an average weekly wage of \$592.56.

Based on the findings of fact are the following:

CONCLUSIONS OF LAW

1. Under Section 42-1-120, Claimant was a covered employee at the time in question, and under Section 42-1-140 the Defendant was a covered Employer.

2. Under Section 42-1-160, Claimant sustained an injury by accident arising out of and in the course of his employment.

3. Under Sections 42-1-10 and 42-1-130, Claimant is entitled to compensation for general disability. Under Section 42-9-10, Claimant is entitled to lifetime compensation for physical brain damage. Claimant's causally related physical brain damage has contributed to his permanent and total disability. Claimant has reached maximum medical improvement.

4. Under Section 42-15-60, Claimant is entitled to adequate and proper medical care related to his injuries, including but not limited to nursing services, medicines, prosthetic treatment replacement, travel reimbursement, hospital care, or any other related medical care needed during this lifetime. Claimant is entitled to a lump sum for up-fitting to his house in the amount of \$88,176.62.

5. Under Section 42-9-10, Claimant is entitled to lifetime compensation for total and permanent disability resulting from physical brain damage. Section 42-9-10 precludes a total lump sum payment. Furthermore, the partial lump sum award is reversed as it represents most of the balance of Claimant's life expectancy award and would leave Claimant with no compensation benefits in short order.

6. Claimant is further entitled to a payment of back temporary total based on the compensation rate of \$592.56 because of Defendants' underpayment since the date of the injury.

ORDER

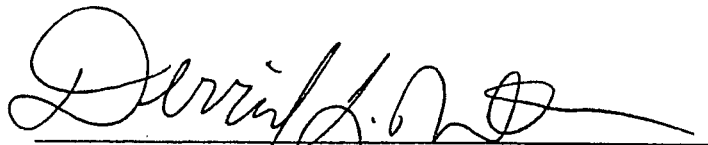
IT IS, THEREFORE, ORDERED Defendants shall pay Claimant total and permanent disability payments for the remainder of his life based on the compensation rate of \$592.56. In addition, Defendants shall pay \$88,176.62 directly to Claimant for up-fitting and improvements done to the home because of Claimant's medical and physical needs. Furthermore, Defendants shall pay a lump sum for back temporary total based on the compensation rate of \$592.56 because of underpayment since the date of injury. Defendants are also ordered to provide adequate and appropriate

causally related medical care during Claimant's lifetime and are responsible for all such medical care already performed.

IT IS FURTHER ORDERED the award of a partial lump sum of \$280,000 is reversed as it represents most of the balance of the life expectancy award and would leave Claimant with no compensation benefits in short order.

AND IT IS SO ORDERED.

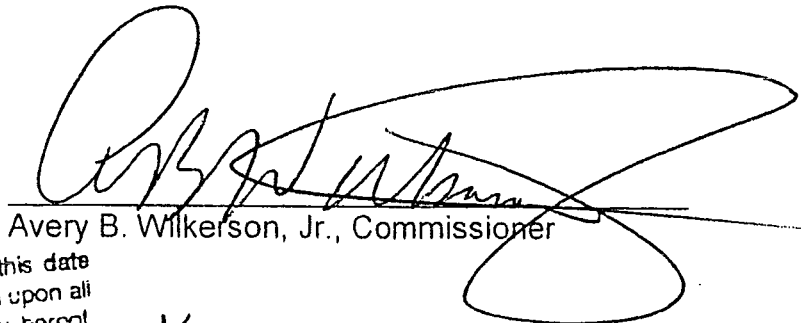
S. C. WORKERS' COMPENSATION COMMISSION


Derrick L. Williams, Commissioner

AFFIRM IN PART/REVERSE IN PART

CONCUR:


David W. Huffstetler, Commissioner


Avery B. Wilkerson, Jr., Commissioner

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

This 1 day of May, 2009
By Ant Bonney Enepp
Administrative Assistant to the Commissioner

VAS
JSM

(L:\0504228.dlw.app)

DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 0504228

John F. Stroud & Sons, Inc./Chartis Insurance Company, ...Employer/Carrier,

v.

South Carolina Second Injury Fund, ...Defendants.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

HEARING:

Held in Florence, South Carolina
on September 21, 2011

APPEARANCES:

Employer/Carrier represented by:
Jared M. Pretulak
Gallivan, White & Boyd, P.A.
P. O. Box 10589
Greenville, SC 29603

Defendant represented by:
Diedre D. Laws
Boykin & Davis, LLC
P.O. Box 11844
Columbia, SC 29211

PURPOSE OF HEARING:

To determine all issues set forth on Form 54 and
Form 55

DECISION AND ORDER:

G. Bryan Lyndon, Commissioner

FILED:

October 20, 2011

* * * * *

STIPULATIONS

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

1. The purpose of the hearing was to determine issues set forth on the Forms 54 and 55.
2. Carrier seeks reimbursement from the South Carolina Second Injury Fund (hereinafter "the Fund") for benefits paid under the South Carolina Workers' Compensation Act for injuries sustained by John Stroud (hereinafter "Mr. Stroud") on or about April 10, 2005, arising out of and in the course of his employment with John F. Stroud & Sons, Inc.; therefore, the South Carolina Workers' Compensation Commission has jurisdiction over the case.
3. All parties received timely and proper notice of the scheduled hearing.
4. Venue for the hearing was properly set in Florence County.
5. Mr. Stroud's average weekly wage at the time of his injury was \$1,028.00, resulting in a compensation rate of \$592.56.
6. The South Carolina Second Injury Fund received timely notice of the Carrier's claim for reimbursement for Mr. Stroud's April 10, 2005 workers' compensation claim.
7. The disability claim for the April 10, 2005 accident has been concluded.
8. The Commission file is made part of the record with the exception of self-serving declarations and unstipulated medical reports.

APA SUBMISSIONS

Under the Administrative Procedures Act, the Hearing Commissioner received the following records into evidence:

APA SUBMISSIONS BY CARRIER

Carrier APA No. 1: John F. McLeod III, M.D., dated July 14, 1992 through December 30, 2005 consisting of eighteen (18) pages;

- Carrier APA No. 2: G. Simpson, M.D., Palmetto Health Richland—Emergency Department, dated July 15, 2004 consisting of fourteen (14) pages;
- Carrier APA No. 3: Lenwood P. Smith, Jr., M.D., Eddie G. Richmond, M.D., James E. Morrison, M.D., Palmetto Health Richland, dated July 15, 2004 through July 19, 2004 consisting of seven (7) pages;
- Carrier APA No. 4: Patrick Connor, M.D., OrthoCarolina, dated April 10, 2005 consisting of one (1) page;
- Carrier APA No. 5: Carolinas Healthcare System, dated April 10, 2005 through June 8, 2005 consisting of fifty (50) pages;
- Carrier APA No. 6: Carolinas Healthcare System—Radiological Services, dated April 10, 2005 through April 5, 2006 consisting of thirty-seven (37) pages;
- Carrier APA No. 7: Abdul Garuba, M.D., Carolinas Specialty Hospital, dated May 18, 2005 through June 2, 2005 consisting of five (5) pages;
- Carrier APA No. 8: Michael J. Bosse, M.D., Carolinas Healthcare System—Orthopaedics, dated June 3, 2005 through April 5, 2006 consisting of seven (7) pages;
- Carrier APA No. 9: Sonya G. Rissmiller, M.D., Sharon K. Kanelos, M.D., Carolinas Healthcare System—Rehabilitation, dated September 8, 2005 through November 12, 2007 consisting of eight (8) pages;
- Carrier APA No. 10: Jeff Haskett, M.S., Anson-Union Regional Prosthetic-Orthotic Services, dated September 13, 2005 through November 12, 2007 consisting of six (6) pages;
- Carrier APA No. 11: Sharon K. Kanelos, M.D., Carolinas Healthcare System—Monroe Clinic, dated May 22, 2007 through November 25, 2008 consisting of nine (9) pages;
- Carrier APA No. 12: John Barkenbus, M.D., North Carolina Neuropsychiatry, dated May 7, 2008 consisting of twenty-six (26) pages;

APA SUBMISSIONS BY DEFENDANT

NONE.

EXHIBITS BY CARRIER

- Carrier Exhibit A: Notice of Possible Second Injury Fund Claim Form dated June 8, 2011 consisting of one (1) page;
- Carrier Exhibit B: Letter from Glenn Scott, M.D. (re: diabetes & below-knee amputation to right leg) dated May 11, 2011 consisting of one (1) page;

Carrier Exhibit C: Letter from L. Randolph Waid, Ph.D. (re: diabetes) dated June 1, 2011 consisting of two (2) pages;

Carrier Exhibit D: Medical Certificate: Glenn L. Scott, M.D. (re: diabetes) dated May 11, 2011 consisting of one (1) page;

Carrier Exhibit E: Medical Certificate: L. Randolph Waid, Ph.D. (re: diabetes) dated May 31, 2011 consisting of one (1) page;

Carrier Exhibit F: Centers for Disease Control and Prevention (Internet Article re: Traumatic Brain Injury) dated August 29, 2011 consisting of nineteen (19) pages;

EXHIBITS BY DEFENDANT

Fund Exhibit A: Decision and Order of the SCWCC dated September 5, 2008 consisting of eleven (11) pages;

Fund Exhibit B: Decision of Full Commission dated May 1, 2009 consisting of seven (7) pages;

STATEMENT OF CASE

This case was heard by the undersigned Commissioner on September 21, 2011 in Florence, South Carolina to determine the issues set forth on Form 54 and 55. Hearing Notices were timely and properly served on all parties of interest at which time all parties were present for the hearing. The South Carolina Workers' Compensation Commission has jurisdiction over the parties and the subject matter of this case.

Mr. Stroud sustained compensable work-related injuries on April 10, 2005 when he injured his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, shoulders, and suffered hearing loss in an airplane crash during the course and scope of his employment per the Decision and Order of the SCWCC dated September 5, 2008. He filed a workers' compensation claim. Ultimately, the claim was concluded by award on September 5, 2008.

On June 28, 2005 Carrier placed the Fund on notice of the intent to file a claim for reimbursement. On June 8, 2011 Carrier filed a Notice of Possible Second Injury Fund Claim Form with the Fund on the basis of preexisting diabetes under S. C. Code § 42-9-400(d)(4). Then, on July 1, 2011, Carrier filed Form 54, requesting a hearing.

At the hearing before the undersigned Commissioner, Carrier contended that it had complied with all statutory requirements for reimbursement under S. C. Code § 42-9-400; therefore, the Fund is responsible for fully reimbursing Carrier and Employer for all payments made on Mr. Stroud's workers' compensation claim.

Carrier contended the evidence demonstrated that Mr. Stroud had preexisting diabetes, a prior traumatic brain injury (concussion) and/or brain damage, and permanent impairment equal to or in excess of seventy-eight weeks resulting from the combination of the preexisting impairments with the subsequent work injuries. Carrier also contended that the preexisting impairments were permanent and serious enough to constitute hindrances or obstacles to Mr. Stroud's employment or reemployment. Carrier further contended that Employer had notice of Mr. Stroud's preexisting diabetes and traumatic brain injury (concussion) and/or brain damage, thereby establishing employer knowledge under S.C. Code § 42-9-400(c). Carrier specifically contended that it was entitled to a presumption of permanency and hindrance or obstacle to employment or reemployment for Mr. Stroud's preexisting diabetes, traumatic brain injury (concussion) and/or brain damage, and his preexisting impairments which combined with his work injuries of April 10, 2005 to result in permanent impairment equal to or in excess of seventy-eight weeks or more under S.C. Code § 42-9-400(d)(2), S.C. Code § 42-9-400(d)(28) and S.C. Code § 42-9-400(d)(34)(b), respectively. Carrier contended that, even without the statutory presumption of hindrance, the medical records and medical questionnaires substantiated that Mr. Stroud's preexisting permanent impairments were of such seriousness so as to constitute hindrances or obstacles to employment or reemployment should he become unemployed. Carrier contended that the medical questionnaires and medical evidence substantiated that Mr. Stroud's 2005 injury combined with or aggravated his preexisting permanent impairments to result in increased overall liability for the Carrier. Carrier also contended that Mr. Stroud's preexisting permanent impairments affected his ability to do his job prior to the April 2005 work accident. Lastly, Carrier

argued that the case relied upon by the Fund to deny reimbursement, City of Greenville v. South Carolina Second Injury Fund, 339 S.C. 141, 528 S.E.2d 91 (Ct. App. 2000), was inapplicable under the facts of the instant action. Carrier contended that in that case the employer did not have knowledge of the employee's preexisting impairments. Furthermore, no evidence was presented to establish the carrier sustained greater medical expenses. Carrier contrasted those facts with that of the instant action, contending that it had specifically submitted evidence both establishing employer knowledge under S.C. Code § 42-9-400(c) and substantially increased costs to Carrier as result of the preexisting permanent impairments. Specifically, Carrier contended that in the instant action, Mr. Stroud's preexisting permanent impairments contributed to him being deemed permanently and totally disabled; Carrier contended that in the aforementioned case the claimant's preexisting impairments did not contribute to his permanent and total disability.

The Fund denied Carrier's entitlement to Second Injury Fund reimbursement and argued Mr. Stroud's medical expenses were solely attributable to the extensive nature of his injuries resulting from the April 10, 2005 airplane crash. The Fund conceded that the employer knowledge requirement of S.C. Code § 42-9-400(c) was met for Mr. Stroud's diabetes and traumatic brain injury (concussion) and/or brain damage, but denied that his preexisting permanent impairments combined with or were aggravated by his April 10, 2005 work-injury to result in substantially increased medical costs for Carrier. The Fund contended that Mr. Stroud's required amputation of his right lower extremity was the direct result of the burns and subsequent infection suffered in the airplane crash, rather than on account of his diabetes. The Fund also contended that Mr. Stroud's prior traumatic brain injury (concussion) did not result in any cognitive impairment before the April 2005 accident and thus did not serve as a risk factor for greater impairment from a subsequent brain injury. The Fund contended that the independent medical evaluation obtained by Carrier substantiated that Mr. Stroud's prior traumatic brain injury did not result in cognitive decline and thus did not serve as a risk for greater impairment.

Lastly, the Fund contended that City of Greenville v. South Carolina Second Injury Fund was applicable as it held when a claimant is deemed permanently and totally disabled, the employer cannot incur greater liability for compensation, and therefore compensation reimbursement should not be awarded.

EVIDENCE OF CASE

The Fund conceded that Carrier established employer knowledge under S.C. Code § 42-9-400(c) for Mr. Stroud's preexisting diabetes and traumatic brain injury (concussion) and/or brain damage. In addition, Carrier also submitted additional evidence establishing employer knowledge. Carrier submitted medical records confirming that Mr. Stroud was diagnosed with diabetes and suffered a traumatic brain injury (concussion) prior to his April 10, 2005 work injuries and actively sought treatment for both conditions (Carrier Exhibit B, p. 192; Carrier Exhibit C, p. 193; Carrier APA 1, pp. 5-10; Carrier APA No. 2, pp. 29, 31, 33, 37, & 40). These medical records confirming the diagnosis and treatment of said conditions combined with Mr. Stroud's position as operator and employee of Employer clearly established employer knowledge under S.C. Code § 42-9-400(c) and are further evidence of the existence of these impairments prior to Mr. Stroud's work-injury of April 10, 2005.

Regarding the diabetes, the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196) substantiated that Mr. Stroud's diabetes existed prior to his April 2005 work accident and combined with or was aggravated by his April 10, 2005 work accident to result in a substantial increase in lost time from work, permanent disability, and medical costs. In addition to the statutory presumption provided for under S.C. Code § 42-9-400(d)(2) and S.C. Code § 42-9-400(d)(34)(b), the medical questionnaires from Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196) substantiate that Mr. Stroud's preexisting diabetes was permanent and a hindrance or obstacle to employment or reemployment.

Carrier also submitted letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94). The letters substantiated that Mr. Stroud's diabetes was permanent and existed prior to his work accident and was of such seriousness as to constitute a hindrance or obstacle to employment or reemployment should he become unemployed (Carrier Exhibit B, p. 192; Carrier Exhibit C, pp. 193–94). The letters also substantiated that Mr. Stroud's preexisting diabetes combined with or was aggravated by his work accident to result in greater disability, greater medical costs, and more lost time from work (Carrier Exhibit B, p. 192; Carrier Exhibit C, p. 194). Specifically, the letter from Dr. Scott noted that because of Mr. Stroud's diabetes there was no salvage option and his right leg required amputation below the knee (Carrier Exhibit B, p. 192).

Regarding Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage, Dr. Waid noted that Mr. Stroud's preexisting traumatic brain injury (concussion) served as a risk factor for greater disability if followed closely by another traumatic brain injury, which indeed did occur on April 10, 2005 (Carrier Exhibit C, pp. 193–94). Dr. Waid concluded that Mr. Stroud's work accident of April 10, 2005 combined with or aggravated his prior traumatic brain injury (concussion) to result in greater disability, greater medical costs, as well as greater lost time from work (Carrier Exhibit C, p. 194). As further support, Carrier submitted a report from the Centers for Disease Control and Prevention which established that a concussion, even if minor, is a traumatic brain injury, and that a prior traumatic brain injury serves as a risk factor for greater disability (Carrier Exhibit F, pp. 197–215). Furthermore, when a previous traumatic brain injury combines with a subsequent traumatic brain injury, it can result in greater disability due to the combined effects of the two injuries (Carrier Exhibit F, pp. 197–215).

In addition to the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), the letters from both doctors (Carrier Exhibit B, p. 192; Carrier Exhibit C, pp. 193–94), and the report from the Centers for Disease Control and Prevention, several medical

records were produced by Carrier to establish its claim for full reimbursement from the South Carolina Second Injury Fund. Included in these documents are records from the following: (1) Medical records from John F. McLeod III, M.D.; (2) Medical records from G. Simpson, M.D., Palmetto Health Richland—Emergency Department; (3) Medical records from Lenwood P. Smith, Jr., M.D., Eddie G. Richmond, M.D., James E. Morrison, M.D., Palmetto Health Richland; (4) Medical records from Patrick Connor, M.D., OrthoCarolina; (5) Medical records from Carolinas Healthcare System; (6) Medical records from Carolinas Healthcare System—Radiological Services; (7) Medical records from Abdul Garuba, M.D., Carolinas Specialty Hospital; (8) Medical records from Michael J. Bosse, M.D., Carolinas Healthcare System—Orthopaedics; (9) Medical records from Sonya G. Rissmiller, M.D., Sharon K. Kanelos, M.D., Carolinas Healthcare System—Rehabilitation; (10) Medical records from Jeff Haskett, M.S., Anson-Union Regional Prosthetic-Orthotic Services; (11) Medical records from Sharon K. Kanelos, M.D., Carolinas Healthcare System—Monroe Clinic; (12) Medical records from John Barkenbus, M.D., North Carolina Neuropsychiatry (Carrier APA Nos. 1–12, pp. 1–190 respectively).

Medical records from Dr. McLeod specifically note that Mr. Stroud was diagnosed with diabetes as far back as September 21, 1998 and received glucophage treatment prior to his accident of April 10, 2005 (Carrier APA No. 1, pp. 5–10). Medical records from Carolinas Healthcare System (Carrier APA No. 5, pp. 42–91) also note that Mr. Stroud's diabetes existed prior to his April 2005 work accident and provide clear evidence that said impairment combined with his work accident to result in a substantial increase in lost time from work, permanent disability, and medical costs. Specifically, Mr. Stroud required amputation of his right lower extremity as a result of the combination of his preexisting diabetes and work accident of April 2005. The medical records from Carolina Healthcare System indicate that on account of Mr. Stroud's diabetes, salvage of his right lower extremity was not an option (Carrier APA No. 5, p. 89). Regarding his prior traumatic brain injury,

medical records from Palmetto Health Richland noted that Mr. Stroud suffered a traumatic brain injury (concussion) prior to his April 2005 work accident (Carrier APA No. 2, pp. 29, 31; Carrier APA 3, pp. 33, 37, & 40). Medical records from Dr. McLeod similarly note that Mr. Stroud had a diagnosis of traumatic brain injury (concussion) prior to the April 2005 work accident (Carrier APA No. 1, p.9).

The Fund failed to present any relevant evidence that Mr. Stroud's preexisting permanent diabetes, traumatic brain injury (concussion) and/or brain damage, and permanent impairment resulting from the combination of the preexisting impairments with the subsequent injuries being equal to or in excess of seventy-eight weeks did not hinder his ability to obtain employment.

Based on the evidence received, including the medical records included in the APA submissions, the Exhibits, and the Commission file, the Findings of Fact are as follows:

FINDINGS OF FACT

IT IS FOUND AS FACT:

1. That the parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as existed on the date of Mr. Stroud's work-related accident, April 10, 2005;
2. That the South Carolina Workers' Compensation Commission has jurisdiction to hear the Carrier's claim for reimbursement from the South Carolina Second Injury Fund arising out of underlying work injuries sustained by Mr. Stroud in the course and scope of his employment with Employer on April 10, 2005;
3. That venue in Florence, South Carolina is proper;
4. That Mr. Stroud's average weekly wage is one thousand two hundred eight and 0/100 Dollars (\$1,208.00), with a corresponding compensation rate of five hundred ninety-two and 56/100 Dollars (\$592.56);

5. That on April 10, 2005 while working for Employer, Mr. Stroud sustained injuries to his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, shoulders, and suffered hearing loss in an airplane crash during the course and scope of his employment per the Decision and Order of the SCWCC dated September 5, 2008;
6. That Mr. Stroud reached maximum medical improvement by August 5, 2008;
7. That Mr. Stroud's disability claim for his April 10, 2005 accident has been concluded;
8. That the South Carolina Second Injury Fund received timely and proper notice of Carrier's claim for reimbursement of compensation paid to Mr. Stroud for his April 10, 2005 work injury;
9. That City of Greenville v. South Carolina Second Injury Fund, 339 S.C. 141, 528 S.E.2d 91 (Ct. App. 2000), as applied to the facts of this instant action, does not affect Carrier's right for full reimbursement for compensation and medical payments made to Mr. Stroud. In the aforementioned case, the claimant was deemed permanently and totally disabled independent of his preexisting impairment; that is, claimant's preexisting impairment did not contribute in any way to his permanent and total disability. Furthermore, in the aforementioned case, the carrier failed to submit sufficient evidence establishing employer knowledge under S.C. Code § 42-9-400(c). Additionally, in the aforementioned case, the carrier failed to submit sufficient evidence proving that it suffered a substantial increase in medical payments as a result of claimant's preexisting condition. As contrasted with the aforementioned case, in this instant action Carrier submitted evidence sufficient to show that Mr. Stroud's preexisting impairments contributed to him being deemed permanently and totally disabled, submitted evidence establishing employer knowledge, and submitted evidence establishing substantially increased medical costs attributable to his preexisting

impairments. First, in the Decision and Order of the SCWCC dated September 5, 2008, the single commissioner found Mr. Stroud to be permanently and totally disabled due to his permanent brain injury and the combined effects of all of his injuries (Carrier Exhibit A, p. 9). Second, Carrier submitted medical evidence establishing that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage, as well as his diabetes contributed to his permanent and total disability. Carrier submitted a letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190), including but not limited to records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case, which collectively established that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage combined with his work injuries of April 10, 2005 to result in greater disability, which in turn contributed to the single commissioner finding him permanently and totally disabled. Carrier also submitted letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-94), medical questionnaires from Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190), including but not limited to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case, which collectively established that Mr. Stroud's preexisting diabetes contributed to the amputation of Mr. Stroud's right lower extremity below the knee. Therefore, unlike the aforementioned case, medical evidence submitted by the Carrier in this instant action clearly establishes that Mr. Stroud's preexisting

impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage directly affected his disability, which in turn factored into the finding that he was permanently and totally disabled. Third, in this instant action, the Fund conceded that Carrier had established employer knowledge under S.C. Code § 42-9-400(c). In addition, Carrier submitted evidence establishing employer knowledge. Mr. Stroud was aware of his preexisting diabetes and traumatic brain injury (concussion) and/or brain damage as evidenced by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case. Mr. Stroud's awareness of his preexisting diabetes and traumatic brain injury (concussion) and/or brain damage combined with Mr. Stroud's position as operator and employee of Employer established employer knowledge under S.C. Code § 42-9-400(c). Lastly, unlike the aforementioned case, in this instant action, Carrier submitted evidence establishing that Mr. Stroud's preexisting diabetes and traumatic brain injury (concussion) and/or brain damage resulted in substantially increased medical costs for Carrier. Carrier submitted the letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31;

Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case, which collectively established that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage combined with his work injuries of April 10, 2005 to result in greater disability and a longer recovery time; this in turn substantially increased Carrier's liability for medical payments and compensation to Mr. Stroud. Additionally, Carrier submitted letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94), medical questionnaires from Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case, which collectively establish that Mr. Stroud's preexisting diabetes contributed to the amputation of Mr. Stroud's right lower extremity below the knee; this in turn substantially increased Carrier's liability for medical payments and compensation to Mr. Stroud. In sum, unlike the aforementioned case, in this instant action Carrier has fulfilled all of the requirements under S.C. Code § 42-9-400 and therefore is entitled to full reimbursement as provided for in the statute;

10. That Mr. Stroud suffered from diabetes prior to his April 10, 2005 work-related accident. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland

(Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

11. That Mr. Stroud suffered a traumatic brain injury (concussion) rising to the level of brain damage prior to his April 10, 2005 work-related accident. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
12. That prior to his injuries of April 10, 2005, Mr. Stroud was aware of his preexisting diabetes and traumatic brain injury and/or brain damage and gave notice to Employer of the same. This finding is supported by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
13. That the Fund conceded that Carrier established employer knowledge under S.C. Code § 42-9-400(c). Additionally, Carrier established employer knowledge independently of

the Fund's concession. Mr. Stroud's awareness of his preexisting diabetes and traumatic brain injury and/or brain damage combined with Mr. Stroud's position as operator and employee of Employer establishes employer knowledge under S.C Code § 42-9-400(c). This finding is supported by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;

14. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(2), that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment if Mr. Stroud should become unemployed. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

15. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(28) that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment if Mr. Stroud should become unemployed. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
16. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(34)(b) that Mr. Stroud's preexisting impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage were permanent and of such seriousness as to constitute hindrances or obstacles to obtaining employment or reemployment if Mr. Stroud should become unemployed as said impairments combined with the subsequent injuries to result in permanent impairment equal to or in excess of 78 weeks. This finding is supported by the record as a whole, including medical questionnaires/completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from

the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), the Decision and Order of the SCWCC finding Mr. Stroud to be permanently and totally disabled (Fund Exhibit A, p. 9), as well as other medical evidence in this case;

17. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed;
18. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed;
19. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage were permanent and of such seriousness as to constitute hindrances or obstacles to employment or reemployment if Mr. Stroud should become unemployed on account of their combining with his work injuries of April 10, 2005 to result in disability ratings equal to or greater than seventy-eight weeks;
20. That Mr. Stroud's preexisting diabetes was a permanent physical condition and was of such seriousness that it served as a hindrance or obstacle to employment or reemployment. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland

(Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

21. That Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was a permanent physical condition and was of such seriousness that it served as a hindrance or obstacle to employment or reemployment. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case. Specifically, the report from the Centers for Disease Control defined traumatic brain injury to include concussions (Carrier Exhibit F, p. 197) and noted that individuals suffering from a concussion may take longer to recover from a subsequent traumatic brain injury (Carrier Exhibit F, p. 201). Dr. Waid contended that Mr. Stroud's prior traumatic brain injury served as a risk factor for greater disability should he suffer another traumatic brain injury (Carrier Exhibit C, p. 193); Dr. Waid found that Mr. Stroud's prior traumatic brain injury (concussion) did in fact cause a greater level of impairment when combined with his April 10, 2005 traumatic brain injury. Further, the Decision and Order of the SCWCC dated September 5, 2008 indicates Mr. Stroud was found to be permanently and totally disabled based upon his permanent brain injury and the combined effects of all his injuries (Fund Exhibit A, p. 9).
22. That the Fund failed to rebut Carrier's evidence that Mr. Stroud's preexisting diabetes was a permanent impairment and of such seriousness as to constitute a hindrance or

obstacle to obtaining employment or reemployment. The Fund failed to present any direct evidence, including medical evidence, purporting to show that Mr. Stroud's preexisting diabetes was not a hindrance or obstacle to his employment or reemployment were he to become unemployed;

23. That the Fund failed to rebut Carrier's evidence that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was a permanent impairment and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment. The Fund failed to present any direct evidence, including medical evidence, purporting to show that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was not a hindrance or obstacle to his employment or reemployment were he to become unemployed. However, Carrier submitted a letter from Dr. Waid (Carrier Exhibit C, pp. 193-94) substantiating that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage served as a hindrance or obstacle to employment because it constituted a risk factor for greater disability resulting from the subsequent traumatic brain injury. Carrier also submitted a report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215) supporting Dr. Waid's contention that a prior traumatic brain injury, including a concussion, creates the risk for greater disability when combined with a subsequent traumatic brain injury.
24. That Mr. Stroud's preexisting diabetes combined with or was aggravated by his April 10, 2005 work accident. This finding is supported by the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190), including but not limited

- to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case;
25. That Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage combined with or was aggravated by his April 10, 2005 work injury. This finding is supported by the record as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case;
26. That the aggravations, as described above, substantially increased the overall liability of Employer and Carrier. This finding is supported by the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), the letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to the medical records from Carolina Hospital System (Carrier APA No. 5, p. 89), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), the Decision and Order of the SCWCC dated September 5, 2008 finding Mr. Stroud to be permanently and totally disabled (Fund Exhibit A, p. 9), as well as other medical evidence in this case;
27. That the evidence in the medical records supports Carrier's claim for Second Injury Fund recovery;
28. That Carrier's questionnaires as contained in Carrier Exhibit D (p. 195) and Carrier Exhibit E (p. 196) are supported by the medical evidence;
29. That the letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94) are supported by the medical evidence;

30. That Carrier is entitled to reimbursement;
31. That Carrier is entitled to reimbursement under multiple theories, any one of which is sufficient to support its claim for reimbursement. Carrier is entitled to reimbursement under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(28), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a);
32. That even if Carrier does not qualify for reimbursement under S.C. Code § 42-9-400(d)(28), Carrier is still entitled to reimbursement under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a), respectively. It is the determination of this Commissioner that Carrier has fulfilled all requirements of S.C. Code § 42-9-400 under each theory, any one of which is sufficient to entitle to Carrier to full reimbursement for all compensation and medical payments made to Mr. Stroud;
33. That Carrier is entitled to reimbursement from the Fund for all indemnity paid to Mr. Stroud in excess of 78 weeks;
34. That Carrier is entitled to full reimbursement from the Fund for fifty percent (50%) of all medical benefits paid to Mr. Stroud in excess of \$3,000.00 within the first seventy-eight (78) weeks after his work injury and one hundred percent (100%) reimbursement of all medical benefits paid after the first seventy-eight (78) weeks following the injury.

CONCLUSIONS OF LAW

Accordingly, as provided under the South Carolina Code of Laws, § 42-17-40, and § 1-23-320, it is the determination of this Commissioner that:

1. According to Pee Dee Transportation v. South Carolina Second Injury Fund, 375 S.C. 60 (2007), the parties to this proceeding are subject to and bound by the

provisions of the South Carolina Workers' Compensation Act, as it existed on the date of Mr. Stroud's work-related accident, April 10, 2005;

2. According to McLeod v. Piggly Wiggly Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984) and Wynn v. Peoples Natural Gas Co., 238 S.C. 1, 118 S.E.2d 812 (1961), the fact finder may not base its decision upon lay testimony in medically complex cases. Additionally, according to Baker v. Graniteville Co., 197 S.C. 21, 14 S.E.2d 367 (1941), evidence from medical experts can be disregarded *only* where there is other competent evidence in the record upon which the finder of fact can base its decision. According to Ballenger v. Southern Worsted Corp., 209 S.C. 463, 40 S.E.2d 681 (1946), and Poston v. Southeastern Construction Co., 208 S.C. 35, 36 S.E.2d 858 (1946), only testimony by the claimant or claimant's spouse as to the claimant's pre and post-accident condition satisfies "other competent evidence" in medically complex cases. In the instant action, only Carrier submitted expert medical evidence and the Fund failed to submit any evidence meeting the standard of other competent evidence. As such, Carrier's medical evidence is given conclusive effect;
3. Under S.C. Code § 42-9-400(f), the Fund received proper and timely notice of Carrier's claim for reimbursement;
4. Under S.C. Code § 42-9-400(c), the Fund conceded that Carrier established employer knowledge. In addition, Carrier submitted evidence which established that Employer had knowledge of Mr. Stroud's diabetes and traumatic brain injury (concussion) and/or brain damage prior to his April 10, 2005 work injury;
5. Under S.C. Code § 42-9-400(d)(2), Mr. Stroud's preexisting diabetes is presumed to be permanent in nature and constitutes a hindrance or obstacle to employment or reemployment;

6. Under S.C. Code § 42-9-400(d)(28), Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage is presumed to be permanent in nature and constitutes a hindrance or obstacle to employment or reemployment;
7. Under S.C. Code § 42-9-400(d)(34)(b), Mr. Stroud's preexisting impairments consisting of diabetes, and/or traumatic brain injury (concussion), and/or brain damage are presumed to be permanent in nature and constitute hindrances or obstacles to employment or reemployment as their combination with the subsequent work-related injuries resulted in permanent impairment equal to or in excess of 78 weeks;
8. Under S.C. Code § 42-9-400(d)(2), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting diabetes was permanent in nature and serious enough to constitute a hindrance or obstacle to his employment or reemployment;
9. Under S.C. Code § 42-9-400(d)(28), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent in nature and serious enough to constitute a hindrance or obstacle to his employment or reemployment;
10. Under S.C. Code § 42-9-400(d)(34)(b), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting impairments consisting of diabetes, and/or traumatic brain injury (concussion), and/or brain damage were permanent in nature and serious enough to constitute hindrances or obstacles to his employment or reemployment;
11. Under S.C. Code § 42-9-400(d), Mr. Stroud had preexisting diabetes which was permanent in nature and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud were to become unemployed;

12. Under S.C. Code § 42-9-400(d), Mr. Stroud had a preexisting traumatic brain injury (concussion) and/or brain damage which was permanent in nature and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud were to become unemployed;
13. Under S.C. Code § 42-9-400(d), the Fund failed to show that Mr. Stroud's preexisting diabetes was not of such seriousness so as to constitute a hindrance or obstacle to his employment or reemployment;
14. Under S.C. Code § 42-9-400(d), the Fund failed to show that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was not of such seriousness so as to constitute a hindrance or obstacle to his employment or reemployment;
15. Under S.C. Code § 42-9-400(a), Carrier has shown that Mr. Stroud's preexisting diabetes, and/or traumatic brain injury (concussion), and/or brain damage combined with or were aggravated by his April 10, 2005 work accident to substantially increase Carrier's overall liability, including increased liability for medical payments and for payment of compensation;
16. Under S.C. Code § 42-9-400(a), Carrier is entitled to full reimbursement from the Fund under multiple theories, including under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(28), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a), any one of which is sufficient to entitle Carrier to full reimbursement from the Fund;
17. Under S.C. Code § 42-9-400(a)(1), Carrier is entitled to full reimbursement of all indemnity paid to Mr. Stroud in excess of the first seventy-eight (78) weeks following the April 10, 2005 work accident;

18. Under S.C. Code § 42-9-400(a)(2), Carrier is entitled to full reimbursement of fifty percent (50%) of all medical benefits paid for treatment of Mr. Stroud's injuries in excess of \$3,000.00 during the first 78 weeks following his April 10, 2005 work accident, and is entitled to reimbursement of one hundred percent (100%) of all medical benefits paid thereafter.

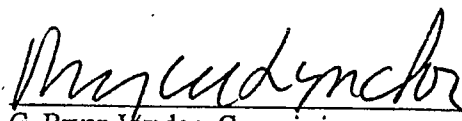
ORDER

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED that the Carrier has qualified for reimbursement from the South Carolina Second Injury Fund for Mr. Stroud's April 10, 2005 workers' compensation claim.

IT IS FURTHER ORDERED that the Carrier is entitled to full reimbursement of all indemnity paid to Mr. Stroud in excess of the first seventy-eight (78) weeks following the April 10, 2005 work injury.

IT IS FURTHER ORDERED that the Carrier is entitled to reimbursement of fifty percent (50%) of all medical benefits paid for treatment of Mr. Stroud's injury in excess of \$3,000.00 during the first seventy-eight (78) weeks immediately following his April 10, 2005 work injury, and entitled to reimbursement for one hundred percent (100%) of all medical benefits paid thereafter.

IT IS SO ORDERED.



G. Bryan Lyndon, Commissioner

South Carolina Workers' Compensation Commission

CERTIFICATE OF SERVICE

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

October 20, 2011

By: Tamara Morris, Administrative Assistant to Commissioner Lyndon

DECISION AND ORDER
OF THE
APPELLATE PANEL
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
W.C.C. FILE NO.: 0504228

John F. Stroud & Sons, Inc./Amercian Home Assurance Co.,..... Employer & Carrier/Respondents,

v.

South Carolina Second Injury Fund, ... Appellant.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

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

FULL AFFIRMATION

APPEARANCES:

Employer & Carrier/Respondents represented by:
Jared M. Pretulak
Gallivan, White & Boyd, P.A.
P. O. Box 10589
Greenville, SC 29603

Appellant represented by:
Latonya D. Edwards, Esq.
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, SC 29210

* * * * *

STATEMENT OF THE CASE

The parties were heard by Commissioner G. Bryan Lyndon on September 21, 2011, in Florence, South Carolina. Commissioner Lyndon issued the following Order:

1. That the Carrier has qualified for reimbursement from the South Carolina Second Injury Fund for Mr. Stroud's April 10, 2005 workers' compensation claim.
2. That the Carrier is entitled to full reimbursement of all indemnity paid to Mr. Stroud in excess of the first seventy-eight (78) weeks following the April 10, 2005 work injury.
3. That the Carrier is entitled to reimbursement of fifty percent (50%) of all medical benefits paid for treatment of Mr. Stroud's injury in excess of \$3,000.00 during the first seventy-eight (78) weeks immediately following his April 10, 2005 work injury, and entitled to reimbursement for one hundred percent (100%) of all medical benefits paid thereafter.

Within the statutory period, the South Carolina Second Injury Fund filed an Application for Full Commission Review of the Hearing Commissioner's Decision and Order (Form 30). In its appeal, the Fund raised the following issues:

1. Did the Hearing Commissioner err in finding as a fact that Carrier is entitled to compensation reimbursement when Mr. Stroud was found to be permanently and totally disabled and such reimbursement is contrary to prevailing case law?
2. Did the Hearing Commissioner err in finding as a fact that Mr. Stroud suffered a traumatic brain injury (concussion) rising to the level of brain damage prior to his April 10, 2005 work-related accident, when such finding is against the great weight of the reliable, probative, and substantial evidence in the record?

3. Did the Hearing Commissioner err in finding as a fact that the Fund conceded knowledge, the error being that the Fund only conceded knowledge of a prior concussion, but not prior brain damage?
4. Did the Hearing Commissioner err in finding as a fact that the Fund failed to rebut the presumption and/or Carrier's evidence that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
5. Did the Hearing Commissioner err in finding as a fact that the Fund failed to rebut the presumption and/or Carrier's evidence that Mr. Stroud's preexisting traumatic brain injury (concussion) was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
6. Did the Hearing Commissioner err in finding as a fact that Mr. Stroud's preexisting diabetes combined with or was aggravated by his April 10, 2005 work accident when such finding is against the preponderance of the reliable, probative, and substantial evidence in the record?
7. Did the Hearing Commissioner err in finding as a fact that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage combined with or was aggravated by his April 10, 2005 work injury when such finding is against the greater weight of the reliable, probative and substantial evidence in the record?

In an Appellate Review, the Panel, pursuant to S.C. Code § 42-17-50, reviews the Award, weighs the evidence presented to the Hearing Commissioner, and, if good grounds are shown, makes its own Findings of Fact and reaches its own Conclusions of Law, consistent with or inconsistent with those of the Hearing Commissioner.

After careful review in the instant case, the Appellate Panel of the South Carolina Workers' Compensation Commission, by unanimous vote, has determined that all of the Hearing Commissioner's Findings of Fact and Conclusions of Law are correct as stated. Accordingly, they are the law of the case, and therefore the Order is sustained in its entirety.

FINDINGS OF FACT

We fully affirm and adopt the following Findings of Fact:

1. That the parties to this proceeding are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as existed on the date of Mr. Stroud's work-related accident, April 10, 2005;
2. That the South Carolina Workers' Compensation Commission has jurisdiction to hear the Carrier's claim for reimbursement from the South Carolina Second Injury Fund arising out of underlying work injuries sustained by Mr. Stroud in the course and scope of his employment with Employer on April 10, 2005;
3. That venue in Florence, South Carolina is proper;
4. That Mr. Stroud's average weekly wage is one thousand two hundred eight and 0/100 Dollars (\$1,208.00), with a corresponding compensation rate of five hundred ninety-two and 56/100 Dollars (\$592.56);
5. That on April 10, 2005 while working for Employer, Mr. Stroud sustained injuries to his left eye, right eye, right leg, left leg, left hip, right arm, torso, ribs, shoulders, and

suffered hearing loss in an airplane crash during the course and scope of his employment per the Decision and Order of the SCWCC dated September 5, 2008;

6. That Mr. Stroud reached maximum medical improvement by August 5, 2008;
7. That Mr. Stroud's disability claim for his April 10, 2005 accident has been concluded;
8. That the South Carolina Second Injury Fund received timely and proper notice of Carrier's claim for reimbursement of compensation paid to Mr. Stroud for his April 10, 2005 work injury;
9. That City of Greenville v. South Carolina Second Injury Fund, 339 S.C. 141, 528 S.E.2d 91 (Ct. App. 2000), as applied to the facts of this instant action, does not affect Carrier's right for full reimbursement for compensation and medical payments made to Mr. Stroud. In the aforementioned case, the claimant was deemed permanently and totally disabled independent of his preexisting impairment; that is, claimant's preexisting impairment did not contribute in any way to his permanent and total disability. Furthermore, in the aforementioned case, the carrier failed to submit sufficient evidence establishing employer knowledge under S.C. Code § 42-9-400(c). Additionally, in the aforementioned case, the carrier failed to submit sufficient evidence proving that it suffered a substantial increase in medical payments as a result of claimant's preexisting condition. As contrasted with the aforementioned case, in this instant action Carrier submitted evidence sufficient to show that Mr. Stroud's preexisting impairments contributed to him being deemed permanently and totally disabled, submitted evidence establishing employer knowledge, and submitted evidence establishing substantially increased medical costs attributable to his preexisting impairments. First, in the Decision and Order of the SCWCC dated September 5, 2008, the single commissioner found Mr.

Stroud to be permanently and totally disabled due to his permanent brain injury and the combined effects of all of his injuries (Carrier Exhibit A, p. 9). Second, Carrier submitted medical evidence establishing that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage, as well as his diabetes contributed to his permanent and total disability. Carrier submitted a letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case, which collectively established that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage combined with his work injuries of April 10, 2005 to result in greater disability, which in turn contributed to the single commissioner finding him permanently and totally disabled. Carrier also submitted letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94), medical questionnaires from Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case, which collectively established that Mr. Stroud's preexisting diabetes contributed to the amputation of Mr. Stroud's right lower extremity below the knee. Therefore, unlike the aforementioned case, medical evidence submitted by the Carrier in this instant action clearly establishes that Mr. Stroud's preexisting impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage

directly affected his disability, which in turn factored into the finding that he was permanently and totally disabled. Third, in this instant action, the Fund conceded that Carrier had established employer knowledge under S.C. Code § 42-9-400(c). In addition, Carrier submitted evidence establishing employer knowledge. Mr. Stroud was aware of his preexisting diabetes and traumatic brain injury (concussion) and/or brain damage as evidenced by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case. Mr. Stroud's awareness of his preexisting diabetes and traumatic brain injury (concussion) and/or brain damage combined with Mr. Stroud's position as operator and employee of Employer established employer knowledge under S.C Code § 42-9-400(c). Lastly, unlike the aforementioned case, in this instant action, Carrier submitted evidence establishing that Mr. Stroud's preexisting diabetes and traumatic brain injury (concussion) and/or brain damage resulted in substantially increased medical costs for Carrier. Carrier submitted the letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the

report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case, which collectively established that Mr. Stroud's prior traumatic brain injury (concussion) and/or brain damage combined with his work injuries of April 10, 2005 to result in greater disability and a longer recovery time; this in turn substantially increased Carrier's liability for medical payments and compensation to Mr. Stroud. Additionally, Carrier submitted letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–94), medical questionnaires from Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190), including but not limited to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case, which collectively establish that Mr. Stroud's preexisting diabetes contributed to the amputation of Mr. Stroud's right lower extremity below the knee; this in turn substantially increased Carrier's liability for medical payments and compensation to Mr. Stroud. In sum, unlike the aforementioned case, in this instant action Carrier has fulfilled all of the requirements under S.C. Code § 42-9-400 and therefore is entitled to full reimbursement as provided for in the statute;

10. That Mr. Stroud suffered from diabetes prior to his April 10, 2005 work-related accident. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194). Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland (Carrier APA No.

2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

11. That Mr. Stroud suffered a traumatic brain injury (concussion) rising to the level of brain damage prior to his April 10, 2005 work-related accident. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case;
12. That prior to his injuries of April 10, 2005, Mr. Stroud was aware of his preexisting diabetes and traumatic brain injury and/or brain damage and gave notice to Employer of the same. This finding is supported by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194), Mr. Stroud's medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case;

13. That the Fund conceded that Carrier established employer knowledge under S.C. Code § 42-9-400(c). Additionally, Carrier established employer knowledge independently of the Fund's concession. Mr. Stroud's awareness of his preexisting diabetes and traumatic brain injury and/or brain damage combined with Mr. Stroud's position as operator and employee of Employer establishes employer knowledge under S.C. Code § 42-9-400(c). This finding is supported by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
14. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(2), that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment if Mr. Stroud should become unemployed. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health

Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

15. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(28) that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment if Mr. Stroud should become unemployed. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
16. That the Carrier is afforded a statutory presumption under S.C. Code § 42-9-400(d)(34)(b) that Mr. Stroud's preexisting impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage were permanent and of such seriousness as to constitute hindrances or obstacles to obtaining employment or reemployment if Mr. Stroud should become unemployed as said impairments combined with the subsequent injuries to result in permanent impairment equal to or in excess of 78 weeks. This finding is supported by the record as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-194), Mr. Stroud's medical records (Carrier APA Nos. 1-12.

pp. 1-190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5-10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), the Decision and Order of the SCWCC finding Mr. Stroud to be permanently and totally disabled (Fund Exhibit A, p. 9), as well as other medical evidence in this case;

17. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed;
18. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed;
19. That the Fund failed to rebut the presumption that Mr. Stroud's preexisting impairments consisting of diabetes and traumatic brain injury (concussion) and/or brain damage were permanent and of such seriousness as to constitute hindrances or obstacles to employment or reemployment if Mr. Stroud should become unemployed on account of their combining with his work injuries of April 10, 2005 to result in disability ratings equal to or greater than seventy-eight weeks;
20. That Mr. Stroud's preexisting diabetes was a permanent physical condition and was of such seriousness that it served as a hindrance or obstacle to employment or reemployment. This finding is based on the records as a whole, including medical questionnaires completed by Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier

Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193–194). Mr. Stroud’s medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA 1, pp. 5–10) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), as well as other medical evidence in this case;

21. That Mr. Stroud’s preexisting traumatic brain injury (concussion) and/or brain damage was a permanent physical condition and was of such seriousness that it served as a hindrance or obstacle to employment or reemployment. This finding is based on the records as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193–94), Mr. Stroud’s medical records (Carrier APA Nos. 1–12, pp. 1–190, respectively), including but not limited to medical records from Dr. McLeod (Carrier APA No. 1, p. 9) and medical records from Palmetto Health Richland (Carrier APA No. 2, pp. 29, 31; Carrier APA No. 3, pp. 33, 37, & 40), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197–215), as well as other medical evidence in this case. Specifically, the report from the Centers for Disease Control defined traumatic brain injury to include concussions (Carrier Exhibit F, p. 197) and noted that individuals suffering from a concussion may take longer to recover from a subsequent traumatic brain injury (Carrier Exhibit F, p. 201). Dr. Waid contended that Mr. Stroud’s prior traumatic brain injury served as a risk factor for greater disability should he suffer another traumatic brain injury (Carrier Exhibit C, p. 193); Dr. Waid found that Mr. Stroud’s prior traumatic brain injury (concussion) did in fact cause a greater level of impairment when combined with his April 10, 2005 traumatic brain injury. Further, the

Decision and Order of the SCWCC dated September 5, 2008 indicates Mr. Stroud was found to be permanently and totally disabled based upon his permanent brain injury and the combined effects of all his injuries (Fund Exhibit A, p. 9).

22. That the Fund failed to rebut Carrier's evidence that Mr. Stroud's preexisting diabetes was a permanent impairment and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment. The Fund failed to present any direct evidence, including medical evidence, purporting to show that Mr. Stroud's preexisting diabetes was not a hindrance or obstacle to his employment or reemployment were he to become unemployed;
23. That the Fund failed to rebut Carrier's evidence that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was a permanent impairment and of such seriousness as to constitute a hindrance or obstacle to obtaining employment or reemployment. The Fund failed to present any direct evidence, including medical evidence, purporting to show that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was not a hindrance or obstacle to his employment or reemployment were he to become unemployed. However, Carrier submitted a letter from Dr. Waid (Carrier Exhibit C, pp. 193-94) substantiating that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage served as a hindrance or obstacle to employment because it constituted a risk factor for greater disability resulting from the subsequent traumatic brain injury. Carrier also submitted a report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215) supporting Dr. Waid's contention that a prior traumatic brain injury, including a concussion, creates the risk for greater disability when combined with a subsequent traumatic brain injury.

24. That Mr. Stroud's preexisting diabetes combined with or was aggravated by his April 10, 2005 work accident. This finding is supported by the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190), including but not limited to medical records from Carolinas Healthcare System (Carrier APA No. 5, p. 89), as well as other medical evidence in this case;
25. That Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage combined with or was aggravated by his April 10, 2005 work injury. This finding is supported by the record as a whole, including the letter from Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), as well as other medical evidence in this case;
26. That the aggravations, as described above, substantially increased the overall liability of Employer and Carrier. This finding is supported by the medical questionnaires of Dr. Scott (Carrier Exhibit D, p. 195) and Dr. Waid (Carrier Exhibit E, p. 196), the letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-94), Mr. Stroud's medical records (Carrier APA Nos. 1-12, pp. 1-190, respectively), including but not limited to the medical records from Carolina Hospital System (Carrier APA No. 5, p. 89), the report from the Centers for Disease Control and Prevention (Carrier Exhibit F, pp. 197-215), the Decision and Order of the SCWCC dated September 5, 2008 finding Mr. Stroud to be permanently and totally disabled (Fund Exhibit A, p. 9), as well as other medical evidence in this case;

27. That the evidence in the medical records supports Carrier's claim for Second Injury Fund recovery;
28. That Carrier's questionnaires as contained in Carrier Exhibit D (p. 195) and Carrier Exhibit E (p. 196) are supported by the medical evidence;
29. That the letters from Dr. Scott (Carrier Exhibit B, p. 192) and Dr. Waid (Carrier Exhibit C, pp. 193-94) are supported by the medical evidence;
30. That Carrier is entitled to reimbursement;
31. That Carrier is entitled to reimbursement under multiple theories, any one of which is sufficient to support its claim for reimbursement. Carrier is entitled to reimbursement under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(28), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a);
32. That even if Carrier does not qualify for reimbursement under S.C. Code § 42-9-400(d)(28), Carrier is still entitled to reimbursement under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a), respectively. It is the determination of this Commissioner that Carrier has fulfilled all requirements of S.C. Code § 42-9-400 under each theory, any one of which is sufficient to entitle to Carrier to full reimbursement for all compensation and medical payments made to Mr. Stroud;
33. That Carrier is entitled to reimbursement from the Fund for all indemnity paid to Mr. Stroud in excess of 78 weeks;
34. That Carrier is entitled to full reimbursement from the Fund for fifty percent (50%) of all medical benefits paid to Mr. Stroud in excess of \$3,000.00 within the first seventy-eight

(78) weeks after his work injury and one hundred percent (100%) reimbursement of all medical benefits paid after the first seventy-eight (78) weeks following the injury.

CONCLUSIONS OF LAW

We fully affirm and adopt the following Conclusions of Law:

1. According to Pee Dee Transportation v. South Carolina Second Injury Fund, 375 S.C. 60 (2007), the parties to this proceeding are subject to and bound by the provisions of the South Carolina Workers' Compensation Act, as it existed on the date of Mr. Stroud's work-related accident, April 10, 2005;
2. According to McLeod v. Piggly Wiggly Co., 280 S.C. 466, 313 S.E.2d 38 (Ct. App. 1984) and Wynn v. Peoples Natural Gas Co., 238 S.C. 1, 118 S.E.2d 812 (1961), the fact finder may not base its decision upon lay testimony in medically complex cases. Additionally, according to Baker v. Graniteville Co., 197 S.C. 21, 14 S.E.2d 367 (1941), evidence from medical experts can be disregarded *only* where there is other competent evidence in the record upon which the finder of fact can base its decision. According to Ballenger v. Southern Worsted Corp., 209 S.C. 463, 40 S.E.2d 681 (1946), and Poston v. Southeastern Construction Co., 208 S.C. 35, 36 S.E.2d 858 (1946), only testimony by the claimant or claimant's spouse as to the claimant's pre and post-accident condition satisfies "other competent evidence" in medically complex cases. In the instant action, only Carrier submitted expert medical evidence and the Fund failed to submit any evidence meeting the standard of other competent evidence. As such, Carrier's medical evidence is given conclusive effect;
3. Under S.C. Code § 42-9-400(f), the Fund received proper and timely notice of Carrier's claim for reimbursement;

4. Under S.C. Code § 42-9-400(c), the Fund conceded that Carrier established employer knowledge. In addition, Carrier submitted evidence which established that Employer had knowledge of Mr. Stroud's diabetes and traumatic brain injury (concussion) and/or brain damage prior to his April 10, 2005 work injury;
5. Under S.C. Code § 42-9-400(d)(2), Mr. Stroud's preexisting diabetes is presumed to be permanent in nature and constitutes a hindrance or obstacle to employment or reemployment;
6. Under S.C. Code § 42-9-400(d)(28), Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage is presumed to be permanent in nature and constitutes a hindrance or obstacle to employment or reemployment;
7. Under S.C. Code § 42-9-400(d)(34)(b), Mr. Stroud's preexisting impairments consisting of diabetes, and/or traumatic brain injury (concussion), and/or brain damage are presumed to be permanent in nature and constitute hindrances or obstacles to employment or reemployment as their combination with the subsequent work-related injuries resulted in permanent impairment equal to or in excess of 78 weeks;
8. Under S.C. Code § 42-9-400(d)(2), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting diabetes was permanent in nature and serious enough to constitute a hindrance or obstacle to his employment or reemployment;
9. Under S.C. Code § 42-9-400(d)(28), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was permanent in nature and serious enough to constitute a hindrance or obstacle to his employment or reemployment;

10. Under S.C. Code § 42-9-400(d)(34)(b), the Fund failed to rebut the statutory presumption that Mr. Stroud's preexisting impairments consisting of diabetes, and/or traumatic brain injury (concussion), and/or brain damage were permanent in nature and serious enough to constitute hindrances or obstacles to his employment or reemployment;
11. Under S.C. Code § 42-9-400(d), Mr. Stroud had preexisting diabetes which was permanent in nature and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud were to become unemployed;
12. Under S.C. Code § 42-9-400(d), Mr. Stroud had a preexisting traumatic brain injury (concussion) and/or brain damage which was permanent in nature and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud were to become unemployed;
13. Under S.C. Code § 42-9-400(d), the Fund failed to show that Mr. Stroud's preexisting diabetes was not of such seriousness so as to constitute a hindrance or obstacle to his employment or reemployment;
14. Under S.C. Code § 42-9-400(d), the Fund failed to show that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage was not of such seriousness so as to constitute a hindrance or obstacle to his employment or reemployment;
15. Under S.C. Code § 42-9-400(a), Carrier has shown that Mr. Stroud's preexisting diabetes, and/or traumatic brain injury (concussion), and/or brain damage combined with or were aggravated by his April 10, 2005 work accident to substantially increase Carrier's overall liability, including increased liability for medical payments and for payment of compensation;

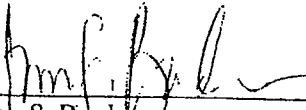
16. Under S.C. Code § 42-9-400(a), Carrier is entitled to full reimbursement from the Fund under multiple theories, including under S.C. Code § 42-9-400(d)(2), and/or S.C. Code § 42-9-400(d)(28), and/or S.C. Code § 42-9-400(d)(34)(b), and/or S.C. Code § 42-9-400(a), any one of which is sufficient to entitle Carrier to full reimbursement from the Fund;
17. Under S.C. Code § 42-9-400(a)(1), Carrier is entitled to full reimbursement of all indemnity paid to Mr. Stroud in excess of the first seventy-eight (78) weeks following the April 10, 2005 work accident;
18. Under S.C. Code § 42-9-400(a)(2), Carrier is entitled to full reimbursement of fifty percent (50%) of all medical benefits paid for treatment of Mr. Stroud's injuries in excess of \$3,000.00 during the first 78 weeks following his April 10, 2005 work accident, and is entitled to reimbursement of one hundred percent (100%) of all medical benefits paid thereafter.

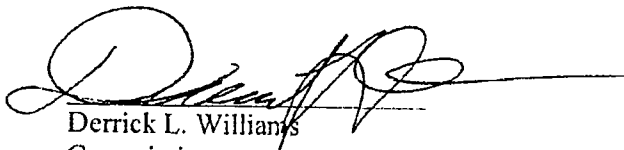
ORDER

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED that the Order of the Hearing Commissioner filed in the above-referenced matter on October 20, 2011, is hereby fully affirmed and is adopted as the Decision and Order of the Appellate Panel of the South Carolina Workers' Compensation Commission.

IT IS SO ORDERED

South Carolina Workers' Compensation Commission


Susan S. Barden
Commissioner


Derrick L. Williams
Commissioner


Gene McCaskill
Commissioner

Filed: 5/22/12

CERTIFICATE OF SERVICE

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

This 22 day of May, 2012
By Valerie D. Deller

Administrative Assistant to the Commissioner

LaTanya Edwards
J. Stuart Moore
Jared M Pretulak
Vincent A Sheheen

STATE OF SOUTH CAROLINA

COUNTY OF CHESTERFIELD

South Carolina Second Injury Fund

Plaintiff(s)

vs.

American Home Assurance Co.

Defendant(s)

Submitted By: Latonya Dilligard Edwards, Esq.

Address: 3790 Fernandina Road, Suite 103, Columbia,
South Carolina 29210

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2012-CP - 13-

362

Bar #: 14593
Telephone #: 803-750-2214
Fax #: 803-750-2377

Other:

E-mail: latonya@dilligardedwards.com

NOTE: The coversheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this coversheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

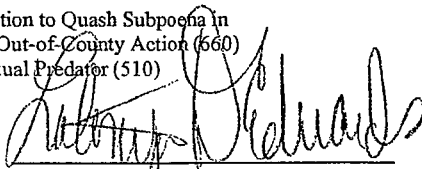
*If Action is Judgment/Settlement do not complete

- ☐ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☒ This case is exempt from ADR. (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

Contracts ☐ Constructions (100) ☐ Debt Collection (110) ☐ Employment (120) ☐ General (130) ☐ Breach of Contract (140) ☐ Other (199)	Torts - Professional Malpractice ☐ Dental Malpractice (200) ☐ Legal Malpractice (210) ☐ Medical Malpractice (220) Previous Notice of Intent Case # 20 ____-CP-_____ ☐ Notice/ File Med Mal (230) ☐ Other (299)	Torts - Personal Injury ☐ Assault/Slander/Libel (300) ☐ Conversion (310) ☐ Motor Vehicle Accident (320) ☐ Premises Liability (330) ☐ Products Liability (340) ☐ Personal Injury (350) ☐ Wrongful Death (360) ☐ Other (399)	Real Property ☐ Claim & Delivery (400) ☐ Condemnation (410) ☐ Foreclosure (420) ☐ Mechanic's Lien (430) ☐ Partition (440) ☐ Possession (450) ☐ Building Code Violation (460) ☐ Other (499)
Inmate Petitions ☐ PCR (500) ☐ Mandamus (520) ☐ Habeas Corpus (530) ☐ Other (599)	Administrative Law/Relief ☐ Reinstate Drv. License (800) ☐ Judicial Review (810) ☐ Relief (820) ☐ Permanent Injunction (830) ☐ Forfeiture-Petition (840) ☐ Forfeiture-Consent Order (850) ☐ Other (899)	Judgments/Settlements ☐ Death Settlement (700) ☐ Foreign Judgment (710) ☐ Magistrate's Judgment (720) ☐ Minor Settlement (730) ☐ Transcript Judgment (740) ☐ Lis Pendens (750) ☐ Transfer of Structured Settlement Payment Rights Application (760) ☐ Confession of Judgment (770) ☐ Petition for Workers Compensation Settlement Approval (780) ☐ Other (799)	Appeals ☐ Arbitration (900) ☐ Magistrate-Civil (910) ☐ Magistrate-Criminal (920) ☐ Municipal (930) ☐ Probate Court (940) ☐ SCDOT (950) ☒ Worker's Comp (960) ☐ Zoning Board (970) ☐ Public Service Comm. (990) ☐ Employment Security Comm (991) ☐ Other (999)
Special/Complex /Other ☐ Environmental (600) ☐ Automobile Arb. (610) ☐ Medical (620) ☐ Other (699)	☐ Pharmaceuticals (630) ☐ Unfair Trade Practices (640) ☐ Out-of State Depositions (650) ☐ Motion to Quash Subpoena in an Out-of-County Action (660) ☐ Sexual Predator (510)		

Submitting Party Signature:



Date: 6/20/2012

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF CHESTERFIELD)
South Carolina Second Injury Fund,)
Defendant/Appellant,)
vs.) CERTIFICATE OF EXEMPTION
FOR ADR
American Home Assurance Company,)
Plaintiff/ Respondent.)
DOCKET NO.: 2012-CP-13- 362

I certify that this action is exempt from ADR because:

☐ this is a special proceeding or action seeking extraordinary relief such as mandamus, habeas corpus of prohibition.

☒ this action is appellate in nature;

☐ this is a post-conviction relief matter;

☐ this is a contempt of court proceeding

☐ this is forfeiture proceeding brought by the State;

☐ this is a case involving a mortgage foreclosure; or

☐ the parties submitted the case to voluntary mediation with a certified mediator prior to the filing of this action.

2012 JUN 21 AM 9
FAYE L. SELLERS
CLERK OF COURT
CHESTERFIELD COUNTY, SC

A True Copy Test
Faye L. Sellers
CLERK OF COURT C.P. & G.S.
CHESTERFIELD COUNTY, SC

Plaintiff/Attorney(s) for Plaintiff(s)

Latonya Dilligard Edwards
Defendant/Attorney(s) for Defendant(s)/Appellant

Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina, 29210

Dated: June 20, 2012

STATE OF SOUTH CAROLINA)
COUNTY OF CHESTERFIELD)
South Carolina Second Injury Fund)
Defendant/Appellant,)
vs.)
American Home Assurance Company,)
Plaintiff/Respondent.)

IN THE COURT OF COMMON PLEAS

DOCKET NO.: 2012-CP-13-362

NOTICE OF INTENT TO APPEAL

A True Copy Attest

Faye L. Sellers

CLERK OF COURT C.P. & G.S.
CHESTERFIELD COUNTY, SC

CLERK OF COURT
CHESTERFIELD COUNTY, SC
FAYE L. SELLERS

2012 JUN 21 AM 9 07

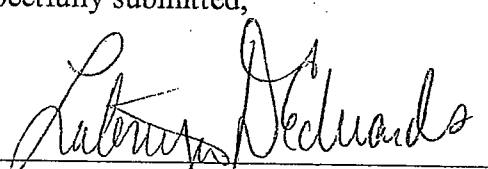
TO: JARED M. PRETULAK, ESQUIRE, ATTORNEY FOR JOHN F. STROUD & SONS, INC. AND AMERICAN HOME ASSURANCE COMPANY; AND THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION.

YOU WILL KINDLY NOTE that the South Carolina Second Injury Fund (hereinafter the "Fund"), pursuant to S. C. Code Ann. §§1-23-380 and 42-17-60, petitions the Court of Common Pleas of Chesterfield County, South Carolina, to reverse the Decision and Order of the Appellate Panel of the South Carolina Workers' Compensation Commission in WCC File No. 0504228 dated May 22, 2012, a copy of which is attached hereto. The grounds for the Fund's petition are as follows:

1. That the Commission's Decision and Order was filed on May 22, 2012, and received by the Fund on May 22, 2012, and, therefore this Appeal is timely.
2. That the Commission's Decision and Order is final and the Fund has exhausted all available administrative remedies.
3. That the Commission committed a reversible error of law in finding that Claimant suffered a traumatic brain injury rising to the level of brain damage prior to his April 10, 2005 work-related accident.

4. That the Commission committed a reversible error of law in concluding that the Fund conceded that Carrier established employer knowledge under S.C. Code § 42-9-400 (c).
5. That the Commission committed a reversible error of law in concluding that Claimant's preexisting traumatic brain injury and diabetes were permanent and serious enough to constitute a hindrance or obstacle to employment or re-employment.
6. That the Commission committed a reversible error of law in concluding that Claimant's preexisting traumatic brain injury and diabetes combined with and were aggravated by the injuries sustained in the April 10, 2005 work accident to substantially increase medical costs, time out of work, and permanent disability than Claimant would have had from the April 10, 2005 work accident alone.
7. That the Commission committed a reversible error of law in concluding that Claimant's preexisting traumatic brain injury and diabetes substantially increased Carrier's liability for medical costs and disability.
8. That the Commission committed a reversible error of law in concluding that Carrier is entitled to full reimbursement from the Fund in accordance with S.C. Code Ann. § 42-9-400.

Respectfully submitted,

By: 

Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
(803) 750-2214

June 20, 2012

STATE OF SOUTH CAROLINA

CHESTERFIELD COUNTY

South Carolina Second Injury Fund,

Defendant/Appellant,

vs.

American Home Assurance Company,

Plaintiff/Respondent.

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO.: 2012-CP-13-362

CERTIFICATE OF SERVICE

A True Copy Attest

Faye L. Sellers

CLERK OF COURT C.P. & G.S.
CHESTERFIELD COUNTY, SC

I, the undersigned employee of Dilligard Edwards, LLC, attorney for the South Carolina Second Injury Fund, 3790 Fernandina Road, Suite 103, Columbia, South Carolina 29210, do hereby certify that I have served the following named individuals with a copy of the Notice of Intent to Appeal by mailing a copy by United States mail, with sufficient postage affixed thereto and return address clearly marked on the date indicated below:

Jared M. Pretulak, Esquire
Gallivan, White & Boyd, P.A.
Post Office Box 10589
Greenville, South Carolina 29603

Virginia Crocker, Judicial Director
SC Workers' Compensation Commission
Post Office Box 1715
Columbia, SC 29202-1715

Erica M. Samuel

Erica M. Samuel

Paralegal to Latonya Dilligard Edwards

June 20, 2012

STATE OF SOUTH CAROLINA

COUNTY OF CHESTERFIELD

South Carolina Second Injury Fund,

Appellant,

v.

American Home Assurance Co.,

Respondent.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

) IN THE COURT OF COMMON PLEAS
) OF THE FOURTH JUDICIAL CIRCUIT

Case Number: 2012-CP-13-00362

CLERK OF COURT CP & GS
CHESTERFIELD COUNTY, S.C.

*True Copy
Filed
Sept 27, 2012*

ORDER AFFIRMING DECISION OF
THE APPELLATE PANEL OF THE
SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION

2012 OCT 12 PM 11 37
CLERK
FAYE
S.C.

ORDER

This matter is before the Court on South Carolina Second Injury Fund's ("the Fund") appeal from the decision of the Appellate Panel of the South Carolina Workers' Compensation Commission ("Appellate Panel") finding that employer, John F. Stroud & Sons, Inc., and carrier, American Home Assurance Co., are entitled to full Second Injury Fund reimbursement for benefits paid or to be paid to the injured employee, John Stroud on the underlying workers' compensation claim.

The parties presented oral arguments on September 17, 2012, at the Chesterfield County Courthouse. After hearing the arguments of counsel, reviewing the memoranda and other documents submitted to the Court, and the applicable authority, the Court hereby affirms the decision of the Appellate Panel as set forth below.

FACTUAL AND PROCEDURAL BACKGROUND

Mr. Stroud sustained compensable work-related injuries on April 10, 2005, when the plane that he was piloting crashed during the course and scope of his employment. He suffered severe injuries to his left and right eyes, left and right legs, left hip, right arm, pelvis, vertebrae,

ribs, femur, face, ankle, lungs, pancreas, mesentery, and brain. Mr. Stroud filed a workers' compensation claim that was concluded by an award on September 5, 2008.

Employer and Respondent sought Second Injury Fund Reimbursement in accord with S.C. Code § 42-9-400, contending that they incurred substantially greater liability for medical costs, disability, and compensation based on prior permanent physical conditions of diabetes and brain damage combining with the April 10, 2005 plane crash injuries to result in permanent impairment equal to or in excess of seventy-eight weeks or more pursuant to § 42-9-400(d)(2), (28), and 34(b).

Commissioner G. Bryan Lyndon held a hearing on September 21, 2011, in Florence, South Carolina. The Commissioner's Decision and Order, filed October 20, 2011, found the claim reimbursable. On October 31, 2011, the Fund filed an Application for Full Commission Review of the Hearing Commissioner's Decision and Order. A hearing took place on March 19, 2012, and on May 22, 2012, the Appellate Panel affirmed the Decision and Order of the Appellate Panel.

The Fund now appeals the Appellate Panel's Decision and Order to this Court.

STANDARD OF REVIEW

The South Carolina Administrative Procedures Act ("APA") establishes the standard for judicial review of decisions by the Appellate Panel. *Frederick v. Wellman, Inc.*, 385 S.C. 8, 15-16, 682 S.E.2d 516, 519 (Ct. App. 2009); see *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 134-135, 276 S.E.2d 304, 306 (1981). Under the scope of review established by the APA, this Court may not substitute its judgment for that of the Appellate Panel as to the weight of the evidence on questions of fact, but may reverse or modify the Appellate Panel's decision if the appellant's

substantial rights have been prejudiced because the decision is affected by an error of law or is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. *Carolinas Recycling Group v. South Carolina Second Injury Fund*, No. 2010-166906, 2012 WL 2125280 at *2 (S.C. Ct. App. June 13, 2012); *see* S.C. Code § 1-23-380. Substantial evidence is defined as evidence that, in viewing the record as a whole, would allow reasonable minds to reach the same conclusion as the Appellate Panel. *Carolinas Recycling Group*, at *2 (citing *Lark*, 276 S.C. at 135, 276 S.E.2d at 306).

ANALYSIS

Reimbursement from the Fund for this April 10, 2005 injury is controlled by S.C. Code § 42-9-400(a), which states,

If an employee who has a permanent physical impairment... incurs a subsequent disability from injury by accident arising out of and in the course of his employment, resulting in compensation and medical liability or either, for disability that is substantially greater, by reason of the combined effects of the preexisting condition and subsequent injury or by reason of aggravation of the preexisting impairment, than that which would have resulted from the subsequent injury alone, ...such employer or his insurance carrier shall be reimbursed... for compensation and medical benefits.

S.C. Code § 42-9-400(a) (1985 & Supp. 2005).

The self-employed Mr. Stroud established that he had prior knowledge of his own impairments of diabetes and brain damage. Thereby, he is entitled to a presumption that those conditions are permanent physical impairments. S.C. Code § 42-9-400(d) (1985 & Supp. 2005).

The Fund argues that it did not concede Mr. Stroud established he had knowledge of his own diabetes and brain injury; that Mr. Stroud's concussion did not rise to the level of "brain damage;" and that although Mr. Stroud is entitled to a presumption of permanent physical impairment for his diabetes, the evidence rebuts this presumption. In reviewing the record as a

whole, this Court cannot hold that the Decision and Order of the Appellate Panel was clearly erroneous as to these findings. The Fund did not contest employer knowledge with regard to any of Mr. Stroud's preexisting impairments at the initial hearing before the Workers' Compensation Commission, and Mr. Stroud obviously knew of his own diabetes if not also his brain damage. In regard to the brain damage, the Appellate Panel was not clearly erroneous in concluding that Mr. Stroud's prior concussion could be termed "brain damage" as used in the statute, in view of the medical evidence presented to the Appellate Panel and the nature of concussions in themselves. The decision of the Appellate Panel was not clearly erroneous in holding that Mr. Stroud was entitled to a presumption of having prior permanent impairments, and it was also not clearly erroneous in concluding that the Fund did not rebut that presumption.

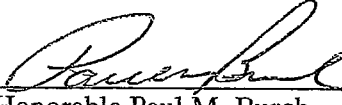
Furthermore, there is substantial evidence on the record that supports the Appellate Panel's Decision and Order that Mr. Stroud's plane crash injuries were substantially greater by reason of the combined effects of his preexisting condition and his plane crash injuries or by the plane crash's aggravation of his preexisting conditions than that which would have resulted from the subsequent injury alone. The medical narratives and medical questionnaires from Dr. Scott and Dr. Waid state that Mr. Stroud's diabetes combined with or was aggravated by the plane crash injuries to result in greater overall liability for the insurance carrier. Dr. Scott concluded that "because of the severity of [Mr. Stroud's] right knee injury, the subsequent deep tissue infection *and* [his] diabetes, there was no other salvage option other than the below-knee amputation of the right leg" (emphasis added). Medical records from Dr. Bosse likewise indicate that Mr. Stroud's preexisting diabetes contributed to him requiring amputation of his right leg after his work accident. A letter from Dr. Waid notes that Mr. Stroud's prior concussion rendered him at greater risk for increased impairment or a longer period of disability should he sustain

another brain injury, and specifically another injury within one year (Mr. Stroud's prior concussion occurred in July 2004 when a backhoe rolled over him, resulting in a loss of consciousness). Dr. Waid concluded, "[I]t is my opinion that... the manner in which [Mr. Stroud] sustained a concussion within a year prior to the accident of April 10th, 2005, served to render him with a greater disability; greater medical costs; as well as more significant disability with loss of time from employment capacities."

CONCLUSION

The Fund's substantial rights have not been prejudice because the decision of the Appellate Panel is not affected by an error of law and is not clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. Viewing the medical evidence as a whole, reasonable minds could reach the same conclusion as the Appellate Panel.

AFFIRMED.


The Honorable Paul M. Burch
Fourth Judicial Circuit

Chesterfield, South Carolina
October 11, 2012

STATE OF SOUTH CAROLINA)

COUNTY OF CHESTERFIELD)

American Home Assurance Co.,
Plaintiff/Respondent,)

vs.)

South Carolina Second Injury Fund,
Defendant/Appellant.)

(In Re: John Stroud v. John F. Stroud &
Sons, Inc.))

IN THE COURT OF COMMON PLEAS

CERTIFICATE OF SERVICE

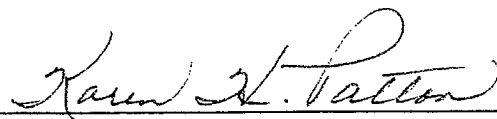
(W.C.C. FILE NO. 0504228)

C.A. No.: 2012-CP-13-00362

The undersigned, Karen H. Patton, paralegal to Jared M. Pretulak, attorney for the Respondent, certifies that on the 1st day of November, 2012, she served a copy of the Circuit Court **ORDER AFFIRMING DECISION OF THE APPELLATE PANEL OF THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION** upon the South Carolina Workers' Compensation Commission and the attorney for the Second Injury Fund, Latonya D. Edwards, via email and Certified Mail, Return Receipt Requested, with due and proper postage affixed thereto, a copy of the same addressed to:

Latonya D. Edwards, Esq.
Dilligard Edwards, LLC
3790 Fernandina Road, Ste. 103
Columbia, SC 29210

Virginia L. Crocker
S. C. Workers' Compensation Commission
P. O. Box 1715
Columbia, SC 29201-1715


Karen H. Patton

November 1, 2012

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 0504228

AMERICAN HOME ASSURANCE CO., *
CLAIMANT, *
*
VERSUS *
*
SOUTH CAROLINA SECOND *
INJURY FUND, *
DEFENDANT. *
*
IN RE: *
*
JOHN STROUD, *
CLAIMANT, *
*
VERSUS *
*
JOHN F. STROUD & SON, *
EMPLOYER, *
AMERICAN HOME ASSURANCE CO., *
CARRIER. *

 COPY

SOUTH CAROLINA WORKERS' COMPENSATION HEARING

PURSUANT TO NOTICE OF WORKERS' COMPENSATION HEARING, THE
WITHIN HEARING WAS TAKEN ON THE 21ST DAY OF SEPTEMBER, 2011,
COMMENCING AT THE HOUR OF 2:29 P.M., IN FLORENCE, SOUTH CAROLINA,
BEFORE THE HONORABLE BRYAN LYNDON, ATTENDED BY COUNSEL AS FOLLOWS:

JAN L. WHITWORTH
VERBATIM REPORTER
COURT REPORTING SERVICES
POST OFFICE BOX 551
ROEBUCK, SC 29376

APPEARANCES

JARED M. PRETULAK, ESQUIRE, OF THE FIRM
GALLIVAN, WHITE & BOYD, P.A.
POST OFFICE BOX 10589
GREENVILLE, SOUTH CAROLINA 29603

ATTORNEY FOR AMERICAN HOME ASSURANCE COMPANY,

DEIDRE D. LAWS, ESQUIRE, OF THE FIRM
BOYKIN & DAVIS, LLC
POST OFFICE BOX 11844
COLUMBIA, SOUTH CAROLINA 29211

ATTORNEY FOR THE SOUTH CAROLINA SECOND
INJURY FUND.

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

4 * * * * * * * * * * * * * * * *

5 BY COMMISSIONER LYNDON:

6 TODAY'S DATE IS 9/21/11. THIS IS SOUTH
7 CAROLINA WORKERS' COMPENSATION CASE FILE NUMBER
8 0504228. THE PURPOSE OF THIS HEARING IS A REQUEST
9 FOR REIMBURSEMENT BY JOHN F. STROUD AND SON AND
10 AMERICAN HOME ASSURANCE COMPANY WHO IS REPRESENTED
11 BY ATTORNEY JARED PRETULAK VERSUS THE EMPLOYER --
12 EXCUSE ME, VERSUS THE SOUTH CAROLINA SECOND INJURY
13 FUND REPRESENTED BY ATTORNEY DEIDRE LAWS. THE
14 PURPOSE OF THE HEARING AS I STATED IS TO DETERMINE
15 WHETHER OR NOT JOHN F. STROUD AND SON AND HOME
16 ASSURANCE ARE GRANTED REIMBURSEMENT. THE DATE OF
17 ACCIDENT WAS 4/10/2005.

18 ARE THERE ANY OBJECTIONS TO APAs, JURISDICTION,
19 VENUE, OR ANY OTHER ITEMS?

20 BY MR. PRETULAK:

21 NO OBJECTIONS.

22 BY MS. LAWS:

23 NO.

24 BY COMMISSIONER LYNDON:

25 WITHOUT OBJECTION, THE COMMISSION FILE BECOMES

1 A PART OF THE RECORD WITH THE EXCEPTION OF SELF-
2 SERVING DECLARATIONS AND UNSTIPULATED MEDICAL
3 REPORTS.

4 PRIOR TO GOING ON THE RECORD, WE HAD A LENGTHY
5 PREHEARING CONFERENCE ON THIS CASE. IT'S SOMEWHAT
6 UNUSUAL, AND RATHER THAN MY TRYING TO PUT THE
7 POSITIONS ON THE RECORD, I WILL LET EACH PARTY PUT
8 THEIR RESPECTIVE POSITIONS ON THE RECORD STARTING
9 WITH THE MOVING PARTY FOR AMERICAN HOME ASSURANCE
10 COMPANY AND JOHN F. STROUD AND SON, MR. PRETULAK.

11 **BY MR. PRETULAK:**

12 THANK YOU, YOUR HONOR. THE CARRIER/EMPLOYER
13 ARE SEEKING REIMBURSEMENT FROM THE SOUTH CAROLINA
14 SECOND INJURY FUND ON BEHALF OF, OF COURSE, THE
15 EMPLOYER AND CARRIER. WE HAVE MET THE STATUTORY
16 REQUIREMENTS FOR EMPLOYER KNOWLEDGE PREEXISTING
17 PERMANENT IMPAIRMENTS, HINDRANCE AND/OR OBSTACLE TO
18 EMPLOYMENT OR RE-EMPLOYMENT, AND INCREASED LIABILITY
19 FOR MEDICAL COSTS, DISABILITY, AND COMPENSATION. WE
20 BELIEVE THAT THIS CASE QUALIFIES UNDER THE LISTED
21 CONDITIONS OF DIABETES AND BRAIN DAMAGE, 42-9-400-D-
22 2 AND 42-9-400-D-28. WE BELIEVE THAT WE QUALIFY FOR
23 REIMBURSEMENT UNDER 42-9-400-D-34-B AND ALSO 42-9-
24 400-1. THE FACTS OF THIS CASE ARE AS FOLLOWS: MR.
25 STROUD OPERATED AND WORKED FOR JOHN S. STROUD AND

1 SONS, INC., WHERE HE WAS INJURED IN THE COURSE AND
2 SCOPE OF HIS EMPLOYMENT ON APRIL THE 10TH, 2005,
3 WHEN HE WAS INVOLVED IN AN AIRPLANE CRASH. PRIOR TO
4 THE DATE OF THE INJURY, MR. STROUD WAS DIAGNOSED AND
5 SOUGHT TREATMENT FOR DIABETES, WHICH CARRIES A
6 PRESUMPTION OF A HINDRANCE AND/OR OBSTACLE FOR
7 EMPLOYMENT OR RE-EMPLOYMENT PURSUANT TO 42-9-40-D-2.
8 FURTHERMORE, HE WAS DIAGNOSED WITH AND SOUGHT
9 TREATMENT FOR A CONCUSSION, NOW COMMONLY REFERRED TO
10 AS A TRAUMATIC BRAIN INJURY. WE WOULD ASK THE
11 COMMISSIONER PLEASE TAKE NOTE OF EXHIBIT "C" AT PAGE
12 194 AND ALSO EXHIBIT "F," WHICH IS THE C.D.C.
13 WEBSITE, WHICH PROVIDES ADDITIONAL INFORMATION ON
14 TRAUMATIC BRAIN INJURIES AND CONCUSSIONS. WE
15 CONTEND THAT THE BRAIN DAMAGE CARRIES A PRESUMPTION
16 OF HINDRANCE AND/OR OBSTACLE TO EMPLOYMENT UNDER 42-
17 9-400-D-28. ADDITIONAL, OR I CAN SAY ALTERNATIVELY,
18 THERE IS A PRESUMPTION THAT EXISTS UNDER 42-9-400-D-
19 34-B, AND THAT THE PRIOR TRAUMATIC BRAIN INJURY
20 COMBINED WITH THE WORK ACCIDENT TO CAUSE AN
21 IMPAIRMENT IN EXCESS OF 78 WEEKS. THE WORK ACCIDENT
22 HAS CLEARLY COMBINED WITH AND AGGRAVATED THE
23 CLAIMANT'S PREEXISTING IMPAIRMENTS. WITH REGARDS TO
24 EMPLOYER KNOWLEDGE, WE WOULD CONTEND THAT THE
25 EMPLOYER KNOWLEDGE REQUIREMENT IS MET BASED ON THE

1 MEDICAL RECORDS PROVIDING EVIDENCE OF TREATMENT FOR
2 MR. STROUD'S PREEXISTING DIABETES AND PREEXISTING
3 TRAUMATIC BRAIN INJURY. MR. STROUD CLEARLY HAD
4 PREEXISTING IMPAIRMENTS BEFORE THE DATE OF THIS
5 ACCIDENT. BECAUSE HE WAS THE OPERATOR AND AN
6 EMPLOYEE OF THE COMPANY, HE HAD ACTUAL KNOWLEDGE OF
7 HIS PREEXISTING CONDITIONS. HE ACTIVELY SOUGHT
8 TREATMENT FOR HIS CONDITIONS PRIOR TO THE DATE OF
9 THIS ACCIDENT. WE BELIEVE THIS IS SATISFIED IN THE
10 EVIDENCE AS PRESENTED IN APA ONE PAGES FIVE, SIX,
11 SEVEN, EIGHT, NINE, AND TEN OF DR. JOHN F. McLEOD,
12 CONFIRMING A DIAGNOSIS OF DIABETES RIGHT AROUND
13 SEPTEMBER THE 21ST, 1998, AND THIS ALSO PROVIDES
14 EVIDENCE OF THE SUBSEQUENT TREATMENT BY WAY OF
15 GLUCOPHAGE. THERE ARE MEDICAL RECORDS OF PALMETTO
16 HEALTH RICHLAND THAT CONFIRM THAT THE CLAIMANT
17 SUFFERED A TRAUMATIC BRAIN INJURY ON 7/15/04 PRIOR
18 TO THE DATE OF ACCIDENT. THE RECORDS CONFIRM A LOSS
19 OF CONSCIOUSNESS, THE PRESENCE OF A HEMATOMA, AND
20 DIAGNOSIS OF A CONCUSSION. THESE ARE LOCATED AT APA
21 TWO, PAGES 29 AND 31 AND APA 30, PAGES 33, 37, AND
22 40. WE WOULD ALSO RELY ON THE MEDICAL RECORDS OF
23 DR. McLEOD. IT ALSO CONFIRMS THE AFOREMENTIONED
24 TRAUMATIC BRAIN INJURY AND THE DIAGNOSIS FOUND AT
25 APA ONE, PAGE NINE REGARDING THE CONCUSSION THAT WE

1 DISCUSSED. WE BELIEVE THAT THE CLAIMANT WAS -- THE
2 CLAIMANT WAS THE OPERATOR AND EMPLOYEE OF THE
3 AFOREMENTIONED COMPANY. HE REPORTED FOR TREATMENT
4 ON THESE DATES FOR HIS CONDITIONS. WE BELIEVE THAT
5 UNDER 42-9-400-C, THE KNOWLEDGE REQUIREMENT HAS BEEN
6 SATISFIED. WITH REGARDS TO THE PREEXISTING
7 PERMANENT IMPAIRMENTS, ACCORDING TO 42-9-400-A,
8 IMPAIRMENT CAN BE FROM ANY CAUSE OR ORIGIN.
9 PERMANENT PHYSICAL IMPAIRMENT IS FURTHER DEFINED IN
10 42-9-400-D AS "ANY PERMANENT CONDITION WHETHER
11 CONGENITAL OR DUE TO INJURY OR DISEASE." HIS
12 IMPAIRMENTS, AND THIS IS THE CLAIMANT'S IMPAIRMENTS
13 PREEXISTED THE COMPENSABLE WORK INJURY. THIS IS
14 EVIDENCED BY THE MEDICAL QUESTIONNAIRE SIGNED BY DR.
15 GLENN SCOTT AND DR. RANDY WAID STATING THAT THE
16 DIABETES PREEXISTED THE APRIL 10TH, 2005, WORK
17 ACCIDENT LOCATED AT EXHIBITS "D" AND "E." THERE IS
18 ALSO A MEDICAL NARRATIVE FROM DR. SCOTT DESCRIBING
19 THE CLAIMANT'S USAGE OF GLUCOPHAGE FOR HIS DIABETES
20 CONDITION PRIOR TO THE WORK ACCIDENT AND THE NEED
21 FOR AN INSULIN INFUSION AFTER HIS WORK ACCIDENT.
22 THIS IS NOTED AT EXHIBIT "B." THERE'S A MEDICAL
23 NARRATIVE FROM DR. WAID DESCRIBING THE CLAIMANT'S
24 HISTORY OF TYPE TWO DIABETES WITH THE NEED FOR THE
25 USE OF GLUCOPHAGE PRIOR TO THE DATE OF ACCIDENT

1 LISTED AT EXHIBIT "C," AND OF COURSE, THE MEDICAL
2 RECORDS OF DR. McLEOD ONCE AGAIN, I'VE NOTED THOSE
3 ALREADY. IT CONFIRMS THE DIAGNOSIS AND TREATMENT,
4 APA ONE, PAGES FIVE, SIX, SEVEN, EIGHT, NINE AND
5 TEN. WE'VE ALSO RELIED ON THE MEDICAL RECORDS OF
6 PALMETTO HEALTH RICHLAND ONCE AGAIN CONFIRMING THAT
7 THE CLAIMANT SUFFERED A TRAUMATIC BRAIN INJURY ON
8 7/15/04 PRIOR TO THE DATE OF ACCIDENT, APA TWO,
9 PAGES 29 AND 31; APA THREE, PAGES 33, 37, AND 40.
10 AND WE HAVE ALREADY MENTIONED THE MEDICAL RECORDS OF
11 DR. McLEOD ONCE AGAIN DISCUSSING THE SAME TRAUMATIC
12 BRAIN INJURY IN JULY OF '04. I WOULD ALSO LIKE TO
13 POINT TO THE MEDICAL NARRATIVE OF DR. WAID, WHICH I
14 THINK IS VERY IMPORTANT. HE NOTES THAT THE JULY
15 2004 CONCUSSION ASSOCIATED A GREATER IMPAIRMENT,
16 DISABILITY, COST, AND LOST TIME FROM WORK AS A
17 RESULT OF THE APRIL 10TH, 2005, ACCIDENT. I THINK
18 THAT THAT IS VERY IMPORTANT WHEN CONSIDERING THIS
19 CASE. WITH REGARDS TO HINDRANCE, MR. STROUD'S
20 PREEXISTING IMPAIRMENTS WERE A HINDRANCE OR
21 OBSTACLES TO EMPLOYMENT OR RE-EMPLOYMENT. THIS IS
22 EVIDENCED BY THE FACT THAT THE STATUTE AFFORDS THE
23 CARRIER A PRESUMPTION UNDER 42-9-400-D-2 FOR
24 DIABETES, AND WE HAVE MENTIONED THE MEDICAL RECORDS
25 REGARDING HIS DIABETES DIAGNOSED AS TYPE TWO PRIOR

1 TO THE ACCIDENT AND HIS ACTUAL TREATMENT. THOSE ARE
2 EXHIBITS B, C, E, F, APA ONE, PAGES FIVE, SIX,
3 SEVEN, EIGHT, NINE, TEN. THERE IS ALSO A
4 PRESUMPTION OF HINDRANCE UNDER 42-9-400-D-28 FOR
5 PRIOR BRAIN DAMAGE. MR. STROUD WAS INVOLVED IN AN
6 ACCIDENT ON JULY THE 15TH, 2004, WHEN A BACKHOE
7 ROLLED OVER HIM. HE SUSTAINED A LOSS OF
8 CONSCIOUSNESS AND A HEMATOMA. HE WAS DIAGNOSED WITH
9 A CONCUSSION. THIS DIAGNOSIS IS SYNONYMOUS WITH A
10 DIAGNOSIS OF A TRAUMATIC BRAIN INJURY, WHICH WE HAVE
11 PROVIDED EVIDENCE OF IN EXHIBIT -- I'M SORRY, BEAR
12 WITH ME FOR A MINUTE - "F." THIS IS THE C.D.C.
13 INFORMATION THAT PROVIDES THAT -- PROVIDES THAT
14 INFORMATION. FURTHERMORE, WE WOULD ARGUE THAT THE
15 COMBINATION OF THE PREEXISTING DIABETES AND/OR THE
16 PREEXISTING TRAUMATIC BRAIN INJURY WITH THE
17 SUBSEQUENT WORK INJURIES OF APRIL THE 10TH, 2005,
18 HAVE RESULTED IN PERMANENT IMPAIRMENT GREATER THAN
19 78 WEEKS, ALLOWING FOR A PRESUMPTION UNDER 42-9-400-
20 D-34-B. IN EXHIBIT "C," DR. WAID MAKES REFERENCE TO
21 THE PRIOR TRAUMATIC BRAIN INJURY. OKAY. HE SAYS
22 "THE JULY 2004 CONCUSSION SERVED AS A RISK FACTOR
23 FOR GREATER IMPAIRMENT ASSOCIATED WITH THE APRIL
24 10TH, 2005, TRAUMATIC BRAIN INJURY. THE COMBINATION
25 OF THE DIABETES WITH THE INJURIES RESULTED IN A

1 SUBSTANTIALLY GREATER MEDICAL COMPLICATIONS
2 INCLUDING BUT NOT LIMITED TO THE NEED FOR AN
3 AMPUTATION. OF COURSE, THIS HAS TO DO WITH THE
4 ACTUAL DIABETES ITSELF. I SHOULD HAVE NOTED THAT.
5 IN APA FIVE, PAGE 89, DR. BOSSE SAYS THAT THE
6 CLAIMANT DEVELOPED A DEEP INFECTION. HE NOTES THAT
7 THE CLAIMANT IS A DIABETIC. AND THEN RIGHT AFTER
8 THAT, HE GOES ON TO SAY THAT THERE IS NO SALVAGE
9 OPTION OTHER THAN A BELOW THE KNEE AMPUTATION.
10 EXHIBIT "B" ALSO, AND I THINK THAT THAT IS DR.
11 SCOTT, IF I'M NOT MISTAKEN. YES, IT IS. DR. SCOTT
12 ALSO SAYS THE DIABETES AND THE INJURIES RESULTED IN
13 THE NEED FOR THIS AMPUTATION. SO, WE HAVE TWO
14 PHYSICIANS THAT ARE IN AGREEMENT WITH THAT. AND I
15 WOULD ALSO JUST POINT OUT THAT THERE IS AN ORDER OF
16 THE COMMISSION THAT FINDS THE CLAIMANT PERMANENTLY
17 AND TOTALLY DISABLED DUE TO THE BRAIN INJURY AND THE
18 COMBINED EFFECTS OF ALL OF HIS INJURIES. IF THERE
19 IS NOT A PRESUMPTION IN THIS PARTICULAR CASE FOR A
20 HINDRANCE OR AN OBSTACLE, WE BELIEVE THAT THE
21 MEDICAL QUESTIONNAIRES THAT WE HAVE COMPLETED BY
22 THESE PHYSICIANS SUPPORT A HINDRANCE OR OBSTACLE.
23 THESE ARE NOTED IN "D" AND "E" WITH REGARDS TO --
24 EXHIBITS "D" AND "E" WITH REGARDS TO THE DIABETES
25 AND EXHIBIT "C" WITH REGARDS TO THE TRAUMATIC BRAIN

1 INJURY. THE THOUGHT PROCESS IS THAT BECAUSE THERE
2 WAS A CONCUSSION, THAT SERVES AS A SUBSTANTIAL RISK
3 FACTOR FOR GREATER IMPAIRMENT IN THE EVENT OF A
4 SUBSEQUENT TRAUMATIC BRAIN INJURY, WHICH THERE WAS.
5 THE FACT THAT THERE ACTUALLY WAS A TRAUMATIC BRAIN
6 INJURY ON APRIL THE 10TH, 2005, IS EVIDENCE IN AND
7 OF ITSELF THAT THERE WAS A HINDRANCE AND/OR OBSTACLE
8 TO EMPLOYMENT OR RE-EMPLOYMENT. THE ONLY EVIDENCE
9 THAT SPEAKS DIRECTLY TO THE QUESTION OF HINDRANCE
10 AND OBSTACLE TO EMPLOYMENT OR RE-EMPLOYMENT IN THIS
11 CASE HAS BEEN SUBMITTED BY THE CARRIER. HINDRANCE
12 IS NOT NECESSARILY THE INABILITY TO COMPLETELY DO A
13 JOB, RATHER THAT THE CLAIMANT MAY NOT BE ABLE TO DO
14 A JOB TO HIS FULL ABILITY AND/OR THE PREEXISTING
15 CONDITION MAY HAVE BEEN AN OBSTACLE OR HINDRANCE TO
16 OBTAINING A JOB OR OBTAINING ANOTHER JOB IF HE WERE
17 TO BECOME UNEMPLOYED. SO, FOR ANYONE THAT APPLIES
18 TO A JOB WITH A PREEXISTING CONDITION, THE
19 CONDITIONS ARE NOT CONSIDERED. BUT WHEN A POTENTIAL
20 HIRE MENTIONS THAT HE HAS A PREEXISTING CONDITION,
21 IT BECOMES AN ISSUE, IN AND OF ITSELF ONCE AGAIN
22 SHOWING US THAT THERE IS BY DEFINITION AN OBSTACLE
23 OR HINDRANCE TO EMPLOYMENT. WITH REGARDS TO THE
24 INCREASED LIABILITY, WE BELIEVE THAT THE GREATER
25 WEIGHT OF THE EVIDENCE SHOWS THAT THE CARRIER

1 INCURRED SUBSTANTIALLY GREATER LIABILITY FOR
2 COMPENSATION, MEDICAL COSTS AND DISABILITY BY REASON
3 OF THE COMBINED EFFECTS AND AGGRAVATION OF THE
4 PREEXISTING IMPAIRMENTS THAN IF THE SUBSEQUENT
5 INJURY HAD OCCURRED ALONE. WE FIND -- WE BELIEVE
6 THAT WE ARE PERMITTED REIMBURSEMENT UNDER 42-9-400-
7 A, 42-9-400-D-2, 42-9-400-D-28, AND 42-9-400-D-34-B.
8 THIS IS EVIDENCED BY THE SIGNED QUESTIONNAIRES OF
9 DR. WAID AND SCOTT REGARDING THE COMBINATION AND
10 AGGRAVATION REGARDING THE DIABETES AND THE HEAD
11 INJURY WITH THE SUBSEQUENT INJURIES RESULTING IN
12 GREATER LIABILITY FOR COMPENSATION, MEDICAL COSTS,
13 AND DISABILITY. ONCE AGAIN, THOSE ARE EXHIBITS "D"
14 AND "E." THE SIGNED MEDICAL NARRATIVE OF DR. SCOTT
15 AGREEING WITH DR. BOSSE THAT THE COMBINATION OF THE
16 PREEXISTING DIABETES AND THE WORK ACCIDENT RESULTED
17 IN THE CLAIMANT'S AMPUTATION. THAT'S AT EXHIBIT "B"
18 AND ALSO APA FIVE, PAGE 89. THE MEDICAL NARRATIVE
19 OF DR. WAID FINDING THAT THE PRIOR JULY 2004
20 TRAUMATIC BRAIN INJURY SERVED AS A RISK FACTOR FOR
21 MR. STROUD SUSTAINING GREATER IMPAIRMENT DUE TO THE
22 TRAUMATIC BRAIN INJURY SUSTAINED ON APRIL THE 10TH,
23 2005, AND JUST A GENERAL REVIEW OF THE MEDICAL
24 RECORDS THAT SHOW THAT THE PHYSICIANS CLEARLY HAD
25 OBSTACLES TO TREATING THIS INDIVIDUAL AS A RESULT OF

1 HIS PREEXISTING CONDITIONS. I WOULD ALSO POINT TO
2 THE EXHIBIT THAT THE SECOND INJURY FUND HAS PROVIDED
3 US, WHICH IS THE ORDER OF THE COMMISSION FINDING
4 THAT THE CLAIMANT IS P AND T, PERMANENTLY AND
5 TOTALLY DISABLED DUE TO THE BRAIN INJURY AND THE
6 COMBINED EFFECTS OF ALL OF HIS INJURIES. CLEARLY,
7 THE PHYSICIANS FELT THAT MR. STROUD HAD INCREASED
8 COST, LOST TIME IN WORK, AND PERMANENT DISABILITY,
9 OR OTHERWISE THEY WOULDN'T HAVE CHECKED THAT OFF AND
10 SIGNED OFF ON IT. I DID WANT TO MAKE NOTE JUST VERY
11 QUICKLY REGARDING THE CITY OF GREENVILLE CASE, THE
12 *CITY OF GREENVILLE VERSUS THE SOUTH CAROLINA SECOND*
13 *INJURY FUND*, THAT THE SECOND INJURY FUND IS RELYING
14 ON TO TRY TO SHOW THAT THEY DO NOT PROVIDE
15 REIMBURSEMENT FOR THIS CASE, I JUST WANT TO POINT
16 OUT THAT THE CITY OF GREENVILLE CASE, THIS
17 INDIVIDUAL'S FALL ACTUALLY RESULTED IN HIS
18 PARALYSIS. IN THAT PARTICULAR CASE, THERE WAS NO
19 EMPLOYER KNOWLEDGE, OKAY, AND THERE WAS NO EVIDENCE
20 THAT THE CARRIER SUSTAINED GREATER MEDICAL EXPENSES.
21 IN OUR CASE, THE PRIOR TRAUMATIC BRAIN INJURY WAS A
22 RISK FACTOR THAT RESULTED IN GREATER IMPAIRMENT,
23 WHICH WE HAVE ESTABLISHED THROUGH THE MEDICAL
24 EVIDENCE. THIS ULTIMATELY RESULTED IN A
25 DETERMINATION OF PERMANENT AND TOTAL DISABILITY, AND

1 THE COMMISSION ALSO FOUND IN OUR CASE THAT THE
2 CLAIMANT WAS PERMANENTLY AND TOTALLY DISABLED AS A
3 RESULT OF THE TRAUMATIC BRAIN INJURY AND THE
4 COMBINED EFFECTS OF THE OTHER INJURIES. CLEARLY, WE
5 HAVE KNOWLEDGE IN THIS CASE. IT WASN'T ESTABLISHED
6 IN THE OTHER CASE. IT'S WITH REGARDS TO BOTH THE
7 DIABETES AND A TRAUMATIC BRAIN INJURY, AND THERE IS
8 EVIDENCE, WHICH IS CLEAR IN THE RECORD OF INCREASED
9 MEDICAL EXPENSES. THIS INCLUDES, AND IT'S CLEARLY
10 NOT LIMITED TO THE FACT THAT THIS GENTLEMAN HAD TO
11 GO AND HAVE AN AMPUTATION AS A RESULT OF
12 COMPLICATIONS BECAUSE OF HIS DIABETES. WE HAVE
13 MEDICAL CERTIFICATES BACKING ALL OF THIS UP AS WELL.
14 WE WOULD SAY THAT THE CASE THAT THEY HAVE CITED DOES
15 NOT APPLY TO OUR SET OF FACTS. WE HAVE PRESENTED
16 ALL THE EVIDENCE IN GOOD FAITH. WE BELIEVE IT
17 SUPPORTS A REQUEST FOR REIMBURSEMENT FROM THE SOUTH
18 CAROLINA SECOND INJURY FUND. THE SECOND INJURY FUND
19 HAS NOT SUBMITTED EVIDENCE THAT WE BELIEVE
20 CONTRADICTS OUR EVIDENCE DIRECTLY ADDRESSING THE
21 QUESTION OF HINDRANCE. FOR ALL OF THESE REASONS, WE
22 CONTEND THAT WE'VE MET THE STATUTORY REQUIREMENTS
23 AND WOULD ASK THAT AN ORDER BE ENTERED REQUIRING THE
24 SOUTH CAROLINA SECOND INJURY FUND TO REIMBURSE THE
25 CARRIER IN FULL PURSUANT TO THE STATUTE.

1 BY COMMISSIONER LYNDON:

2 ALL RIGHT.

3 BY MR. PRETULAK:

4 THANK YOU.

5 BY COMMISSIONER LYNDON:

6 THANK YOU VERY MUCH, AND MS. LAWS.

7 BY MS. LAWS:

8 YES. INITIALLY, I WOULD START OUT WITH RESPECT
9 TO THE 2008 ORDER BY YOU, COMMISSIONER LYNDON, AND
10 THE 2009 APPELLATE PANEL ORDER, WHICH DID FIND THAT
11 THE CLAIMANT WAS PERMANENTLY AND TOTALLY DISABLED.
12 THAT RELATING TO THE COURT OF APPEALS CASE OF CITY
13 OF GREENVILLE VERSUS THE SOUTH CAROLINA SECOND
14 INJURY FUND, WE DON'T CONTEND THAT THE CASES HAVE
15 SIMILAR FACTS. THAT IS NOT THE REASON THAT WE, YOU
16 KNOW, POINT OUT THAT CASE. WE'RE NOT CONTESTING
17 EMPLOYER KNOWLEDGE, AND IT IS NOT THE FACTS OF THE
18 CASE; IT IS THE RESULT OF THE CASE. AND IN BOTH
19 CASES, THE CLAIMANT WAS DETERMINED TO BE PERMANENTLY
20 AND TOTALLY DISABLED. WITH THAT IN MIND, THE
21 SUPREME COURT HAS HELD -- THE HOLDING OF THAT CASE
22 IS WHEN YOU GET TO THAT POINT, WHEN YOU GET TO THE
23 CLAIMANT BEING PERMANENTLY AND TOTALLY DISABLED, THE
24 EMPLOYEE -- THE EMPLOYER CANNOT INCUR GREATER
25 LIABILITY FOR COMPENSATION, AND THEREFORE

1 COMPENSATION REIMBURSEMENT SHOULD NOT BE AWARDED.
2 AND THAT IS OUR POSITION ON THAT. WITH RESPECT TO
3 THE MEDICAL PAYMENTS AND THE DISABILITY, WE FIND
4 THAT WITH RESPECT TO COMPENSATION FOR THOSE PIECES,
5 THE MEDICAL EVIDENCE DOES NOT SUPPORT THE
6 QUESTIONNAIRE FOR THE DOCTORS AS SUBMITTED BY THE
7 CARRIER. WITH RESPECT TO THE DIABETES, FIRST, THE
8 MEDICAL RECORDS NOTE THAT THE CLAIMANT DID HAVE A
9 HISTORY OF DIABETES, BUT THERE IS NO EVIDENCE TO
10 SUPPORT THAT THE INJURIES SUSTAINED BY THE CLAIMANT
11 WERE MADE WORSE BY THE DIABETES. LET'S TAKE INTO
12 CONTEXT THE SEVERITY OF THIS ACCIDENT. THE CLAIMANT
13 NOSE DIVED IN A PLANE CRASH. HE SUSTAINED A
14 FRACTURED VERTEBRA, FRACTURED PELVIS, MULTIPLE RIB
15 FRACTURES, A FEMUR FRACTURE, MID-FACE FRACTURES,
16 FRACTURED ANKLE, FLUID AROUND THE LUNGS, PANCREAS
17 AND MESENTERY; A COLLAPSED LUNG, GRAIN HEMORRHAGE
18 AND LEFT TEMPORAL LOBE INFARCT, AND THOSE WERE JUST
19 THE ONES THAT I UNDERSTOOD. SO, YOU KNOW, THIS WAS
20 VERY SEVERE AND IT'S NOT SAYING THAT WE AREN'T
21 SEEING WHERE THE DIABETES OR THE BRAIN INJURY WITH
22 RESPECT TO HOW SEVERE THE INJURIES WERE HAD A PART
23 TO PLAY IN WHAT ACTUALLY HAPPENED TO HIM. THE
24 MEDICAL RECORDS WITH RESPECT TO PRIOR TO THE PLANE
25 CRASH AT -- EXCUSE ME, AFTERWARDS, APA PAGE 10 AND

1 11, THE DOCTOR NOTES THAT THE GLUCOSE LEVELS WERE
2 EITHER VERY STABLE OR STABLE. AND ALSO, THERE'S
3 ALSO INDICATION THAT THE SURGERIES WERE NOT
4 COMPLICATED BY THE DIABETES. AT CARRIER APA PAGE
5 132, IT LISTS ALL THE COMPLICATIONS THAT THE
6 CLAIMANT HAD DURING HIS ENTIRE STAY IN THE HOSPITAL,
7 AND NEITHER DIABETES OR THE PRIOR CONCUSSION PLAYED
8 A FACTOR IN THOSE INJURIES. AT CARRIER APA PAGES
9 84, 142 AND 156, IT STATES THAT THE CLAIMANT'S PRIOR
10 MEDICAL HISTORY, FAMILY HISTORY AND REVIEW OF
11 SYSTEMS WERE NON-CONTRIBUTORY TO THE DIAGNOSES THAT
12 HE WAS GIVEN WITH RESPECT TO ALL OF HIS INJURIES.
13 AT CARRIER'S APA 165, IT INDICATES THAT THE
14 AMPUTATION WAS DUE TO THE SEVERE INFECTION THAT
15 BEGAN AFTER THE PLANE CRASH. WHEN HE DID CRASH, HE
16 -- FROM WHAT I UNDERSTAND OF THE MEDICAL RECORDS, HE
17 ALSO SUSTAINED SOME BURNS FROM THE IMPACT. THAT LED
18 TO AN INFECTION, WHICH LED TO THE AMPUTATION. SO,
19 WE BELIEVE THAT THE EXTENT OF THE CLAIMANT'S
20 INJURIES WERE SOLELY DUE TO THE SERIOUSNESS OF THE
21 PLANE CRASH AND NOT NECESSARILY RELATED TO THE
22 PREEXISTING CONDITIONS. WITH RESPECT MORE
23 SPECIFICALLY TO THE BRAIN INJURY, AGAIN, WE NOTE
24 THAT THE MEDICAL RECORDS DO NOTE A PRIOR CONCUSSION,
25 BUT THERE IS NO EVIDENCE THAT THE CONCUSSION PLAYED

1 A PART IN ALL THE INJURIES THAT WERE SUSTAINED AFTER
2 THE PLANE CRASH. AT CARRIER'S APA 33 THROUGH 36, A
3 C.T. OF THE BRAIN WAS NEGATIVE FOLLOWING THE
4 ORIGINAL CONCUSSION IN JULY OF 2004. AT APA 38,
5 CARRIER'S APA 38, IT INDICATES THAT MOTOR AND
6 SENSORY WAS INTACT AND THAT HE COULD MOVE ALL
7 EXTREMITIES. SO, EVEN AFTER THE CONCUSSION, THERE
8 WAS NO BRAIN DAMAGE. THERE WAS NO HINDRANCE TO HIS
9 EMPLOYMENT, AND FOLLOWING NOW WE MOVE FORWARD --
10 FAST FORWARD TO THE PLANE CRASH, AT CARRIER'S APA 43
11 AND 44, A C.T. SCAN OF THE HEAD WAS NEGATIVE. MOTOR
12 WAS INTACT IN ALL EXTREMITIES, AND SENSORY WAS FINE.
13 AND ALSO AFTER THE PLANE CRASH, THERE WAS NO LOSS OF
14 CONSCIOUSNESS. AT CARRIER'S APA 94, IT NOTES THAT
15 THE INJURIES FOUND IN THE HEAD C.T., WHICH THIS IS
16 THE ACTUAL RECORD FROM THE C.T. THAT WAS TAKEN ON
17 THE DAY OF THE INJURY, AND IT WAS GIVEN SO -- IF WE
18 HAVE AFTER THE CONCUSSION SCANS WERE NEGATIVE --
19 AFTER THE CONCUSSION. THEN WE HAVE THE PLANE CRASH,
20 AND WE HAVE C.T. SCANS AND THERE'S ISSUES. THAT IS
21 WHERE WE ARE SAYING THE PLANE CRASH ITSELF AND THE
22 SEVERITY OF THE CRASH AND THE SEVERITY OF THE
23 INJURIES THAT HE SUSTAINED BECAUSE OF THE CRASH
24 RELATED TO THE RESULTS OF THE C.T. SCANS AFTERWARDS.
25 THE DOCTOR'S IMPRESSION OF ANOTHER HEAD C.T. TAKEN

1 APPROXIMATELY TWO WEEKS AFTER THE PLANE CRASH
2 INDICATES FURTHER DAMAGE, WHICH IS REPRESENTATIVE OF
3 POST TRAUMATIC EDEMA OR INFARCT RELATING TO THE
4 TRAUMA OF THE PLANE CRASH. AT CARRIER'S APA 165
5 THROUGH 169, THAT'S WHERE WE NOTE THAT A.I.G. HAD AN
6 INDEPENDENT MEDICAL EVALUATION DONE IN WHICH THE
7 DOCTOR NOTES THAT THE CLAIMANT'S DIFFICULTIES ARE
8 COMMON SEQUELA OF CLOSED HEAD INJURIES SUCH AS THE
9 ONE THAT THE CLAIMANT SUSTAINED, AND THAT IS
10 REFERRING TO AGAIN THE TRAUMATIC PLANE CRASH. AND
11 IT ALSO WAS NOTED IN THE SINGLE COMMISSIONER'S ORDER
12 FOUND AT FUND APA TAB ONE, PAGE FIVE. WE FIND THAT
13 THERE IS JUST -- THERE SEEMS TO BE A DIFFERENCE IN
14 THE MEDICAL OPINIONS. CARRIER RELIES ON THE MEDICAL
15 OPINION OF DR. WAID, WHICH WAS DONE IN JUNE OF 2011.
16 HOWEVER, THE INDEPENDENT EVAL THAT THEY HAD DONE
17 ACTUALLY IN 2008 DOES NOT INDICATE SOME OF THE
18 THINGS THAT ARE INDICATED IN THE LATER
19 QUESTIONNAIRE. AT CARRIER APA 168, IT SPECIFICALLY
20 STATES, QUOTE, "THOUGH MENTION IS MADE OF A PRIOR
21 CONCUSSION, THERE ARE NO DOCUMENTED CONCERNS OF PRE-
22 INJURY COGNITIVE DECLINE." THIS IS IN DIRECT
23 CONFLICT TO WHAT IS STATED IN CARRIER APA 193 WHERE
24 DR. WAID IS MAKING HIS STATEMENTS, AND HE INDICATES
25 THAT THE PRIOR DOCTOR'S EVALUATION NOTES THAT PRIOR

1 CONCUSSION SERVED AS A RISK FACTOR. DR. BARKENBUS'
2 EVALUATION, THAT INDEPENDENT EVALUATION, AT CARRIER
3 168 DOES NOT NOTE THAT, THAT THE CONCUSSION PLAYED A
4 RISK IN THE GREATER IMPAIRMENT. HE IN FACT NOTES
5 THE PRIOR CONCUSSION BUT SAYS THAT HE DOES NOT SEE
6 ANY PRE-COGNITIVE DECLINE. AT FUND APA TAB ONE,
7 PAGE FIVE, THE COMMISSION ALSO NOTED THAT THE
8 INDEPENDENT EVALUATION WHICH STATED THAT TRAUMATIC
9 HEMORRHAGE WAS A RESULT OF THE PLANE CRASH. DURING
10 THE WORKERS' COMP HEARING WHEN THE WIFE IS DETAILING
11 SOME OF THE COGNITIVE ISSUES THAT HER HUSBAND WAS
12 HAVING, SHE NOTED THAT HE SUFFERED FROM NONE OF
13 THESE IMPAIRMENTS PRIOR TO THE PLANE CRASH, AND THAT
14 HE ONLY EXPERIENCED THEM AFTER THE SEVERE HEAD
15 TRAUMA SUSTAINED IN THE PLANE CRASH. THAT'S AT FUND
16 APA TAB ONE, PAGE FOUR. AND SO, WE JUST FEEL THAT
17 SPECIFICALLY WITH THE COMMISSIONER'S ORDERS AND THE
18 APPELLATE ORDER WHERE WE DO NOTE THAT P.T.D. WAS
19 GIVEN AND THE BRAIN INJURY AND THE COMBINED EFFECT
20 OF ALL INJURIES, BY THAT WE'RE -- WE CONTEND THAT
21 THE COMBINED EFFECTS OF THE INJURIES IS NOT
22 NECESSARILY THE COMBINED EFFECT OF THE CONCUSSION.
23 IT WAS THE FACT OF THE SEVERE INJURIES THAT HE HAD,
24 AND BY COMBINED EFFECT OF THE INJURIES, HE WAS
25 PERMANENTLY AND TOTALLY DISABLED, BECAUSE WE WEREN'T

1 JUST LOOKING AT HIS BRAIN. HE HAD ISSUES WITH HIS
2 ARMS. HE HAD ISSUES WITH HIS LEGS. IT WAS
3 AMPUTATED. HE HAD FLUID AROUND THE LUNGS. HE HAD
4 ISSUES WITH HIS PANCREAS. THAT WAS ALL AFTER THE
5 PLANE CRASH. THAT IS WHAT WE'RE SAYING THE BRAIN
6 WITH THE COMBINED EFFECTS OF THE REST OF HIS BODY
7 CONSIDERING AFTER THE PLANE CRASH IS WHAT LED TO THE
8 P.T.D. AND SO WE RESPECTFULLY DECLINE AND SAY THAT
9 THE CARRIER SHOULD BE DENIED REIMBURSEMENT.

10 BY COMMISSIONER LYNDON:

11 OKAY. ANYTHING ELSE?

12 BY MR. PRETULAK:

13 NO, YOUR HONOR.

14 BY COMMISSIONER LYNDON:

15 IF THERE IS NOTHING ELSE, THAT CONCLUDES THE
16 PROCEEDING.

17 (THERE BEING NO FURTHER STATEMENTS, THIS HEARING WAS
18 CONCLUDED AT THE HOUR OF 2:53 P.M.)

CERTIFICATE OF NOTARY PUBLIC
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
COLUMBIA, SOUTH CAROLINA
WCC FILE NO. 0504228

AMERICAN HOME ASSURANCE CO., *
CLAIMANT, *
VERSUS *
SOUTH CAROLINA SECOND *
INJURY FUND, *
DEFENDANT. *
IN RE: *
JOHN STROUD, *
CLAIMANT, *
VERSUS *
JOHN F. STROUD & SON, *
EMPLOYER, *
AMERICAN HOME ASSURANCE CO., *
CARRIER. *

I, JAN L. WHITWORTH, A NOTARY PUBLIC FOR THE STATE OF SOUTH CAROLINA, DULY COMMISSIONED AND QUALIFIED AS SUCH, DO HEREBY CERTIFY THAT THE FOREGOING **21** PAGES REPRESENTS A TRUE AND ACCURATE TRANSCRIPT OF THE FOREGOING HEARING TAKEN ON THE 21ST DAY OF SEPTEMBER, 2011. THAT THE ORAL HEARING WAS DULY TAKEN AND TRANSCRIBED.

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

IN WITNESS WHEREOF, I HAVE SET MY HAND AND OFFICIAL SEAL THIS 24TH DAY OF SEPTEMBER, 2011.

JAN L. WHITWORTH
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES: 3/12/2014

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

BEFORE THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO. 0504228

AMERICAN HOME ASSURANCE,)
) FULL COMMISSION HEARING
CLAIMANT,) PANEL B
vs.)
) COMMISSIONER McCASKILL- CHAIR.
SOUTH CAROLINA SECOND) COMMISSIONER BARDEN
INJURY FUND,) COMMISSIONER WILLIAMS
)
EMPLOYER,)
)
IN RE: JOHN STROUD v.)
JOHN F. STROUD & SON,)
)
)

 **COPY**

THE WORKERS' COMPENSATION HEARING, TAKEN BEFORE
CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR THE
STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF
1:45 P.M., MONDAY, MARCH 19, 2012, SOUTH CAROLINA
WORKERS' COMPENSATION COMMISSION, 1333 MAIN STREET,
COLUMBIA, SOUTH CAROLINA 29202.

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

APPEARANCES

FOR THE SOUTH CAROLINA SECOND INJURY FUND

LATONYA DILLIGARD EDWARDS, ESQUIRE
DILLIGARD EDWARDS, LLC
3790 FERMANDINA ROAD, SUITE 103
COLUMBIA, SOUTH CAROLINA 29210
803-750-2214

FOR THE DEFENDANTS

JARED M. PRETULAK, ESQUIRE
GALLIVAN, WHITE & BOYD, PA
POST OFFICE BOX 10589
GREENVILLE, SOUTH CAROLINA 29603
864-271-5354

REPORTED BY

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

INDEX

BY MS. EDWARDS.	3
BY MR. PRETULAK	9
BY MS. EDWARDS.	17
CERTIFICATE	18

EXHIBITS

(No Exhibits Proffered)

1 THE COURT REPORTER: Today is March 19, 2012.
2 This is South Carolina Workers' Compensation Case
3 Number 0504228. This is the case of American Home
4 Assurance, Claimant, versus The South Carolina Second
5 Injury Fund; In Re: John Stroud v. John F. Stroud and
6 Son. The Appellant is the Defendant The South
7 Carolina Second Injury Fund, represented by Attorney
8 Latonya Edwards. The Respondent is represented by
9 Attorney Jared M. Pretulak.

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

14 THE COURT: Ms. Edwards.

15 BY MS. EDWARDS: Good afternoon. I'm going to be
16 very, very brief. This is a case where the Claimant
17 had preexisting diabetes. He also had a presumption
18 that it was a hindrance to his employment. We're
19 asserting that the medical records in evidence shows
20 otherwise. Now, just briefly, this accident occurred
21 when Claimant was in a plane crash. Claimant suffered
22 injuries to his left and right eye, left and right
23 leg, left hip, right arm, a fractured pelvis, a
24 fractured vertebrae, multiple rib fractures, a femur
25 fracture, ribcage fracture, fractured ankle, fluid

1 around the lungs, pancreas, collapsed lung, second and
2 third degree burns, brain hemorrhage among other
3 things. Okay. So this was a very, very serious
4 injury. Claimant also, as a result, and this is at
5 Carrier APA pages 10, 114, 132, 133, Claimant suffered
6 amputation of his lower right leg and the amputation
7 came from (inaudible) loss and other problems. So
8 that's finding -- APA page 7. The findings have
9 determined that this was a very severe injury and even
10 in the absence of the diabetes Claimant would have had
11 the same outcome. And we point to some of the medical
12 evidence in the record beginning at Carrier APA page

13 --

14 COMMISSIONER BARDEN: The amputation was a result
15 of complications with the diabetes (inaudible) or the
16 injury itself?

17 MS. EDWARDS: You know -- certainly we're
18 asserting that it's from the injury itself. There may
19 be -- and I'll let Jared address that, there may be
20 something in there that might have attributed to his
21 diabetes. I'm not sure, so I'm being very honest
22 about that. I'm not sure whether it's attributable to
23 the diabetes or the severity of the plane crash.

24 Okay?

25 COMMISSIONER BARDEN: Wouldn't we need to know

1 that?

2 MS. EDWARDS: Yes. Yes, you would, Your Honor, I
3 agree with that, you would. And that might change
4 things, you might -- might need to know that. I'm
5 going to let Jared address that, but as information --
6 of course, we didn't concede that there was
7 preexisting brain damage, because I think that the
8 Carrier is asserting that because the Claimant had a
9 concussion the fact that there was preexisting brain
10 damage. We do agree that he had diabetes. But
11 certainly we assert that a concussion doesn't
12 automatically equal brain damage. At Carrier APA page
13 33, this is a medical record indicating the accident
14 where some heavy machinery rolled over him in 2004;
15 this is a prior injury. Now, as a result of this
16 accident he did have some shoulder and scapular pain.
17 He admitted loss of consciousness, but once he got
18 into the hospital he was moving all of his extremity
19 and (inaudible).

20 COMMISSIONER BARDEN: The loss of consciousness
21 would not count out (inaudible)?

22 MS. EDWARDS: I don't think it is, Your Honor,
23 but like I say -- I don't think it is, but -- like I
24 said, I'll let Jared address that. I don't think it's
25 that he specifically had brain damage. At Carrier APA

1 pages 33 and 34, this was where he was able to answer
2 all the questions appropriately in the prior rollover
3 accident. He had fine prior motor strength and the CT
4 Scan of the head was negative. The CT Scan also
5 revealed that there was no median or skull fractures;
6 this was prior to the injury and there was no midline
7 shift (inaudible) or abnormal density from the brain.
8 The overall impression on the (inaudible) and the
9 brain were normal. That's Carrier APA page 35, 36 and
10 38. There also was an IME which noted that -- it
11 mentioned the prior concussion and there were some
12 concerns about pre-injury cognitive decline, but our

13 --

14 COMMISSIONER BARDEN: So, if anything, your
15 reference of brain injury is of cognitive brain
16 injury?

17 MS. EDWARDS: Yes, that's correct, yes, ma'am.
18 Yes. And so -- so we're asserting, as I indicated,
19 that the diagnosis of the -- of the concussion, the
20 cognitive report of the concussion but that did not
21 rise to the level of permanent brain damage. And we
22 also assert --

23 COMMISSIONER BARDEN: Maybe I misunderstood.

24 MS. EDWARDS: Yes, ma'am.

25 COMMISSIONER BARDEN: The cognitive problem that

1 you referenced, that was pre-date of injury, correct?

2 MS. EDWARDS: Yes, Honor.

3 COMMISSIONER BARDEN: Okay. Just want to make
4 sure I understand.

5 MS. EDWARDS: That's at Carrier APA page 168 --
6 just to make sure that's the right page. Because I
7 had so many pages I didn't actually bring the records,
8 so I'm relying on my case notes. And some of what I
9 would cite -- it's at page 168 where it noted some
10 pre-injury cognitive decline and (inaudible). We also
11 assert that the concussion was not a hindrance to
12 employment and that it would not substantially
13 increase the liability, and once again we would cite
14 the APAs at pages 33 through 38 which reveals a -- a
15 solid range that was normal (inaudible). And the
16 discharge doesn't address any complications Claimant
17 had with his concussion, but does indicate that he
18 suffered a serious -- I'm sorry, it doesn't indicate
19 -- I'm sorry, that he suffered permanent damage or any
20 serious damage. And based on that we also cite some
21 other APAs in the medical records but they're on kind
22 of (inaudible), but I'll also cite you to Carrier APA
23 pages 43 and 44, which again references the plane
24 crash, the main issues (inaudible) and the operative
25 order, the extremities being intact and there were

1 also complications, the Carrier APA pages 54 and page
2 140. Also, Carrier APA pages 94 and 165 CT Scans on
3 the same day the Claimant was admitted to the hospital
4 indicate injury to the brain, including traumatic
5 hemorrhage. This is post injury, at Carrier APA page
6 112, this is a CT Scan that noted several
7 abnormalities after the brain injury as opposed to
8 what the scan was before.

9 COMMISSIONER BARDEN: What I'm hearing you say,
10 and you tell me, but is it -- the cognitive issues,
11 you feel like the reason for them would be to find the
12 fact that if I do believe that this injury itself is
13 --

14 MS. EDWARDS: That's correct.

15 COMMISSIONER BARDEN: But if the cognitive issue
16 -- and in fact, the objection --

17 MS. EDWARDS: That's correct. I will concede to
18 that, yes. I will concede to that.

19 COMMISSIONER BARDEN: It would be the compilation
20 of all these injuries?

21 MS. EDWARDS: That's right, the injury was very,
22 very severe as I've indicated with the plane crash,
23 and we believe that the preexisting diabetes -- like I
24 say, we don't --

25 COMMISSIONER BARDEN: And diabetes, it looks to

1 me like maybe in his records its type 2; did he ever
2 have type 1 and was -- did he have to take insulin or
3 was he on Glucophage or other medication?

4 MS. EDWARDS: I don't know if he had to take
5 insulin or -- like I said, I'm going to let Jared
6 address that. I don't believe so, but that's not
7 really something I would --

8 COMMISSIONER BARDEN: Okay. So you're big events
9 were primarily -- primarily the plane crash?

10 MS. EDWARDS: Primarily the severity of the
11 injuries, Your Honor.

12 COMMISSIONER BARDEN: From the plane crash?

13 MS. EDWARDS: Right. And we believe that the
14 diabetes would not have played any role in the extent
15 of the significance of the injuries he sustained from
16 the crash, so Your Honor is correct. That's what I
17 believe is our strongest argument.

18 COMMISSIONER BARDEN: Okay. Thank you.

19 MS. EDWARDS: So I'm going to rest there and let
20 Mr. Pretulak present his case.

21 THE COURT: Mr. Pretulak.

22 BY MR. PRETULAK: May it please the Court. This
23 is, in my mind and I think the Single Commissioner's
24 mind, a pretty straight forward Second Injury Fund
25 case. If you will look at the evidence, which is a

1 very thick record, you will see that there are a lot
2 of medicals that show the severity of the injuries; I
3 think we've talked about that already. But at the end
4 of the day the Carrier/Employer has to do something
5 and that's prove the elements under 42-9-400. Now if
6 we're able to prove those elements the way the Statute
7 is written is we're entitled to the reimbursement. In
8 other -- in this particular case the interesting thing
9 is there are actually multiple theories for
10 reimbursement; there's five actually. But
11 42-9-400(D34B) that's combined effect theory, I'm
12 going to explain that, but there are multiple theories
13 within that theory for reimbursement. So that's
14 obviously one of the diabetes (inaudible). We know
15 that the diabetes preexisted. There are medical
16 records of this guy's treatment. Glucophage was
17 something that he was provided treatment with. We
18 know that it preexisted and he was treating on the day
19 of the accident.

20 COMMISSIONER BARDEN: So you think even if the
21 diabetes is being treated and he wasn't noncompliant;
22 we know he was going to the doctor and getting
23 medication, you know, is there a record indicating it
24 was un-controlled or he was noncompliant, and this is
25 my question; do you believe if someone is taking

1 medication for diabetes and going to the doctors, and
2 we know they're compliant, they're going to get a
3 prescription, they're paying attention to what the
4 doctor has outlined for them, do you believe that that
5 is an automatic hindrance or obstacle to employment?

6 MR. PRETULAK: Well, that's interesting. I do,
7 actually, however, --

8 COMMISSIONER BARDEN: So you really don't need us
9 if you can establish that there's a medical record
10 where somebody is taking their medication for
11 diabetes, you think you've got that prong met?

12 MR. PRETULAK: I think I do. I think there's
13 more to this particular argument.

14 COMMISSIONER BARDEN: Okay.

15 MR. PRETULAK: Because with this particular case,
16 and once again, I've got doctors that have gone back,
17 looked through the records as a whole and said -- on
18 top of the (D2) and said, listen, this is a hindrance
19 and obstacle. But on top of that for this particular
20 case the interesting thing is I think that diabetes
21 combined with the accident results in disability in
22 excess of 78 weeks which comes in under (D34B).

23 COMMISSIONER BARDEN: Now, is there -- I didn't
24 see a notation on the date of the accident when the --
25 under the emergency -- but that came later,

1 (inaudible)?

2 MR. PRETULAK: Correct. Absolutely. And Dr.
3 Bosie, who actually conducted the amputation
4 references in the note, (inaudible) we've got his
5 deposition -- amputation that the diabetes wrote --
6 the page number I think is 80 -- look at 89; I hope I
7 have that right.

8 COMMISSIONER BARDEN: Actually it looks like -- I
9 think it's one that I've got right here --

10 MR. PRETULAK: I want to say it's 89.

11 COMMISSIONER BARDEN: All right.

12 MR. PRETULAK: But -- but here's the other thing
13 too. They use reference -- the guy uses reference,
14 okay. He knew that there were issues with the healing
15 process and most of us understand that that's an issue
16 --

17 COMMISSIONER BARDEN: Issues with the
18 (inaudible)?

19 MR. PRETULAK: Correct.

20 COMMISSIONER BARDEN: Developed with (inaudible)
21 resulting (inaudible). Okay.

22 MR. PRETULAK: But he references the diabetes
23 right underneath that as well --

24 COMMISSIONER BARDEN: I got you. I'm hearing
25 you. I got you.

1 MR. PRETULAK: - Okay. And Dr. Scott then goes
2 back, discusses all this and agrees that he did the
3 absolute right thing; the diabetes was clearly
4 something that contributed. So this particular case
5 under (D34B), this is obviously that combination which
6 gets us in the presumption. So he did a -- a (D2). I
7 think that we've clearly established it under (D34B),
8 therefore, we're -- we're covered. But I think this
9 goes even further. I've said it's -- there's five
10 theories that I have. The brain damage theory is the
11 weakest one. (D28) is our weakest argument and I
12 don't mind telling you that one bit, but under that
13 same argument that we have under (D34B), okay, it's
14 the same thing with the preexisting traumatic brain
15 injury which it is. The concussion may not rise to
16 the level of brain damage, but it is considered by all
17 the CDC a traumatic brain injury. Dr. Wade looked at
18 that and said this gentleman's disability was
19 increased as a result of that preexisting risk factor.
20 But in this particular case if he had not had that
21 second traumatic brain injury he may not have been a
22 lifetime candidate, we don't know. But Dr. Wade said
23 that if combined with it, it had caused more lost
24 time, more medicals and increased disability and
25 that's in the records. With regards to the other

1 grounds we also say this combination kind of exists
2 with regards to the diabetes and the brain injury and
3 the subsequent accident. That's kind of a final
4 theory. So those injuries combined with the
5 subsequent accident result back -- it gives you a pre
6 -- it gives you a presumption after the fact, quite
7 frankly, but it's there. So we say that (D2), (D34B)
8 under three theories and (D28), and I don't mind
9 telling you that (D28) is probably our weakest
10 argument. If any one of those theories is satisfied.
11 We argue under 42-9-400(A) that we're entitled to the
12 reimbursement, we shall pay in the first incident,
13 Second Injury Fund shall reimburse. When they changed
14 the Statute in 2007 they had the opportunity to change
15 that and they didn't, and so to me that means that we
16 have the exact same Rule that's gone all the way, all
17 the way. The perfect example in this case, how do you
18 split -- how do you split this up? How are we
19 supposed to now go back and figure out what's covered
20 and what's not? That's what the Statute -- that's
21 why the Legislature did what they did with regards to
22 that Statute, so if any one of our theories is
23 satisfied we say that we're entitled to reimbursement.
24 It must be pointed out that this is a medically
25 complex case and I don't think anyone will disagree

1 with the fact. This man was in a plane accident, he
2 was in the hospital for a long time and he had
3 substantial medical treatment, including, of course,
4 the amputation that we talked about. The McLeod and
5 Wynn cases are, of course, the cases that deal with
6 those issues and the fact remains that we're the only
7 folks that submitted medical evidence in this case.
8 The Second Injury Fund did not object to that
9 evidence, they did not depose the doctors and they
10 didn't submit any other expert evidence. In order to
11 rebut the presumption you would think that there would
12 need to be something that was submitted in order to
13 rebut the presumption that we've established. We
14 would say that that's not been accomplished in this
15 particular case, so at the end of the day the Single
16 Commissioner was compelled by the evidence, found that
17 there was not any competent evidence to disregard our
18 expert evidence and so found the reimbursement under
19 the multiple theories that I've gone over today.
20 Specifically with regard to diabetes, I think we've
21 discussed that so I'm not going to get into any
22 greater detail unless y'all have any more questions
23 about our theory on the diabetes. And I think I've
24 discussed the traumatic brain injury as well. Once
25 again, we've talked about the (D34B); I think the CDC

1 report that was submitted into evidence, not objected
2 to and relied upon in conjunction with Dr. Wade's
3 opinions clearly establishes the prior traumatic brain
4 injury with -- at least with regards to (D34B). I've
5 talked about how I think the traumatic brain injury
6 and the diabetes combined with the -- the two of those
7 with the -- with the accident under (D34B). So, this
8 -- the case -- the Greenville case that's cited, and I
9 want to bring that up, because I think it's very
10 important. In reviewing this case I get the feeling
11 that the argument is being made that for some reason
12 in a case where an individual is being permanently and
13 totally disabled, at the end of the day there
14 shouldn't be reimbursement; that's what I feel the
15 Second Injury Fund is arguing. And -- and you really
16 need to get down to the meat and bone -- or the meat
17 and potatoes of the Greenville case to understand what
18 happened there. In the Greenville case the Claimant
19 was found permanently and totally disabled independent
20 of any preexisting impairment. Okay. I think we've
21 established that and that's already been discussed
22 today. But you also have to realize that the Carrier
23 failed to -- to basically prove their case. They had
24 elements that they were supposed to prove and they
25 didn't do it in that particular case. The Employer

1 knowledge of medical costs is the biggest ones that we
2 saw. So in Greenville they failed to meet the burden
3 of the 42-9-400. We've not done that. In our
4 particular case we've got 42-9-400 under multiple
5 theories and at the end of the day we would say that
6 even if four out of the five theories failed and we're
7 able to get it under one, we're entitled to that full
8 reimbursement. So, as mentioned before, it's our
9 position that Greenville was denied reimbursement
10 because 42-9-400 was not satisfied. We have satisfied
11 42-9-400 and because we've done that we believe that
12 the Full Panel should, in fact, affirm in full the
13 decision of the Single Commissioner.

14 Thank you.

15 THE COURT: Ms. Edwards.

16 BY MS. EDWARDS: Just briefly. I'm not even
17 going to cite to the record on it, but let me just --
18 I think I did a pretty job arguing my own case. So
19 really if anybody doesn't see what I'm arguing, if I
20 don't see it, that's not what I'm arguing. I just
21 wanted to say that because I don't want to give
22 anybody an impression that I'm making an argument that
23 the Carrier is asserting. I am not making that
24 argument and I would just simply rest my case.

25 THE COURT: That concludes the hearing.

1

(The hearing concluded at 2:01 p.m.)

2

3

STATE OF SOUTH CAROLINA)
)
COUNTY OF LEXINGTON)

CERTIFICATE

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

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

THE FOREGOING TRANSCRIPT CONSISTING OF 18
TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND
COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT
THE TIME AND PLACE AFORESAID TO THE BEST OF MY SKILL
AND ABILITY;

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

WITNESS MY HAND AND SEAL THIS 5TH DAY OF MAY,
2013.

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

STATE OF SOUTH CAROLINA)
) COURT OF COMMON PLEAS
COUNTY OF CHESTERFIELD) 2012-CP-13-00362

SOUTH CAROLINA SECOND INJURY)
FUND)
)
) PLAINTIFF)
) vs.) TRANSCRIPT OF RECORD
)
AMERICAN HOME ASSURANCE)
COMPANY)
)
) DEFENDANT)

September 17, 2012
Chesterfield, South Carolina

B E F O R E:

THE HONORABLE PAUL M. BURCH, JUDGE.

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

JARED M. PRETULAK, ESQUIRE
Attorney for the Plaintiff

LATOYA DILLIGARD EDWARDS, ESQUIRE
Attorney for the Defendant

HATTIE O. GORDON
Circuit Court Reporter

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I N D E X

Colloquy	4
Certificate of Reporter	24

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

EXHIBITS

NO EXHIBITS WERE MARKED OR ADMITTED INTO THE RECORD

COLLOQUY

MS. EDWARDS: Your Honor, I'm Latonya Edwards and I represent the Appellant, so it's my appeal.

THE COURT: Okay.

MS. EDWARDS: If you're ready for me to get started I'll go right on ahead.

THE COURT: We're ready.

MS. EDWARDS: Okay. The Second Injury Fund is appealing the Hearing Commissioner -- I'm sorry. The Full Commission's order and we're citing various errors and citing various reasons for why that decision should be reversed. Let me first start off by our argument. One of the issues that we dispute is knowledge. At -- and we do have a record, and I believe that both Mr. Pretulak submitted one as well as myself.

It's my appeal, so all of this is in the record provided to the Court as well as in my brief that was forwarded to the Court. But we are first arguing that the Hearing Commissioner's finding that the funds conceded knowledge was error. And the reason we believe that was error because we certainly agree that this claimant had a concussion. We deny that brain damage -- the concussion rises to any level of brain damage.

That finding on the conceding of knowledge is at Finding of Fact Number 13, and so we dispute that and we

1 assign that as an error by the Full Commission panel
2 warranting reversal.

3 We also would note that the medical records indicate
4 that claimant was involved in a heavy machinery roll over
5 accident in July 2004. So this is an older case. That is
6 at Carrier AP Page 33. And while the claimant admitted to
7 maybe loss of consciousness once he was at the hospital he
8 was capable of moving all extremities. He was having
9 conversation and answering question. This is also at
10 Carrier AP Pages 33 through 34 which is in the record.

11 And his C.T. scan of the brain indicated that it was
12 normal. It didn't have any lesions, any skull fractures,
13 and the overall impression of the skull and brain was that
14 it was a normal C.T. scan. This is at Carrier AP Pages 35
15 through 36 and 38.

16 Also, there also is an independent medical
17 evaluation, and this is to be taken in conjunction with
18 all the other medical evidence. Dr. John Barkinbus, he
19 noted that the claimant -- he said, and this is a quote at
20 Carrier APA Page 168. And it says, "No mention is made of
21 prior concussion. There is no documented concern of
22 pre-injury cognitive decline."

23 And this goes to whether the pre-existing condition
24 was serious enough to be a hinderance to employment
25 pursuant to the statutory requirements and 42-9-400 of the

1 statute. And so we would also assert that Dr. Barkinbus'
2 position supports our argument that the prior concussion
3 was not a hinderance to employment. It did not rise to
4 the level of permanent brain damage we believe as
5 evidenced by the 2004 medical records and this independent
6 medical evaluation. And this is also at Hearing
7 Transcript Page 18, Carrier APA Pages 33 through 38 and
8 Line 68. So that's one of the reasons.

9 Another reason that we're assigning error to the a
10 Hearing Commissioner -- I'm sorry. The Panel -- the
11 Worker's Comp Panel's decision was that once again we
12 dispute that the prior concussion -- we agree the claimant
13 had a prior concussion before this injury. We deny that
14 that was a hinderance to employment, and we would also
15 cite some of the same records that I just cited where in
16 2004 he had negative scans, C.T. scans, Carrier APA Pages
17 33 through 38.

18 The discharge summary does not address any
19 complications he had as a result of this concussion. It
20 does not indicate that he suffered any serious or
21 permanent brain damage or that this concussion would cause
22 a hinderance to his employment. This is at Carrier APA
23 Pages 37 through 39.

24 Also, Dr. Barkinbus, again at Carrier APA Page 168
25 notes that claimant was functioning fine prior to

1 April 10, 2005 accident and he was also flying planes
2 solo. So he was flying planes by himself prior to this
3 accident. And let me just back up because the claimant
4 had a very, very severe injury. The extent of the
5 injuries were the plane crashed, and he suffered multiple
6 injuries broken bones, brain damage as a result of this
7 plane crash that he sustained on April 10, 2005.

8 The records at -- another reason that we dispute or
9 we are requesting reversal is because we deny that the
10 prior concussion combined with or was aggravated by the
11 April 10, 2005 plane crash, and we cited the following
12 records to support that argument at Carrier APA Pages 43
13 and 44. Immediately when the claimant arrived to the
14 emergency room on the day of the plane crash the C.T. scan
15 was negative, motor and sensory and upper and lower
16 bilateral extremities were intact and there was no loss of
17 consciousness according to those records.

18 Additionally, the C.T. scan of the claimant's head,
19 taken approximately two weeks post-injury after the
20 incident -- the accident, plane crash, indicates that the
21 damage represented post-traumatic edema. And so certainly
22 we would assert that the causes of claimant's problems
23 were from the work injury and not based on this
24 pre-existing concussion that we allege was not a
25 hinderance to his employment.

1 Also at claimant's, after the 2004 concussion -- I'm
2 sorry, just said that. But at Carrier APA Pages 12 and
3 118 it also cites findings that the injury were
4 post-traumatic from the plane crash. And once again
5 that's Pages 112 and 118. Also Page 168 also indicates
6 post-trauma amnesia, which also in our mind indicates that
7 the plane crash; that the injuries from the plane crash is
8 what caused all of claimant's medical problems and
9 subsequent condition.

10 As it relates to the -- I'm sorry. In addition to
11 this argument we would also like to cite in support from
12 APA Page Five, a copy of the underlying claim on the Forms
13 50 and 51 also notes that the claimants disability was a
14 result of the trauma plane crash itself. And the decision
15 acknowledges Dr. Barkinbus' evaluation which revealed that
16 claimant suffered a traumatic hemorrhage and subdural
17 hematoma during the plane crash.

18 At Fund APA Page Four we used this to cite that the
19 Commission relied heavily on the undisputed testimony of
20 the claimant's wife. We don't have a problem with that.
21 We are also going to rely on it to support our argument
22 that the decision should be reversed. The claimant's wife
23 testified that the claimant suffered from none of his
24 impairments prior to the plane crash and that he only
25 experienced them after the severe head trauma sustained in

1 the accident, and that's a quote.

2 Therefore, claimant's wife even acknowledges that he
3 did not have any of those problems prior to his work
4 injury, only subsequent. And that's at Fund APA Page
5 Four. Also the concussion was never discussed as a
6 contributing factor to his resulting disability from the
7 plane crash. The claimant did have pre-existing diabetes
8 as well. That's another pre-existing condition. We
9 acknowledge that.

10 And per 42-9-400 we are entitled to a presumption
11 that that is a hinderance to employment, but we believe
12 that the medical evidence rebuts that presumption. And we
13 would cite to the following medical records at Carrier APA
14 Pages Five and 10. The medical reports prior to the plane
15 crash indicates onset of diabetes in 1998. As a result
16 claimant began dietary management of the diabetes and was
17 prescribed (medication). Claimant was not restricted from
18 working while managing his diabetes at any time or after
19 the first diagnosis or before the plane crash.

20 In August of 2005 there is -- this is at Carrier APA
21 Page 10. During claimant's first follow up visit after
22 being released from the hospital all of the claimant's
23 injuries were listed and while the diabetes is mentioned
24 for historical purposes there is no indication that it
25 played a part in the severity of the injuries.

1 Claimant followed up with his physician in August of
2 that year, of 2005, and it notes that the Glucophage
3 glaucosis have been very stable. Carrier APA Page Ten.
4 Glaucosis have been very stable. His Type Two diabetes
5 was also stable. And he requested Glucophage medication
6 which he previously used to control the diabetes. Once
7 again this is at Carrier APA Page 10.

8 Eight months after the crash claimant's Glucophage
9 levels were still noted as stable. That's at Carrier APA
10 Page 11. Additionally, the discharge summary from
11 Carolina Specialty Hospital at Carrier APA Pages 132 and
12 133 indicates that one of the claimant's complications was
13 second to third degree burns from the plane crash. And
14 it's noted that the right lower extremity was infected.

15 And let me also say in conjunction with that, that
16 claimant had an amputation, and that was based on, at
17 Carrier APA Page 82, it notes that based on the
18 observation of severe tissue damage, infection,
19 instability of the joint, and requirements for tissue
20 transfer and ankle and subtiler fusion, the claimant was
21 better served by amputation.

22 So I believe that carrier is asserting that the
23 amputation was the result of his diabetes when in fact we
24 believe that the medical records at Page 82 and 163
25 indicate that the amputation resulted from the plane crash

1 which resulted in tissue danger, infection, instability of
2 the joint, so on and so forth.

3 Dr. Barkinbus, also at Carrier APA Page 165,
4 indicated that there was complications of the right ankle
5 injury including the infection which demanded a right
6 below knee amputation.

7 Your Honor, we also believe that in addition to those
8 arguments that the Appellant Panel erred in finding that
9 claimant's disability -- I'm sorry. That Carrier is
10 entitled to reimbursement for claimant's permanent and
11 total disability. One of the requirements under of
12 statute is that there be a substantial increase in carrier
13 liability for medical costs and permanent disability.

14 We certainly assert that based on all of that, the
15 cites, the references to the record that I just cited,
16 that there was no substantial increase based on the
17 pre-exist concussion but that plane injury -- the plane
18 crash which resulted in severe injuries and a leg
19 amputation as well as brain injury was a direct cause of
20 the claimant's medical costs and permanent disability.
21 And we would certainly request that the decision of the
22 Appellate Panel be reversed.

23 And I will be happy to answer any questions Your
24 Honor may have had.

25 THE COURT: All right.

1 MR. PRETULAK: Your Honor, may it please the Court.
2 This is a Worker's Compensation claim. Of course, now on
3 appeal there is a different standard of review. And, of
4 course, I'm sure you're fully aware of that, but just to
5 point out what we're looking at today is a situation where
6 there has to be some type of error of law or the decision
7 that was rendered by the Single Commissioner and the full
8 panel was not supported by substantial evidence.

9 We've submitted a rather substantial record on appeal
10 for your review, and so I'd say that there probably is
11 substantial evidence to warrant the actual decisions that
12 have been rendered previously. With that all being said
13 when I, know you, look at the evidence in the case there
14 is a lot that's been pointed to that goes back to this
15 underlying claim. And in a Worker's Comp underlying claim
16 we are not looking, necessarily, at the same issues that
17 we are looking about when we're talking about the Second
18 Injury Fund. Just wanted to point that out at the get go.

19 But in this particular case we're asking that you
20 look at all the evidence. Everything that's been
21 submitted. This is a very complicated matter. There is a
22 brain injury involved which in Worker's Comp means that
23 there is going to be lifetime benefits that are due to
24 this injured party.

25 And so the question we believe is have we satisfied

1 the elements of 42-9-400, and we say that we have. We say
2 that we've done so on multiple theories. We're not just
3 talking about this prior brain damage that's been eluded
4 to on multiple occasions. We're talking first about
5 42-9-400(D)2 which gives a presumption of disability --
6 sorry. Hinderance or obstacle to employment or the
7 pre-existing diabetes. So there is a presumption there
8 under (D)28, the prior brain damage we discussed, but we
9 also have three different theories under (D)34(b).

10 And under (D)34(b) it says that a pre-existing
11 impairment combined with a subsequent accident the results
12 in disability in excess of 78 weeks render to presumption.
13 And we say that there is a presumption under diabetes
14 alone, under the pre-existing concussion; that traumatic
15 brain injury that he suffered in 2004, and then the two,
16 the diabetes and the concussion together.

17 We have five different theories for compensation for
18 reimbursement in this particular case. We believe that
19 we've satisfied all the elements, but if we did not
20 satisfy all of the element and we've only satisfied one of
21 those theories we're entitled to reimbursement under
22 42-9-400(a) which says, "If the elements have been
23 satisfied the first incident the carrier shall pay
24 compensation and medical benefits. And in the second
25 instance the Second Injury Fund shall reimburse subject

1 for the statutory deductions."

2 We submitted expert evidence in this March case
3 because this is complicated. Dr. Scott and Dr. Wade
4 corroborate our position, and you can see their evidence
5 that's been submitted in the record. It's in the APAs
6 that were submitted by the defendant -- by the carrier in
7 this case at Exhibit B, Pages 192 and Exhibit D, Page 195.
8 For Dr. Wade it Exhibit C, Pages 193 to 194. Exhibit F,
9 Page 195.

10 And as I mentioned this is a medically complexed case
11 so we need that kind of expert evidence. At the end of
12 the day you look at everything, and the fact remains that
13 we are the only party that submit the evidence in this
14 case. Whether it's evidence from the treatment that
15 occurred back in 1998 when he was originally diagnosed
16 with diabetes to the present, really. And the entire
17 course of treatment, including the medical evidence that
18 we submitted, the expert evidence that we submitted, to
19 corroborate our position.

20 The Fund never objected that evidence. They never
21 deposed any of the doctors involved, and they didn't go
22 and obtain their own expert evidence. So the only
23 substantial evidence that exists is the evidence that we
24 have submitted in this particular case. When the Single
25 Commissioner and the Full Commissioner looked at the

1 evidence they agree we satisfied the evidence under
2 42-9-400. And they said that under all five of those
3 theories we presented.

4 With regards to the employer knowledge argument, if
5 you take a look at the record from the Single Commission,
6 which I've submitted into evidence, on Page 15 of the
7 transcript, Lines 16 through 17, the Fund specifically
8 states on the record that they did not contest employer
9 knowledge. So to go back at this point and to say that
10 they're now contesting it seemed a bit disingenuous.

11 With that said let's say, for instance, that they did
12 in fact preserve the issue and it's properly in field at
13 this point. The individual that we're talking about here
14 was the owner/operator of the company that we're
15 discussing. He was there for the medical treatment for
16 his pre-existing diabetes. He was there when the backhoe
17 rolled over him in 2004 knocking him unconscious. He
18 knows he diagnosis. He was there the entire time. So we
19 would contest that employer knowledge is definitely there.

20 Going to the diabetes, it is a pre-existing condition
21 that before the changes in 2007 allowed for a presumption
22 of hinderance or obstacle under (D)2. We're arguing that
23 it has been satisfied under (D)2 and (D)34(b) as I
24 mentioned earlier. (D)2 allows for that presumption. Dr.
25 McLeod, who has also been his treating physician for

1 years, talks about the diabetes in the course of treatment
2 he can follow all the way through. Dr. Wade and Dr. Scott
3 also discussed the treatment that's been rendered in the
4 past. So we knows that this was pre-existing. But let's
5 assume, for instance, that we're able to rebut that
6 presumption that's been provided to us in the statute.
7 They can't get around the presumption that's permitted in
8 (D) 34(b).

9 And what (D) 34(b) does is it essentially allows you
10 to go back and find that there was a presumption of the
11 hinderance or obstacle if you can prove that pre-existing
12 impairment, diabetes in this case, combined with the
13 subsequent accident to result in impairment greater than
14 78 weeks. This individual has a lifetime case. His
15 impairment and disability is far in excess of 78 weeks.

16 We say that occurred with the diabetes. They point
17 to the fact that they think that this amputation had
18 nothing to do with the diabetes. That's simply not the
19 case. Dr. Boscee was the physician that was there that
20 day, he eludes to the diabetes in his notes which is
21 located at Page 89, which is APA Number Five of the
22 submissions that was presented by the employer and
23 carrier.

24 When he reported to the E.R. on the day of the
25 accident his diabetes was so out of control that he

1 required an insulin infusion. He never had anything like
2 that in the past. It was monitored and controlled through
3 the use of this Glucophage and showing up to his doctor
4 every so often. So to say that there was some type of
5 aggravation or combination just doesn't appear correct
6 based on the medical records. And then taking the
7 information that we have from Dr. Wade and Dr. Scott I
8 think we can clearly show in fact that there was some
9 combination and/or aggravation at the very least.

10 With regards to the pre-existing concussion, and we
11 refer to this as traumatic brain injury, cause that's what
12 it is. The C.D.C. says that's what it is, and that's been
13 submitted into evidence as well. But Dr. Wade didn't even
14 refer to that information, and he was able to find that
15 that traumatic brain injury that this individual had was
16 in fact aggravated as a result of this plane crash.

17 And what he specifically says is that this prior
18 traumatic brain injury served to render the claimant with
19 greater disability, greater medical costs, and more lost
20 time from work, which is exactly what the statute requires
21 that we show. And as indicated again, once again, the
22 C.D.C. agrees with this. When there is a prior concussion
23 or traumatic brain injury within a year of the subsequent
24 accident there is evidence that shows that these
25 individuals have a more difficult time. And in this

1 particular case actually has permanent brain damage as a
2 result.

3 And I've mentioned, of course, that the final
4 theory -- one of the final theories under D(34)b where you
5 have traumatic brain injury, prior traumatic brain injury
6 and this diabetes combining with the subsequent accident
7 to result in disability of excess of 78 weeks. You can
8 look at the forms that have been filed with the Commission
9 to see exactly how high the medical costs are. You can
10 follow on a weekly basis from this point forward how much
11 indemnity that this individual is being paid, and it's
12 also supported by the medical evidence in this case.

13 There has been a lot of emphasis on the other side on
14 (D)28. That's 42-9(D)28 which says, "If prior brain
15 damage was a presumption of hinderance and obstacle," and
16 under (D)28 we would acknowledge that that's probably our
17 weakest position. There are C.T.s that they've eluded to.
18 and the fact that the C.T. right after the accident, the
19 second accident, the actual Worker's Compensation accident
20 that we're talking about, it shows the guy had a clear
21 C.T. of his brain.

22 It wasn't until days later that something showed up
23 on his C.T. But the bottom line is that that's probably
24 our weakest position. We don't think that it matters if
25 we're unable to provide all the evidence necessary to

1 prove that one theory under (D)20 because we've satisfied
2 all four of the other theories that I talked about today.
3 And I will elude back to 42-9-400(a).

4 Finally, and I don't know if the exact case was
5 referenced, but it's definitely referenced in both out
6 briefs. That's the Greenville case. In the Greenville
7 case I've seen it argued and I believe it's being argued
8 in this case that any time a claimant is rendered
9 permanently and totally disabled in a Worker's
10 Compensation Claim for some reason they shouldn't be
11 entitled to or that there should not be any reimbursement
12 to the carrier or the employer because that's the worse
13 outcome you can possible have.

14 And that's not what the Greenville case says. If you
15 read the Greenville case very closely you will find that
16 that's not what it stands for one bit. And in that
17 particular case that found that the individual was
18 permanently and totally disabled as a result of the
19 accident itself. He was deemed a paraplegic.

20 Furthermore, the Court outlines the carrier/employer
21 failures. In order to get Second Injury Fund
22 reimbursement you have got to satisfy all of the elements
23 of reimbursement. The carrier clearly did not do that.
24 They couldn't prove employer knowledge, and they couldn't
25 prove that there was an increase in the medical costs. So

1 they failed to meet their burden under 42-9-400 the Courts
2 had no option other than to find against them.

3 But in our case we did prove all the elements. We
4 proved them, we think, under five theories. At the very
5 lease four theories. We submitted evidence of employer
6 knowledge. We submitted evidence of increased medical
7 costs and disability. We've shown that the accident
8 combined with the pre-existing conditions under 42-9-400,
9 under all four to five theories that we discussed. So
10 when you take a look at everything you can see that we
11 have satisfied the elements where the individuals in the
12 Greenville case did not.

13 With, and I think I mentioned this and I just want to
14 point it out again, with regards to this leg amputation
15 diabetes is clearly references, and then it's tied back to
16 Dr. Scott. And every single physician that we used has
17 gone back and referenced medical records. This is not a
18 check off box. There are actually letters that they have
19 written explaining why they found what they found. So
20 this is not evidence that's not substantiated in the
21 record.

22 So at the end of the day we would ask that you please
23 uphold the Single Commission and the Full Panel of the
24 South Carolina Worker's Compensation Commission. Thank
25 you very much. I'll answer any questions you may have.

1 THE COURT: All right. Thank you.

2 MS. EDWARDS: Just briefly, Your Honor, if I may.

3 THE COURT: Yes.

4 MS. EDWARDS: Just to address a few things. On the
5 knowledge issue we concede knowledge of a concussion. We
6 do not concede knowledge of brain damage. So we're not
7 being disingenuous. We're just stating the fact. We
8 don't believe that the concussion rises to the level of
9 brain damage.

10 Second, Mr. Pretulak states 42-9-400 (d)34(b). That
11 section still requires that the combination of the
12 pre-existing condition and work injury create an event of
13 78 weeks or more.

14 We also assert that there was no combination of the
15 pre-existing conditions than rose of the level of causing
16 carrier greater liability.

17 As it relates to the City of Greenville case I'm not
18 going to rehash that. Of course, I dispute that it says
19 what Mr. Pretulak says it says, but I will rely on Your
20 Honor's interpretation of that case to make the decision
21 on what that case says.

22 And, finally, the only thing I would say is if this
23 claimant was perfectly health and if he had had this plane
24 crash is there any doubt in anybody's mind that he would
25 have -- would not have had a lifetime claim and traumatic

1 brain injury. So if he had come in and he hadn't had
2 diabetes and he had had a concussion but he had had a
3 really, really bad plane crash that resulted in all of
4 these thing he still would have been in the same
5 condition. And because he still would have been in the
6 same condition that's why we should win because there is
7 no combination of the pre-existing condition.

8 He still would have been in the same position he's in
9 now if he had been a perfectly healthy individual and
10 sustained this severe plain crash. And so that's -- I
11 would just conclude by saying that that is why we should
12 win this case. And that's what proves that there is not a
13 combination because if he had been perfectly healthy he
14 still would be in the same situation that he's in now.
15 Thank you, Your Honor.

16 MR. PRETULAK: If I may raise just one last point.
17 I'm sorry.

18 MS. EDWARDS: I'm sorry. If Your Honor would like to
19 speak. I'm sorry.

20 THE COURT: All right. This matter is under
21 advisement. If you've got any further material exchange
22 them with each other. Any proposed orders we would like
23 them in ten days.

24 MS. EDWARDS: None, Your Honor.

25 THE COURT: Okay. All right. Let us have a little

1 time to look this over.

2 MS. EDWARDS: Your Honor, can I give my card to the
3 court reporter just in case I need a transcript?

4

5

END OF TRANSCRIPT OF RECORD

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 11
- 12
- 13
- 14
- 15
- 16
- 17
- 18
- 19
- 20
- 21
- 22
- 23
- 24
- 25

I, HATTIE O. GORDON, Official Court Reporter for the 4th Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Chesterfield County, South Carolina, on the 17th day of September, 2012.

18
19
20
21
22
23
24
25

January 28, 2013

HATTIE O. GORDON, Court Reporter

BOYKIN & DAVIS, LLC

Attorneys and Counselors at Law

220 STONERIDGE DRIVE, SUITE 100
COLUMBIA, SOUTH CAROLINA 29210

POST OFFICE BOX 11844
COLUMBIA, SOUTH CAROLINA 29211

TELEPHONE: 803-254-0707

FACSIMILE: 803-254-5609

CHARLES J. BOYKIN*
KENNETH A. DAVIS
ADRIANNE L. TURNER
DEIDRE D. LAWS
KIMBERLY A. GERTNER
REAGAN S. FLEMMING
SHAWN D. EUBANKS
COURTNEY M. LASTER

PETER E. KEUP*
LATONYA DILLIGARD EDWARDS*
OF COUNSEL

dlaws@boykinlawsc.com

October 31, 2011

* CERTIFIED CIVIL ARBITRATOR AND MEDIATOR
† ALSO ADMITTED IN CALIFORNIA
‡ ALSO ADMITTED IN NORTH CAROLINA

Virginia Crocker, Judicial Director
South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Re: American Home Assurance Company v. S.C. Second Injury Fund
(In Re: John Stroud v. John F. Stroud & Sons, Inc.)
SWCC No.: 054228; SIF No.: 116667

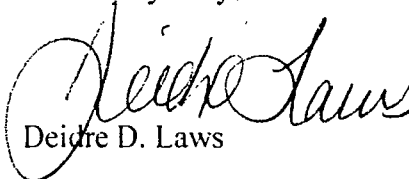
Dear Ginger:

Enclosed please find the original and three (3) copies of the Second Injury Fund's Form 30 Request for Commission Review, along with a check for One Hundred and Fifty Dollars (\$150.00) to cover the cost of the appeal and the signed Order.

Please let me know if additional information is necessary.

With kind regards, I am

Yours very truly,


Deidre D. Laws

/slo

cc: Jared M. Pretulak, Esquire (w/encls.)



Claimant's Name: John Stroud SSN: 238-68-3216 Employer's Name: John F. Stroud & Sons, Inc.
Address: 971 NC Zoar Road Address: 927 East Boulevard
City: Cheraw State: SC Zip: 29520 City: Chesterfield State: SC Zip: 29709
Home Phone: _____ Work Phone: () - Insurance Carrier: American Home Assurance Company
Preparer's Name: Deidre D. Laws Law Firm: Boykin & Davis, LLC Preparer's Phone #: (803) 254-0707

REQUEST FOR COMMISSION REVIEW

Request for Commission Review by ☐ claimant ☐ employer ☒ SCSIF (check one) Date of injury: 4/10/05 (m/d/yyyy)

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

See Attachment.

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

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Jared M. Pretulak, Esquire, Gallivan, White & Boyd, P.A.,
PO Box 10589, Greenville, SC. 29603
Name

in the 31 day of October, 2011 by ☒ first class mail ☐ personal service ☐ certified mail.

Deidre D. Laws Attorney October 31, 2011
Preparer's Signature Title Date

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

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

ATTACHMENT TO FORM 30
REQUEST FOR COMMISSION REVIEW
SCWCC NO. 054228 ; SCSIF NO. 116667
DATE: October 31, 2011
Page 2 of 2

QUESTIONS PRESENTED

1. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 9) that Carrier is entitled to compensation reimbursement when Mr. Stroud was found to be permanently and totally disabled and such reimbursement is contrary to prevailing case law?
2. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 11) that Mr. Stroud suffered a traumatic brain injury (concussion) rising to the level of brain damage prior to his April 10, 2005 work-related accident, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
3. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 13) that the Fund conceded knowledge, the error being that the Fund only conceded knowledge of a prior concussion, but not prior brain damage.
4. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 20) that the Fund failed to rebut the presumption and/or Carrier's evidence that Mr. Stroud's preexisting diabetes was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
5. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 21) that the Fund failed to rebut the presumption and/or Carrier's evidence that Mr. Stroud's preexisting traumatic brain injury (concussion) was permanent and of such seriousness as to constitute a hindrance or obstacle to employment or reemployment if Mr. Stroud should become unemployed, when such finding is against the greater weight of the reliable, probative, and substantial evidence in the record?
6. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 24) that Mr. Stroud's preexisting diabetes combined with or was aggravated by his April 10, 2005 work accident when such finding is against the preponderance of the reliable, probative, and substantial evidence in the record?
7. Did the Hearing Commissioner err in finding as a fact (Finding of Fact No. 25) that Mr. Stroud's preexisting traumatic brain injury (concussion) and/or brain damage combined with or was aggravated by his April 10, 2005 work injury when such finding is against the greater weight of the reliable, probative and substantial evidence in the record?

DDL

South Carolina Workers' Compensation Commission

1333 Main Street, Suite 500

Post Office BOX 1715

Columbia, SC 29202-1715

(803) 737-5739



PRE-HEARING BRIEF

WCC File No: 504228

Employer/Carrier: John F. Stroud & Sons, Inc. and American Home Assurance Company

Defendant's Name: South Carolina Second Injury Fund

(In Re: **John Stroud v. John F. Stroud & Sons, Inc. and American Home Assurance Company**)

Address: 100 Executive Center, Suite 101

Address: 927 East Boulevard

City: Columbia State: SC Zip: 29210

City: Chesterfield State: SC Zip: 29709-1835

Carrier: American Home Assurance Company

Employer Phone: (843) 623-6285

Preparer's Name: Jared Pretulak

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

☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: \$592.56 2. AWW: \$1,208.00 Date of Injury: April 10, 2005

3. Type of injury and body part(s): Multiple injuries to the head, brain, right lower extremity, eyes and left upper extremity.

4. Facts in controversy: See attached addendum.

5. Legal issues involved: § 42-9-400 (see attached addendum); Ellison v. Frigidaire Home Products and other applicable statutes, case law and regulations.

6. Unusual aspects: Not applicable.

7. Witnesses (designate if expert*): The employer/carrier relies on APA submissions. The employer/carrier reserves the right to add witnesses.

8. Exhibits: See attached addendum. The employer/carrier reserves the right to add exhibits.

9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): See attached APA submissions.

10. Name, address, and specialty, if any, of the treating physician: See attached APA submissions index.

11. Impairment rating(s); body part(s); physician and date of opinion: _____

12. I am amending my Form 54 in the following manner: We request reimbursement under § 42-9-400 (a), § 42-9-400 (d)(34)(b), and § 42-9-400 (d)(28)--brain damage.

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

Signature: Jared M. Pretulak 09/06/2011

Email: jpretulak@gwblawfirm.com

Date of hearing: September 21, 2011

Time needed for hearing: 30 minutes

On behalf of ☐ Claimant ☒ Carrier

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

WCC Form # 58
Rev. 9/07

58

PRE-HEARING BRIEF

ADDENDUM

John F. Stroud & Sons, Inc. and American Home Assurance Company

-vs-

S.C. Second Injury Fund

(IN RE: John Stroud v. John F. Stroud & Sons, Inc.)

W.C.C. No.: 504228

SIF No.: 116667

4. John F. Stroud & Sons, Inc. and American Home Assurance Company seek indemnity and medical reimbursement from the South Carolina Second Injury Fund for injuries suffered by the Claimant on April 10, 2005 and all treatment directly associated with those injuries. The Carrier originally submitted a Second Injury Fund Claim Form on June 8, 2011 based on multiple injuries to the head, brain, right lower extremity, eyes, and left upper extremity. The Carrier has submitted documents substantiating employer knowledge of Mr. Stroud's pre-existing conditions.

The evidence of the case supports the Carrier's claim for benefits. On April 10, 2005, Mr. Stroud injured his head, brain, right lower extremity, eyes and left upper extremity in the course and scope of his employment. He subsequently aggravated his pre-existing conditions due to his injuries. The Carrier has produced medical certificates from the treating physicians both confirming the pre-existing conditions pre-dated the work injury at issue and that the conditions met all of the requirements of § 42-9-400. Further, the medical evidence substantiates that the pre-existing conditions were aggravated by and combined with the current injuries to meet the requirements of § 42-9-400 to establish the Carrier's right to reimbursement.

The Carrier further contends that it has met all statutory criteria for Employer knowledge in this case. Specifically, Mr. Stroud was both the Employer and the Claimant. The medical evidence verifies Mr. Stroud actively sought and was provided medical treatment for diabetes and a head injury (concussion) prior to the date of accident. This clearly demonstrates evidence of Employer knowledge of the pre-existing conditions prior to the date of injury.

The pre-existing impairments serve as presumptions of hindrances and/or obstacles to employment or reemployment. The statute under § 42-9-400(d)(2) lists diabetes as a presumed hindrance or obstacle to employment or reemployment. In addition, it lists under § 42-9-400(d)(28) brain damage as a presumed hindrance or obstacle to employment or reemployment. Lastly, based on the impairment and ultimate disability assigned to the Claimant as a result of the severe injuries sustained to multiple body parts in combination with his pre-existing conditions, the Carrier would be granted a presumption of hindrance and/or obstacle to employment or reemployment under § 42-9-400(d)(34)(b), given that the apparent impairment would be equal to or greater than a disability of 78 weeks or more. In addition, they, by reason of the combined effects of

ADDENDUM

John F. Stroud & Sons, Inc. and American Home Assurance Company v. S.C. Second Injury Fund

(IN RE: John Stroud v. John F. Stroud & Sons, Inc.)

Page 2

the pre-existing impairments and subsequent injuries, substantially increased the Carrier's liability for medical payments, disability, and compensation. The Carrier's liabilities were also substantially increased by the aggravation of the pre-existing conditions. Having met all statutory criteria for a Second Injury Fund claim, the Carrier requests full reimbursement from the Second Injury Fund as per the statute.

5. The Employer is entitled to reimbursement per § 42-9-400(d)(2), § 42-9-400(d)(28), § 42-9-400(d)(34)(b), and § 42-9-400(d)(a). Section 42-9-400(a) governing on April 10, 2005, included reimbursement for pre-existing impairments which increased liability for medical costs, disability, and compensation through the combined effects and/or aggravation. Even without the presumption of hindrance under § 42-9-400(d)(2), § 42-9-400(d)(28), § 42-9-400(d)(34)(b), the Carrier has medical statements proving increased liability to the Carrier by reasons by reasons of the combined effects of pre-existing conditions under § 42-9-400(a), as well as aggravation of the pre-existing impairments.
8. See attached APA submission index. The Carrier reserves the right to submit additional exhibits.

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

John F. Stroud & Sons, Inc. and American)
Home Assurance Company,)
Employer/Carrier,)

-v.-)

South Carolina Second Injury Fund,)
Defendant.)

(IN RE: John Stroud v. John F. Stroud &)
Sons, Inc.))

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION
COMMISSION

NOTICE OF WITNESSES AND WRITTEN
REPORT(S)/PHYSICIAN OR OTHER EVIDENCE
TO BE INTRODUCED ON BEHALF OF
EMPLOYER/CARRIER

W.C.C. FILE NO. 504228

TO: SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION AND SOUTH
CAROLINA SECOND INJURY FUND.

YOU ARE HEREBY NOTIFIED THAT THE Employer/Carrier, pursuant to the provisions of
the South Carolina Workers' Compensation Act and South Carolina Code Section 1-23-330, (1976, as
amended), herewith submit the following reports/physician or other evidence on behalf of the
Employer/Carrier, to wit:

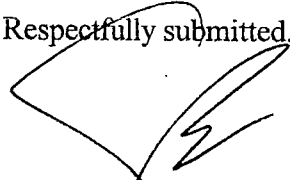
See attached EMPLOYER/CARRIER'S APA SUBMISSIONS

YOU ARE FURTHER HEREBY NOTIFIED that you have the right to cross-examination; and,
should you desire to exercise said right, you are to forthwith schedule the deposition(s) of any of the
physicians or other person(s), whose reports are submitted, for the purposes of cross-examination.

YOU ARE FURTHER NOTIFIED that the originals of the documents referred to herein, or
photocopies received from said physicians/ others, will be submitted to the Commissioner at the hearing for
insertion in the file of the South Carolina Workers' Compensation Commission and inclusion into evidence
on behalf of the Employer/Carrier.

YOU ARE FURTHER NOTIFIED that the Employer/Carrier does not anticipate calling any witnesses at this time. The Employer/Carrier reserves the right to amend this list of witnesses.

Respectfully submitted,



Jared M. Pretulak
Gallivan, White & Boyd, P.A.
P.O. Box 10589
Greenville, SC 29603
(803) 271-9580

Attorney for the Employer/Carrier.

Greenville, S.C.

September 6, 2011

cc: South Carolina Second Injury Fund

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)
John F. Stroud & Sons, Inc. and American)
Home Assurance Company,)
)
Employer/Carrier,)
-vs-)
South Carolina Second Injury Fund,)
)
Defendant.)
)
(IN RE: John Stroud v. John F. Stroud &)
Sons, Inc. and American Home Assurance)
Company))
_____)

BEFORE THE SOUTH CAROLINA
WORKERS' COMPENSATION
COMMISSION

CERTIFICATE OF SERVICE

W.C.C. FILE NO. 504228

The undersigned Martha Crampton, secretary to Jared M. Pretulak, attorney for the Employer/Carrier, certifies that on the 6th day of September, 2011, she served a copy of the EMPLOYER/CARRIER'S FORM 58 and NOTICE OF WITNESSES AND WRITTEN REPORTS BEFORE THE WORKERS' COMPENSATION COMMISSION upon the defendant, South Carolina Second Injury Fund, by depositing in the United States Mail, via certified mail delivery, with due and proper postage affixed thereto, a copy of the same addressed to:

Latonya Edwards
Attorney for the
South Carolina Second Injury Fund
Boykin & Davis, LLC
P.O. Box 11844
Columbia, SC 29211



Martha Crampton

September 6, 2011

John F. McLeod III, M.D.
110 Doctors Drive Suite B-2
Cheraw, SC 29520

7-14-92 John F. Stroud (Dunk)

- S: Stopped up ear feeling since fell over in water when he was riding on the lake 3 days ago on the back of an intertube. Decreased hearing since.
O: Looks well. BP150/100 P88 T98.4 WT186½ HT5'10". Lt TM: looks normal except for possible very tiny hole in the superior, anterior portion, other wise negative. Rt. auditory canal is completely occluded with wax. Neck: no nodes. Wax was irrigated after a long irrigation process. TM is intact, looks like fluid behind it, slight redness.
A: 1. External Auditory Occlusion resolved, 2. Possible Otitis Media.
P: Septra DS 1 bid. F/U 2 wks.

10-5-92 DOT with Dr. J. McLeod

10-30-92 John F. Stroud

- S: Small skin tag type lesion in the axillae has become sore and inflamed over last 24h.
O: BP130/90 P89 T98.0 WT189½. 4x4cm skin tag in area noted above that is tender around and underneath it. Feels like may have slight cystic component.
A: Skin tag and suspected epidermal cyst
P: Lesion was excised and wound closed with 5-0 Nylon. Did indeed some cystic like "cheesy" material in it. F/U 1 wk.

11-6-92 John F. Stroud (Dunk)

- S: See last note. Wound healing well. Sutures removed. Also has lesion on rt upper arm he would like to have removed. Has a 4 x 4 round raised lesion that appears to be a wart he's tried to treat and has not come off. Used Hyfrecator and destroyed the lesion. F/U soon for a small lesion on neck we will excise.

12-1-92 John F. Stroud (Dunk)

- S: Small growth on rt anterior neck, been present more than a yr. Would like it removed.
O: BP140/90 WT187. .5 x .5cm raised papule on area as described above. Was excised and wound closed with 5-0 Nylon, specimen sent for histology.
A: Growth on rt neck
P: F/U 3 days.

12-4-92 Wound healing well. Sutures removed. Histo: Compound nevus

3-25-93 John F. Stroud

- S: Last sev days some lower back ache and aching in testicles. Hx of Prostatitis once before.
O: BP150/100 T98.2 WT187. Back: non tender, Gent: no lesions or tenderness, Prosta normal size, non tender, UA: 4-6 RBCs and occ WBC.
A: Suspect Prostatitis
P: Septra DS bid #30 with 1 refill. F/U for complete physical and BP.

John F. McLeod III, M.D.
110 Doctors Drive Suite B-2
Chenow, SC 29520

9-14-93 John F. Stroud

S: C/O rt elbow with discomfort over lateral aspect for last sev wks. Also main problem with numbness of lt fingers, mostly middle and ring fingers and most of symptoms from elbow down. No neck pain or problems or recent injuries.
O: BP156/90 P80 WT186. Rt elbow with mild tenderness over the later-epicondyle other- wise good ROM and no edema. Lt arm and hand: appear normal and non tender. Good motor function. Sensations seems intact now.
A: 1. Rt Epicondylitis 2. Possible lt sided upper ext radiculopathy or other
P: Advil 3 tabs tid for next 2 wks, if not improving Lodine 300mg bid #40, if not im- proving F/U for further testing as discussed.

9-27-93 App. Carolyn Neurologic Clinic - 11-8-93 10 AM
Dr. Paul Tuttle - ~~cancelled~~
9-28-93 App. Dr. Jack Young - Pinehurst - 10-29-93 1 PM - ~~cancelled~~

11-11-93 John F. Stroud

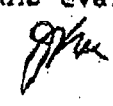
S: Here for CDL physical and would like over all physical. See last note. Saw Dr. Tuttle concerning the lt hand fingers with numbness. This is some better already before he saw him, changed him to Naprosyn and feels like he probably had some pinched nerve. Also concerned last 1 month difficulty maintaining and getting erections.
PMH: States hes had elevated BPs but no treatment, (mostly in doctor's offices). No other medical problems. Some hearing loss hes had evaluated before and wears a hearing aid that helps alot with that.
Current Meds: Naprosyn 500mg bid for fingers
Allergies: Penicillin
Smoking: no
Alcohol: fairly regularly with beer and mixed drinks
PSH: Negative
O: BP150/100 P80 WT182 HT5'9½". HEENT: negative, Chest: clear, Heart: normal sounds, Abd: soft, Gent: no lesions, Rectal: negative, Prostate: no nodules, Ext: no lesions, UA: WNL, ECG: WNL.
A: Mild elevated BP 2. Hearing loss corrected with hearing aid 3. Erectile Dysfunction
P: Exec with TSH and PSA, Testosterone level, Testosterone 200mg IM, Yocon 5.4mg tid #100 R2, decrease or stop the ETOH and F/U 1 month.

12-21-93 John F. Stroud

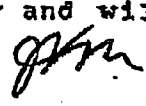
S: Says hes doing better. Wants a refill on Yocon. Saw Dr. Tuttle and says hes got neck spurs that probably cause some nerve root irritation but that is also better with less lt arm and hand symptoms. Is on no medicine for that.
O: BP140/90 and repeat 160/100 P60 WT186½. No other exam changes.
A: 1. LUE Radiculopathy improved 2. Erection problem improved 3. Elevated BP, at this point I would like to follow this and not start on any medication as it is down at times. Thinks it is due to his job.
P: Yocon 5.4mg tid #100 R2 and F/U on BP within 6 months. Have other BPs made too.

John F. McLeod III, M.D.
16 Doctors Drive Suite B-2
Charaw, SC 29520

8-29-94 John F. Stroud

- S: See last notes. He did well with erections for sev months but now last 2 wks no erection. Is off the Yocon now as it didn't seem to make any difference he said. Still drinks some on weekends some mostly, no smoking. See lab profile with normal lipids.
- O: BP150/100 both arms P98 WT189. External gent: no lesions.
- A: Erectile dysfunction/impotence
- P: Testosterone 200mg IM, referral to Dr. Finkler for his evaluation.
- 

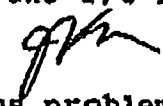
8-1-94 John F. Stroud

- S: Lesion on side of neck that's been present for many months and would like it removed. Also request some Rogaine for scalp, been in the vertex for sev yrs at least.
- O: BP140/90 WT185. Small filiform wart on rt lateral neck that was removed with scissors and base cauterized. Does have male pattern baldness in the vertex.
- A: Wart removed 2. Male pattern baldness
- P: Rogaine lcc bid to area affected 60cc bottle R5. Discussion concerning its use, after this he still wants to give it a try and will F/U as needed.
- 

9-15-94 John F. Stroud

- S: Said he awoke this morning and when he rolled over in bed he felt like he was dizzy, like the room was moving. This lasted for a few seconds to a minute. Has had several episodes throughout this morning where he turns his head or bends over and comes up fast where he feels like things are moving on him. Feels like he going to loose his balance. Usually stabilizes in a matter of half a minute. No nausea or vomiting. Did have a bad shake up around June, car crash while racing. Said he was somewhat dizzy and had to rest in bed for 2 days but resolved totally and has been back to work normally since.
- O: BP160/100 repeat 140/95 P74 T98. Also tells me he had 6 beers last night, drinks mostly beer in episodes. HEENT: negative, Chest: clear, Heart: normal sounds, Neuro: intact except for Nystagmus when we rotate his head and this causes immediate symptoms. Is relieved in a matter of seconds.
- A: Vestibulitis
- P: Antivert 25mg tid #30 R1, rest, no alcohol and F/U if not resolving within 1 wee or sooner if needed.

3-27-95 John F. Stroud



- S: Rt ear stopped up last 2 days, chronic sinus problems and would like to have further evaluation. Was evidently in some type of oxygen chamber over weekend due to CO poisoning from car racing
- O: BP140/90 T96.7 WT192½. Rt TM: dull & mild erythema, Lt TM: normal, Pharynx: clear, Nose: clear
- A: ROM and possible Sinusitis with ETD
- P: Septra DS bid x 2 wks, Sinufed bid #28, referral to Dr. Robertson.

John F. McLeod III, M.D.
110 Doctor's Drive Suite B-2
Charaw, SC 29520

7-6-95 John F. Stroud (Dunk)

- S: Flake of metal blew in eye from exhaust on welder a few minutes ago.
O: BP150/90. Small metal flake in eye on limbus, removed, no abrasion noted, vision OK, completely relieved of pain
A: FB in eye; no evidence of abrasion after staining
P: P/O prn.

10-31-95 Dunk Stroud

- S: 1 wk ago had some foreign matter fly in his eye while doing some bulldozing. Felt like he got it out but since then felt somewhat scratchy in upper part of eyelid. No drainage. Vision OK.
O: BP140/90 P88 WT190. Rt eye with no redness, no FB noted. Upper lid looks OK. Pupil reactive. Pain and no abrasions seen
A: Possible conjunctiva abrasion or lid abrasion
P: Garamycin tid. Offered referral and he will let me know if not improved.

4-8-96 Records sent to Equifax Services. Med. Record fee of \$15 paid.

Request for his wife (Linda) was sent & ck of \$15 returned to Equifax - Linda has never been seen in our office as pt. copy to chart

8-1-97 John Stroud

- S: Came in for DOT exam. Also would like to have skin tag removed from the right neck. And as well, he has had recent problems with pain over the tail bone area for some period of weeks to months. More so, since he has been driving a tanker truck. He states, he has also had at some times some swollen hemorrhoids.
- O: BP140/98 P74 T98 Wt189 Ht 5'10". Heent: negative, Chest: Clear, Heart: RRNS
Abd: soft, No masses, HSM, Ext: no edema, Anal area - he has evidence of some external hemorrhoids skin tags. Digital exam for brain tumor is negative
Prostate: no lesions. The anoscope shows very small internal hemorrhoid. Also, he had a small pustule over the tip of the coccyx that was popped and has a small hole there. At the moment, not tender and no fluctuance and no erythema. The small skin was removed from the left neck. He also has Hemangioma over the right posterior scalp that hasn't changed. He states in years as well in small mole that is skin colored and smooth over the left parietal scalp that he says has been there for many, many years unchanged.
- A: 1) Small internal hemorrhoid in the recent and external hemorrhoids stable
2) possible Pilonidal cyst pustule in that area that is open. 3) Skin tag
4) mild elevated BP that he had in the past and does not desire treatment for this time.
- P: Keflex 500mg #30, Anusol HC Supp #20 prn if needed for later. Sitz baths, CBC, Chem Prof, Lipid Prof, PSA, at his request UA with trace glucose. Offered surgical referral concerning the possible pilonidal cyst problem but he would like to wait and see.

8-8-97 fasting glucose .04 - 135

JOHN F. MCLELLAN, III, M.D.
440 Doctors' Drive Suite B-2
Cheraw, S.C. 29520
(803) 537-8832

8-8-97 Dunk Stroud

- S: FU on Glucose, as he had a level of 146 on last lab, we think that was at random. Family history of diabetes.
O: Glucose today fasting is 135.
A: Slightly elevated fasting glucose but not over 140.
P: Recheck in 2 weeks with 2 hour PP glucose and HBA1C and Fu on those.

8/10/98 Dunk Stroud

- S: Over last wk has developed a white lesion on right upper eyelid. Also has had some watery irritated feeling right eye. Saw Dr. Phillips today and was prescribed Tobradex and was told possible had slight infection. Also would like reg. check up. Hx of mild elevated glucose in the past and mildly elevated BP. Current meds none. Smoking, no. Alcohol use, yes.
O: BP 144/88 repeat was 150/90 P68 W192 HEENT no acute lesion. No masses. Right eye, appears normal. Has a small cyst on the right upper lid that was opened and contents expressed. Chest clear. Heart reg rate, normal sounds. Abd. soft, no masses. Genitalia no lesion. Rectal is neg. Prostate normal size for age and no lesions. Ext. no edema.
A: Skin cyst as above removed 2) Hx of mild elevated glucose 3) Hx of mild elevated BP 4) Suspected mild conjunctivitis
P: He is going to use the Tobradex as Dr. Phillips prescribed. FU with either me or Dr. Phillips in the next wk if not improving, sooner if needed. CBC, chem profile, lipid profile, PSA and HBA1C at his req for lab as well as concerning elevated glucose and FU on lab.

8/14/98 - patient notified to FU about blood sugar levels to come in fasting are a.m. (water only) on

9-21-98: Called and returned phone again about blood test indicating diabetes. Told to come in for followup. At same time doctoring above on phone.

9/28/98 Dunk Stroud

- S: See prior note, FU concerning new onset of type II DM. States he's doing alright except for at times he notices his vision is not exactly focused mostly at distances. Strong family history of DM with Mother and 1 brother.
O: BP 145/90 P76 Wt 188. No exam changes from last visit, Glucose is 183 fasting today. States he also ate some candy bars yesterday, and we have discussed holding off glucose products by phone.
A: Type II DM, recent onset, over some period of months.
P: Start Dietary mang. with referral to Nalle Clinic for diabetic teaching and dietary instruction. Glucometer prescribed and instructed to check glucoses bid and FU 1 month with readings. Sooner if his readings are out of the range, consistently as discussed.

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE-SUITE B2
CHERAW, S.C. 29520

11/24/98 Dunk Stroud

- S: FU on DM. He's feeling well, dieting and lost some weight. Glucoses are ranging mostly in the low 100's fasting, and below 200 in the PM.
O: BP 140/90 P 84 Wt 174. Chest clear, Heart RR, Abd soft,
A: Type II DM with new onset and improved control
P: Continue diet, FU for in & out HBA1C in 1 month and will go from there.

5/10/99 Dunk Stroud

- S: Injured low back 2 weeks ago when he was lifting a steel eye beam and felt pain in it right away. He's trying to work some since but continues to hurt, hurts more with different movements at times Lt leg is weak, but no pain there. Also skin lesions on the Rt face he would like removed. Present for a number of months. Also FU on type II DM.
O: BP 130/90 P 80 Wt 168. Has a SK lesion on the Rt temporal area, small AK lesion just above the Rt eye brow. Chest clear, heart RR, Abd soft, back no specific tenderness, SLR's are negative, Neuro intact with good reflexes at the knees and ankles,
A: 1. Back injury suspect sprain possible disc problem or other. 2. Type II DM with home glucose in the low 100's fasting. Glucose here today was 105. 3. SK and AK on Rt face.
P: Facial lesions destroyed with hyfrecator, Lodine 400mg # 20 R2, Schedule MRI of LS Spine, and decrease activities, and FU afterwards.

12/20/99 John Stroud

- S: For some per. of days and especially last 2 days he's had some pain behind the L. Knee more so with walking. Does not hurt at a rest. No injury.
O: BP 130/80 P 76 Wt 180. Mildly tender in the posterior aspect of the L. Knee with question of some slight thickening of the muscle there. Has good ROM but has pain with full extension. Good flexion. Knee with no laxity and no effusion.
A: Possible leg muscle sprain.
P: Lodine 400mg #30 R2. Decrease activities. Offered further studies and he'd like to wait and see and FU if not responding.

11-14-01 John F. Stroud

- S: Came req. complete exam as well as DOT exam as well as he's had problems with last 1 or 2 wks with vague discomfort in the groin/pelvic area at times with some slight burning with urination. Also he's had a small lesion on the right upper forehead that he would like removed that has been present for a number of months.
O: BP 120/72 P 74 Wt 177. Hcent neg. Chest clear. Heart RR/NS. Abd. soft, no masses or MSM. Ext. no edema. Good pulse in both feet. Genitalia no lesions, no hernia. Rectal neg. Prostate no lesions palpated. Neuro intact. Skin he's got a small sandpapery feeling lesion on the left upper forehead area consistent with a AK.
A: #1. Type II DM on diet control #2 AK #3. Possible prostatitis
P: CBC, HBA1C, CMP, PSA done. AK lesion was destroyed with hyfrecator. Septra DS #30. FU on lab and FU if not responding.

02-12-02 John Stroud

- S: Last 5 days he has had some itchy feeling and then subsequent rash erupted over the RL mid upper back area and spread over the RL chest. Some fatigue otherwise working daily.
O: BP 124/70 P 70 T 98.4 WT 169. Hcent neg. Chest clear. Heart RR. NS. Abd. soft, no masses, no edema. Skin erythematous rash over the dermatome area of the RL upper back and around the RL chest with some vesicles.
A: #1. H Zoster. #2. Type II DM on diet control.
P: CBC, CMP, HBA1C done. Valtrex 1gm #21, Darvocet N100 #30 R2. FU in 2 wks if not resolved.

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE-SUITE B2
CHERAW, S.C. 29520

2-14-02. Chertney's Drug. Glucophage 1000 mg 1/2 tabs
bid. H 31 R X 5. v glucose reading after 2 wks. norm

3-14-02 John Stroud

S: FU regarding Type II DM. Very mild elevation of HBA1C at 7.1 on 2-12-02. Also FU regarding H zipper. Also he has noticed a lump on his back that is non painful. Also he has had some blood in his semen recently, had this before several months ago. Fasting glucoses have been from low to mid 100's, see copy in chart.

O: BP 126/88 P 80 W 178. Skin lesions of rosier have healed. Hcent neg. Chest is clear. Heart reg rate. Abd soft. Extremities no edema. Gent, no lesions. Prostate exam done a few months ago was neg. Back there is about a 3x3cm. mobile lipoma feeling lump on the R upper back.

A: #1 Type II DM with elevation of HBA1C, mild. #2 Back lump, susp. lipoma. #3 Hematospermia of undetermined etiology.

P: Increase Glucophage to 1000mg bid #62 R5. Referral to Dr. Winston Godwin for back lump as he would like to have this removed. Referral to Hawes clinic regarding hematospermia FU 2m or sooner if needed.

3-15-02 Appt. with Dr. Weisner, 3-19-02, 1:15 pm.

Appt. with Dr. Godwin, 3-26-02, 3:15 pm. Pt's employee, Julia, notified, records faxed. RBS

9-18-02 John Stroud

S: Here for check up and refills. Reports he is doing well. Last time he checked glucoses, poss. 2m ago or so it was stable in low 100's fasting and low 160s 2h PP.

O: BP 130/85 P 66 W 170. Hcent neg. for any acute findings. Chest clear. Heart RR, NS. Abd soft, no masses or HSM. Extremities no edema. Gent, no lesions or hernia. Rectal neg. Prostate no lesions palpated.

A: #1 Type II DM.

P: HBA1C done. Refill; Glucophage 1000mg bid #62 R5. FU 6m.

4-1-03 Cy-Lid Drug glucophage 1000 mg #62 1 tab
bid. m.w.s.

5-16-03 John Stroud

S: Here for check up. No complaints. Glucose has been fairly stable in the low 100s fasting.

O: BP 140/84 P 72 W 173. Hcent neg. Neck no nodes. No thyromegaly. No carotid bruits. Chest clear. Heart RR, NS. Abd. soft, no masses or HSM. Extremities no edema. Good pulses in both feet. Gent, no lesions noted. Rectal heme. neg, brown stool. Prostate no lesions. UA; neg.

A: #1 Type II DM. #2 Hearing loss.

P: CBC, HBA1C, Lipid prof, CMP, PSA drawn. Refill; Glucophage 1000mg bid #62 R5. FU 6m.

6-12-03 John F. Stroud

S: C/o last 4d of L foot with some swelling and some soreness but actually is better last 1-2d. Has done a lot of driving and using clutch a lot but does not recall any injury.

O: BP 140/80 P 76 T 96.4 W 173. L foot is with some very mild edema and tenderness over the ant. aspect of the mid foot to over the ant. ankle areas. No redness, no increased warmth. Gait normal with no limp. Leg is nontender and has no edema.

A: #1 Susp. foot/ankle tendonitis, poss. other.

P: Bextra 20mg qd #30. Decrease activities. FU 2w if not responding.

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE-SUITE B2
CHERAW, SC 29520

6-26-03 John F. Stroud

- S: See last note. Still having some mild foot swelling, no pain.
O: BP 134/72 P 76 T 96.4 W 175. L foot with some very mild edema, nontender. Nontender over the ankle. Good pulse in foot. Leg is nontender with no edema. Normal gait.
A: #1 Mild foot edema, poss. related to stress type injury, tendonitis or other.
P: Cont. Bextra 20mg qd. Ortho referral. FU after pri.

6-26-03 Appt. with Dr. DuPuy. 6:30-03 12:15. Noted + Permed RSB

10-26-03 C/P of field drug. Glucophage 1000 q bid #62 NK -
must F/u PSK

12-10-03 John F. Stroud

- S: Here for check up and refills. Doing well except for 1m of R plantar heel pain after walking all day. Glucoses are staying stable.
O: BP 138/76 P 72 W 167. Heart neg. Neck no nodes. No carotid bruits. Chest clear. Heart RR, NS. Abd. soft, no masses or HSM. Extremities no edema. Good pulse both feet. R heel appears normal, no sig. tenderness on palpation. No foot lesions noted.
A: #1 Type II DM. #2 Susp. PF.
P: CMP, HBA1C drawn. Refill; Glucophage 1000mg bid #62 RS. Celebrex 200mg #30 RI. Decrease activities on feet. FU if not responding.

1-12-04 John F. Stroud

- S: Last 1d R LBP with radiation to RLE. Hurts more with certain movements. No numbness. No bladder or bowel problems.
O: BP 140/88 P 74 W 167. Back mildly tender over the R SI area. SLRs with some pain on the R at 45%, more so in the back than in the leg. Nero grossly intact with reflexes present at the knees and ankles. Sensation intact.
A: #1 Back pain, poss. sprain, OA or sciatica.
P: Lodine 400mg #30 RI. Lorocet 10/650mg #20 RI prn. Rest. Discussed further studies, he declined. FU 1w if not improving.

1-15-04 John Stroud

- S: FU. States he is improved but still has some pain in the RLE as well as R buttock area.
O: BP 130/78 P 72 W 171. The back and buttock area are nontender. He has some pain with SLR on the R at about 45 degrees but not much radiation with it. Nero grossly intact with reflexes present at the knees and ankles. Sensation intact.
A: #1 Susp. sciatica poss. or underlying lumbar HNP/OA or other.
P: Cont; Lodine 400mg bid, Lorocet 10/650mg #30 prn. Rest. Refer to Dr. Asher for neurosurg. consult. FU afterwards.

1-28-04 John Stroud

- S: FU re. back pain with radiation. States he is 90% better. Still hurts some in the R buttock with radiation to the lower leg int.
O: BP 140/60 P 72 W 170. Mildly tender over the R SI area. SLRs with pain on the R at about 45 degrees. Nero intact with good reflexes at the knees and ankles. MRI of LS spine showing some disc bulging at L4/5 into the L foramina. Changes of OA at LS/S1, facet hypertrophy with L foramina narrowing.
A: #1 Sciatica, poss. related to underlying lumbar DDD/OA. #2 Type II DM.
P: Cont; Lodine 400mg bid #60. Has appt. with Dr. Asher for neurosurg. consult. FU afterwards prn.

1-28-04 Appt. with Dr. Asher, 2-2-04, 3:15pm. Charlotte office. Bring films. Pt. notified and records faxed. RSB.

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE-SUITE B2
CHERAW, S.C. 29520

4-13-04 John Stroud

- S: Last 1w some mild swelling of L foot with no pain. Occ. after he does a lot of truck driving. This has happened before. Also has recur, R heel pain, only when wearing work boots. States it is better now that he is wearing tennis shoes.
- O: BP 130/74 P 72 W 173. L foot ? of tr. edema compared to the R foot. There is no tenderness. Good pulse in the foot. R foot is normal, non tender over the heel or other areas. Good pulse in R foot. Nero intact.
- A: #1 Int. L foot edema, mild, poss. related to VI or activities. #2 R heel pain, int.
- P: Lodine 400mg bid that he is using pm. Jobst hose. Offered further studies, he declined. FU if any persistence or worsening.

6-28-04 CIP field Glucophage 1000mg #60 / bid NR

7-15-04 John F. Stroud

- S: Called to ER to evaluate pt, after having accident when his tractor flipped over sideways while he was in the cab. There was some brief LOC, then c/o R shoulder blade area pain. Taken to ER by ambulance.
- O: Vital signs stable. He is alert and oriented. Head has a small bruised area over the forehead, L side. Otherwise no skull defects. TMs normal, no blood. External eyes on lesions noted except for mild edema around L orbital area. No facial defects palpated. Pharynx clear. Neck non tender. Chest clear, bilat. with good air exchange. He has tenderness over the R scapula area and upper back area, adj. to scapula. No crepitus palpated. Heart RR, NS. Abd. soft, non tender. Extremities no specific tenderness of the arms or legs. or sign of deformity. Nero grossly intact with ability to move all extremities. CT of the brain, C-spine, chest abd/pelvis showing changes consistent with pulmonary contusions and ? of rib fx.
- A: #1 Pulmonary contusions, bilat. susp. rib fxs. #2 Concussion. #3 Susp. contusions to other areas of the body.
- P: Pt. was transferred by helicopter to Palmetto Baptist in Columbia, in coordination with ER physician.

DATE: 7-29-04

WT 168 HT T 97.4 BP 140/90 P 74 R

7-23-04 John F. Stroud

- S: FU from hosp. at Palmetto Richland for multiple trauma after turning over on a tractor. See note of 7-15-04. I do not have notes from hosp. but pt. reports he had small fx of C-spine that was stable and did not need any treatment or neck collar, R clavicle fx, and 1 R rib fx, as well as pulmonary contusions. Overall doing OK.
- O: Small, tender area over the R temporal area, no skull defects palpated. Neck no specific tenderness. Chest clear. Has tenderness over the R lat. mid rib cage area as well as R mid to distal clavicle with no obvious deformity. Heart RR, NS. Abd. soft, non tender, no masses. Extremities no deformity. Has a healing abrasion on the R ankle.
- A: #1 S/p concussion. #2 Pulmonary contusions, bilat. #3 R wrist fx, #4 R clavicle fx, #5 R ankle abrasion.
- P: Refill; Percocet 5/325mg #30, Glucophage 1000mg #62 R5. Gradual activities. He does not desire any ortho consult. FU 3w.

DATE: 2-3-05 WT 175 HT
T 97.6 BP 120/80 P 76 R

2-3-05 John Stroud

- S: Here for check up and refills. Also 10d cold with sinus cong, drainage, cough, occ. sputum, no fever. Glucoses have been stable in the low 100s fasting usually.
- O: Heent neg. except nasal cong. Neck no lesions. Chest clear. Heart RR, NS. Abd. soft, no masses or HSM. Extremities no edema. Good pulse both feet. Gent. no lesions, no hernia. Rectal heent neg. brown stool, no lesions, prostate no lesions.
- A: #1 R1. #2 Type II DM.
- P: CBC, CMP, Lipid profile, HBA1C. PSA drawn. Quisil #20. Doxycycline 100mg #20. Refill; Glucophage 1000mg bid #62 R5. PU prn or 6m.

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE- SUITE B2
CHERAW, S.C. 29520

A
DATE: 3-11-05 WT 175 HT 5' 8"

T BP 130/80 P 73 R

DOT Exam done. See Form in Chart.
JFM

3-11-05 John F. Stroud

- S: Here for DOT exam. PMH: Type II DM, on Glucophage 1000mg bid, no other meds.
O: Hcent neg. Neck no lesions. Chest clear. Heart RR, NS. Abd. soft, no masses or HSM. Extremities no edema. Good pulse both feet. Gent. no lesions, no hernia palpated. IJA; neg.
A: #1 Type II DM, controlled.
P: Forms completed. Cont. Glucophage 1000mg bid. FU 5m.

DATE: 6-2-06 WT HT

T BP 130/80 P 72 R

6-2-05 John F. Stroud

- S: FU after prolonged hosp. for multiple trauma. See discharge summary from 5-17-05 from Carolina Health Care. Overall doing well. Taking Percocet for pain.
O: Hcent neg. Neck no lesions. Chest clear. Heart RR, NS. Abd. soft, no masses. Extremities mild edema LLE. Has BKA on the R.
A: #1 S/p multiple trauma from plane crash: 1) L3, L4 vertebral body fx. 2) R sacral fx. 3) L urostavulum fx, s/p surg. L hip. 4) R PTX, s/p chest tube. 5) Multiple rib fx. 6) Fluid around pancreas and mesentary. 7) R femur fx. 8) R ankle fx, now s/p R BKA. 9) Subarachnoid/subdural hematoma. 10) Bilal. hypogastric embolization. 11) Complex mid face fx, incl. L isfort III, R isfort II, and mandible fx. 12) L pleural effusion. 13) L temporal lobe infarct. 14) Bilal frontal hydromas and R parietal hydromas. 15) Burns, s/p skin grafting to abd., R thigh. 16) L forearm/wrist fx.
#2 Type II DM. #3 Loss of vision L eye and partial loss of vision R eye.
P: Refill; Percocet 5/325mg #180 taking 1q 4-6h. Other meds are: Senna 2 caps qd, Vit C 500mg qd, Calcium 500mg with vit D bid, Diltiazem 30mg q8h, Clonidine 0.1mg bid, Glucotrol XL 5mg qd. Has FU with multiple physicians. FU here 1m.

DATE: 8-24-05 WT HT

T BP 116/78 P 73 R

8-24-05 John Stroud

- S: FU re. Type II DM and medications. See past notes. Also refill on Percocet. Glucoses have been very stable in low 100s fasting.
O: Hcent neg for acute findings. Chest clear. Heart RR, NS. Abd. soft. Extremities no edema of LLE, BKA on R.
A: #1 Type II DM, stable. #2 Hx of recent tachycardia while hosp. for multiple trauma, stable. #3 HTN, developed in hosp. curr. stable on Clonidine.
P: CBC, CMP, HBA1C drawn. Refill; Glucotrol XL 5mg qd, Diltiazem 30mg q8h, Clonidine 0.1mg bid, all 1m RS. Also pt. would like to use Glucophage 100mg bid to use it up and will hold Glucotrol at that time, then restart when Glucophage is out at his request. Refill; Percocet 10/650mg #120. FU 1-2m. He has other physicians to FU, see prior notes.

9-22-05 written Rx for Percocet 10/650 #120 cur

JOHN F. McLEOD, III, M.D.
110 DOCTORS DRIVE- SUITE B2
CHERAW, S.C. 29520

DATE: 11-2-05 WT 146 HT
BP 110/66 P 70 R

11-2-05 John F. Stroed

- S: Here for checkup. Wife states he has had rash around mouth area for weeks to months. Also has rash in the scalp with flaking. Also FU on HTN, Type II DM. Glucoses have been stable. Requests something to help with insomnia that has been present for weeks to months. Also requests refill of Percocet for LLE pain, s/p hip fx.
- O: Hcent neg. Chest clear. Heart RR. Extremities no edema L leg. Skin he has gen. erythema perioral areas, as well as eyebrows, upper nasal area, consistent with seb derm. Scalp with some minor changes consistent with seb derm with sl. flaking.
- A: #1 Seb derm. #2 Type II DM, stable. #3 HTN. #4 S/p multiple traumas, sec. to plane crash, as listed on 8-2-05. #5 Insomnia.
- P: Refill; Percocet 10/650mg #120. Tridesalon 0.05% 30gm R3. Lidex sol. 0.05% 1 bottle R3 pm scalp rash. Cont: Glucotrol XL 5mg qd, Diltiazem 30mg q8h, Clonidine 0.1mg bid. FU pm or 3m. *Yvonne 2/3/06*

11-10-05 C-field Drug Lunesta 2mg 1 qhs prn
Insomnia #30 Rk one. mwo

11-17-05 C/P field Lodine 400mg 1 bid #60 can out nacy

11-23-05 Infant flu Vacc Im *BR*

12-8-05 ~~C/P~~ written Rx Percocet 10/650 #120 1/2-1946h
pin pain.

DATE: 12-27-05 WT 154 HT

T BP P R

12-27-05 John F. Stroed

- S: C/o some weeks to months hot flash type of sensation that lasts for a brief period of time then resolves. Happens several times a day. Requests testosterone level checked. Otherwise stable. Glucoses have been stable.
- O: Hcent neg. Neck no lesions. Chest clear. Heart RR. Extremities no edema.
- A: #1 Hot flash symptoms, uncertain etiology. #2 Type II DM. #3 HTN. #4 S/p multiple traumas, listed 8-2-05, sec. to plane crash. #5 Chronic insomnia.
- P: CBC, CMP, HBAIC, Testosterone level drawn. Refill; Percocet 10/650mg #120, Glucotrol XL 5mg qd, change Diltiazem 30mg to Diltiazem XR 120mg qd, Clonidine 0.1mg bid, Lunesta 2mg hs, all 1m RS. FU on labs, make plans then.

12-30-05 Pt will start on test enj 200mg q 2-4 wks due to
testosterone level being low. C/P.



LABORATORY CORPORATION OF AMERICA

SPECIMEN 043-277-0576-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				
SS#238683216 MCLBOD III		FASTING: N PHONE: 843-623-6868 DOB: 3/28/1943		
PATIENT NAME STROUD, JOHN F		SEX M	AGE (YR/MOS.) 58 / 10	
PL ADDR: 927 E MAIN STREET CHESTERFIELD SC 29709-0000				
DATE OF SPECIMEN 2/12/2002	TIME 12:06	DATE RECEIVED 2/12/2002	DATE REPORTED 2/13/2002	TIME 9:19 4405
TEST		RESULT		

CLINICAL INFORMATION	
CD-91022619804	
PHYSICIAN ID. JM	PATIENT ID. 10396
ACCOUNT: JOHN F MCLBOD III PO BOX 923 110 DOCTORS DR CHERAW SC 29520-0000	
ACCOUNT NUMBER: 39096303	

COMP. METABOLIC PANEL (14)						
Glucose, Serum	✓148 H	mg/dL	65	-	109	BN
BUN	12	mg/dL	5	-	26	BN
Creatinine, Serum	1.2	mg/dL	.5	-	1.5	BN
BUN/Creatinine Ratio	10					
Sodium, Serum	138	mmol/L	135	-	148	BN
Potassium, Serum	4.4	mmol/L	3.5	-	5.5	BN
Chloride, Serum	103	mmol/L	96	-	109	BN
Carbon Dioxide, Total	25	mmol/L	20	-	32	BN
Calcium, Serum	9.6	mg/dL	8.5	-	10.6	BN
Protein, Total, Serum	6.7	g/dL	6.0	-	8.5	BN
Albumin, Serum	4.1	g/dL	3.5	-	5.5	BN
Globulin, Total	2.6	g/dL	1.5	-	4.5	
A/G Ratio	1.5		1.1	-	2.5	
Bilirubin, Total	.7	mg/dL	.1	-	1.2	BN
Alkaline Phosphatase, Serum	61	IU/L	25	-	150	BN
AST (SGOT)	19	IU/L	0	-	40	BN
ALT (SGPT)	22	IU/L	0	-	40	BN
Hemoglobin A1c						
Hemoglobin A1c	7.1 H	%	4.5	-	5.7	BN

(Factors such as duration of diabetes, adherence to therapy and the age of the patient should also be considered in assessing the degree of blood glucose control)

The following ranges may be used for interpretation of results:
HgbA1c degree of glucose control:
>8% Action suggested*
<7% Goal of Diabetic Therapy**
<6% Normal

*High risk of developing long term complications such as retinopathy, nephropathy, neuropathy, cardiopathy, etc. **Some danger of hypoglycemic reaction in type I diabetics. Some glucose intolerant individuals and "sub-clinical" diabetics may demonstrate HgbA1c levels in this area.

HgbA1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better

Results are Flagged in Accordance with Age Dependent Reference Ranges
Continued on Next Page

Laboratory Corporation of America

SPECIMEN 136-075-0201-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				SSN: 238-58-3216

MCL80D IU		FASTING: Y	
PHONE: 843-623-2591		DOB: 3/28/1943	
PATIENT NAME STROUD, JOHN T.		SEX M	AGE/WEIGHT/MOSS 60/160/1
PT. ADDR: 927 EAST MAIN STREET CHESTERFIELD SC		29709-0000	
DATE OF SPECIMEN 5/16/2003	TIME 9:48	DATE RECEIVED 5/16/2003	DATE REPORTED 5/19/2003
		TIME 8:36	B625

CLINICAL INFORMATION	
CD: 91022005242	
PHYSICIAN ID. JM	PATIENT ID. 10396
ACCOUNT: JOHN F MCLEOD III	
110 DOCTORS DR STE B2 CHERAW SC 29520-0000	
ACCOUNT NUMBER: 39096303	

CBC WITH DIFFERENTIAL/PLATELET

TEST	RESULT	LIMITS	LAB
White Blood Cell (WBC) Count	6.2 X 10 ³ /uL	4.0 - 10.5	BN
Red Blood Cell (RBC) Count	4.93 X 10 ⁶ /uL	4.10 - 5.60	BN
Hemoglobin	15.6 g/dL	12.5 - 17.0	BN
Hematocrit	45.8 %	36.0 - 50.0	BN
MCV	93 fL	80 - 98	BN
MCH	31.7 pg	27.0 - 34.0	BN
MCHC	34.1 g/dL	32.0 - 36.0	BN
RDW	12.5 %	11.7 - 15.0	BN
Platelets	235 X 10 ³ /uL	140 - 415	BN
Polys	56 %	40 - 74	BN
Lymphs	28 %	14 - 46	BN
Monocytes	8 %	4 - 13	BN
Eos	5 %	0 - 7	BN
Basos	1 %	0 - 3	BN
Polys (Absolute)	3.6 X 10 ³ /uL	1.8 - 7.8	BN
Lymphs (Absolute)	1.7 X 10 ³ /uL	0.7 - 4.5	BN
Monocytes (Absolute)	0.5 X 10 ³ /uL	0.1 - 1.0	BN
Eos (Absolute Value)	0.3 X 10 ³ /uL	0.0 - 0.4	BN
Baso (Absolute)	0.1 X 10 ³ /uL	0.0 - 0.2	BN

COMP. METABOLIC PANEL (14)

Glucose, Serum	139 H mg/dL	65 - 100	BN
BUN	16 mg/dL	5 - 26	BN
Creatinine, Serum	1.0 mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	16	12 - 20	

Effective May 19, 2003 the reference intervals will be
changing to:

8 - 27

Sodium, Serum	139 mmol/L	135 - 148	BN
Potassium, Serum	4.5 mmol/L	3.5 - 5.5	BN
Chloride, Serum	103 mmol/L	96 - 109	BN
Carbon Dioxide, Total	28 mmol/L	20 - 32	BN
Calcium, Serum	9.4 mg/dL	8.5 - 10.6	BN
Protein, Total, Serum	7.0 g/dL	6.0 - 8.5	BN
Albumin, Serum	4.3 g/dL	3.6 - 4.8	BN
Globulin, Total	2.7 g/dL	1.5 - 4.5	
A/G Ratio	1.6	1.1 - 2.5	
Bilirubin, Total	0.6 mg/dL	0.1 - 1.2	BN

Results are Flagged in Accordance with Age Dependent Reference Ranges
Continued on Next Page

Laboratory Corporation of America

SPECIMEN 136-075-0261-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #: 2
ADDITIONAL INFORMATION SSN: 238-68-3216				
MCLEOD III		FASTING: Y PHONE: 843-623-2591 DOB: 3/28/1943		
PATIENT NAME STROUD, JOHN F		SEX M	AGE (YR/MOS) 60 / 1	
PT. ADDR: 917 EAST MAIN STREET CHESTERFIELD SC 29709-0000				
DATE OF SPECIMEN 5/16/2003	TIME 9:48	DATE RECEIVED 5/16/2003	DATE REPORTED 5/19/2003	TIME R 36 8625

CLINICAL INFORMATION CD- 91022605242	
PHYSICIAN ID. JM	PATIENT ID. 10396
ACCOUNT: JOHN F MCLEOD III	
110 DOCTORS DR STE B2 CHERAW SC 29520-0000	
ACCOUNT NUMBER: 39096503	

TEST	RESULT	LIMITS	LAB
Alkaline Phosphatase, Serum	45 IU/L	25 - 160	BN
AST (SGOT)	15 IU/L	0 - 40	BN
ALT (SGPT)	18 IU/L	0 - 40	BN
LIPID PANEL			
Cholesterol, Total	154 mg/dL	100 - 199	BN
Triglycerides	138 mg/dL	0 - 149	BN
> HDL Cholesterol	39 L mg/dL	40 - 59	BN
VLDL Cholesterol Calc	27 mg/dL	5 - 40	
LDL Cholesterol Calc	87 mg/dL	0 - 99	
Hemoglobin A1c			
> A1c	6.8H	4.5 - 5.7	BN

Current guidelines recommend a treatment goal of <7% for diabetic patients. A1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glyco-hemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

Prostate-specific Ag, Serum 1.0 ng/mL 0.0 - 4.0 BN

Abbott MEIA methodology.

LAB: BN LABCORP BURLINGTON
1447 YORK COURT, BURLINGTON, NC 27215-2230

DIRECTOR: FRANK HANCOCK MD

Laboratory Corporation of America

SPECIMEN 344-075-0236-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #1
ADDITIONAL INFORMATION SSN: 238-68-3216				
MCLEOD III PHONE: 843-623-2591 DOR: 3/28/1943		FASTING: Y		
PATIENT NAME STROUD, JOHN F		SEX M	AGE (YR./MOS.) 60 / 8	
PT. ADDR: 927 EAST MAIN STREET CHICKSTERFIELD, SC 29709-0000				
DATE OF SPECIMEN 12/10/2003	TIME 13:16	DATE RECEIVED 12/10/2003	DATE REPORTED 12/12/2003	TIME 8:54
1161				
TEST			RESULT	LIMITS
COMP. METABOLIC PANEL (14)				LAB

> Glucose, Serum	130 H	mg/dL	65 - 109	BN

Labcorp will be changing the cut-point to detect Impaired Fasting Glucose from 110 to 100 mg/dL to comply with the November 2003 recommendations from the ADA.

EFFECTIVE JANUARY 26, 2004 the reference intervals will
be changing to: 65 - 99 mg/dL

BUN	20	mg/dL	5 - 26	BN
Creatinine, Serum	0.9	mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	22		8 - 27	
Sodium, Serum	138	mmol/L	135 - 148	BN
Potassium, Serum	4.8	mmol/L	3.5 - 5.5	BN
Chloride, Serum	106	mmol/L	96 - 109	BN
Carbon Dioxide, Total	21	mmol/L	20 - 32	BN
Calcium, Serum	9.4	mg/dL	8.5 - 10.6	BN
Protein, Total, Serum	7.2	g/dL	6.0 - 8.5	BN
Albumin, Serum	4.3	g/dL	3.6 - 4.8	BN
Globulin, Total	2.9	g/dL	1.5 - 4.5	
A/G Ratio	1.5		1.1 - 2.5	
Bilirubin, Total	0.6	mg/dL	0.1 - 1.2	BN
Alkaline Phosphatase, Serum	50	IU/L	25 - 160	BN
AST (SGOT)	13	IU/L	0 - 40	BN
ALT (SGPT)	18	IU/L	0 - 40	BN

Hemoglobin A1c

> A1c	6.4 H	%	4.5 - 5.7	BN

Current guidelines recommend a treatment goal of <7% for diabetic patients. A1c may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

LAB: BN LABCORP BURLINGTON
1447 YORK COURT, BURLINGTON, NC 27215-2230

DIRECTOR: FRANK HANCOCK MD

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report



LabCorp Burlington
1447 York Court, Burlington, NC 27215-2230

Phone: 888-200-5439

SPECIMEN 236-075-0150-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION SSN: 238-68-3216				
MCLEOD III PHONE 843-623-2591		FASTING: N DOB 3/28/1943		
PATIENT NAME STROUD, JOHN F		SEX M	AGE (YR/MOS) 62 / 4	
PT. ADDR.: 927 EAST MAIN STREET CHESTERFIELD		SC	29709-0000	
DATE OF SPECIMEN 8/24/2005	TIME 13:20	DATE RECEIVED 8/24/2005	DATE REPORTED 8/25/2005	TIME 14:37
CLINICAL INFORMATION CD-20075512982				
PHYSICIAN ID. JM		PATIENT ID. 10396		
ACCOUNT: JOHN F MCLEOD III AFTER HOURS #843-537-9934 110 Doctors Dr Ste B2 Chicaw SC 29320-0000				
ACCOUNT NUMBER: 39096303				

TEST	RESULT	LIMITS	LAB
CBC With Differential/Platelet			
White Blood Cell (WBC) Count	5.9 x10E3/uL	4.0 - 10.5	BN
Red Blood Cell (RBC) Count	4.46 x10E6/uL	4.10 - 5.60	BN
Hemoglobin	13.3 g/dL	12.5 - 17.0	BN
Hematocrit	39.6 %	36.0 - 50.0	BN
MCV	89 fL	80 - 98	BN
MCH	29.8 pg	27.0 - 34.0	BN
MCHC	33.6 g/dL	32.0 - 36.0	BN
RDW	14.4 %	11.7 - 15.0	BN
Platelets	320 x10E3/uL	140 - 415	BN
Neutrophils	58 %	40 - 74	BN
Lymphs	33 %	14 - 46	BN
Monocytes	7 %	4 - 13	BN
Eos	2 %	0 - 7	BN
Basos	0 %	0 - 3	BN
Neutrophils (Absolute)	3.4 x10E3/uL	1.8 - 7.8	BN
Lymphs (Absolute)	1.9 x10E3/uL	0.7 - 4.5	BN
Monocytes (Absolute)	0.4 x10E3/uL	0.1 - 1.0	BN
Eos (Absolute)	0.1 x10E3/uL	0.0 - 0.4	BN
Baso (Absolute)	0.0 x10E3/uL	0.0 - 0.2	BN
Comp. Metabolic Panel (14)			
Glucose, Serum	149 H mg/dL	65 - 99	BN
BUN	13 mg/dL	5 - 26	BN
Creatinine, Serum	0.7 mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	19	8 - 27	
Sodium, Serum	137 mmol/L	135 - 148	BN
Potassium, Serum	4.2 mmol/L	3.5 - 5.5	BN
Chloride, Serum	100 mmol/L	96 - 109	BN
Carbon Dioxide, Total	28 mmol/L	20 - 32	BN
Calcium, Serum	9.7 mg/dL	8.5 - 10.6	BN
Protein, Total, Serum	7.0 g/dL	6.0 - 8.5	BN
Albumin, Serum	3.7 g/dL	3.6 - 4.8	BN
Globulin, Total	3.3 g/dL	1.5 - 4.5	
A/G Ratio	1.1	1.1 - 2.5	
Bilirubin, Total	0.2 mg/dL	0.1 - 1.2	BN
Alkaline Phosphatase, Serum	64 IU/L	25 - 160	BN
AST (SGOT)	14 IU/L	0 - 40	BN
ALT (SGPT)	13 IU/L	0 - 55	BN

Please note reference interval change

Hemoglobin Alc

Pat Name: STROUD, JOHN F Pat ID: 10396 Spec # 236-075-0150-0 Seq #: 8936

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page



LabCorp Burlington

1447 York Court, Burlington, NC 27215-2230

Phone: 888-200-6439

SPECIMEN 236-075-0150-0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page #1 2
ADDITIONAL INFORMATION SSN: 238-68-3216				
MCLBOD III FASTING N PHONE 843-623-2591 DOB: 3/28/1943				
PATIENT NAME STROUD, JOHN F		SEX M	AGE(YR/MOS) 62 / 4	
PT. ADDR: 927 EAST MAIN STREET CHESTERFIELD SC 29709-0000				
DATE OF SPECIMEN 8/24/2005	TIME 13:20	DATE RECEIVED 8/24/2005	DATE REPORTED 8/25/2005	TIME 14:27 8936
TEST		RESULT		

CLINICAL INFORMATION CD-20075512982	
PHYSICIAN ID. JM	PATIENT ID. 10396
ACCOUNT: JOHN F MCLBOD III AFTER HOURS #843-537-9934 110 Doctors Dr Ste B2 Chesaw SC 29526-0000	
ACCOUNT NUMBER: 39096503	
LIMITS	LAB

> ☐ Alc 5.9H % 4.5 - 5.7 BN

Current guidelines recommend a treatment goal of <7% for diabetic patients. Alc may be overestimated in diabetic patients exhibiting poor control and who are also heterozygous or homozygous for HgbS or HgbC. Total glycohemoglobin is a better indicator of diabetic control in patients with these hemoglobin variants.

LAB: BN LabCorp Burlington
1447 York Court, Burlington, NC 27215-2230

DIRECTOR: Frank Hancock MD

Pat Name: STROUD, JOHN F

Pat ID: 10396

Spec #: 236-075-0150-0

Seq #: 8936

Results are Flagged in Accordance with Age Dependent Reference Ranges
Last Page of Report



LabCorp Burlington
1447 York Court, Burlington, NC 27215-2230

Phone: 888-200-5439

SPECIMEN 362-277-0014.0	TYPE S	PRIMARY LAB BN	REPORT STATUS COMPLETE	Page # 1
ADDITIONAL INFORMATION BBN: 238-083216				
MCLEOD IU PHONE: 843-623-2591		FASTING: N DOB: 3/28/1943		
PATIENT NAME STROUD, JOHN F		SEX M	AGE(YR/MOS) 62 / 8	
PT. ADDR: 927 EAST BLVD CHESTERFIELD		SC	29709-0000	
DATE OF COLLECTION TIME 12/27/2005 1427	DATE RECEIVED 12/28/2005	DATE REPORTED 12/29/2005	TIME 639	763

CLINICAL INFORMATION CD-20075514130	
PHYSICIAN ID. JM	PATIENT ID. 10396
ACCOUNT: JOHN F MCLEOD III AFTER HOURS #843-537-9934 110 DOCTORS DR STE B2 CHERAW SC 29520-0000	
ACCOUNT NUMBER: 39096303	

TEST	RESULT	LIMITS	LAB
CBC With Differential/Platelet			
White Blood Cell (WBC) Count	7.3 x10E3/uL	4.0 - 10.5	BN
Red Blood Cell (RBC) Count	4.63 x10E6/uL	4.10 - 5.60	BN
Hemoglobin	14.7 g/dL	12.5 - 17.0	BN
Hematocrit	43.4 %	36.0 - 50.0	BN
MCV	94 fL	80 - 98	BN
MCH	31.8 pg	27.0 - 34.0	BN
MCHC	33.9 g/dL	32.0 - 36.0	BN
RDW	12.5 %	11.7 - 15.0	BN
Platelets	261 x10E3/uL	140 - 415	BN
Neutrophils	56 %	40 - 74	BN
Lymphs	36 %	14 - 46	BN
Monocytes	5 %	4 - 13	BN
Eos	3 %	0 - 7	BN
Basos	0 %	0 - 3	BN
Neutrophils (Absolute)	4.1 x10E3/uL	1.8 - 7.8	BN
Lymphs (Absolute)	2.6 x10E3/uL	0.7 - 4.5	BN
Monocytes (Absolute)	0.4 x10E3/uL	0.1 - 1.0	BN
Eos (Absolute)	0.2 x10E3/uL	0.0 - 0.4	BN
Baso (Absolute)	0.0 x10E3/uL	0.0 - 0.2	BN
Comp. Metabolic Panel (14)			
Glucose, Serum	146 H mg/dL	65 - 99	BN
BUN	16 mg/dL	5 - 26	BN
Creatinine, Serum	0.8 mg/dL	0.5 - 1.5	BN
BUN/Creatinine Ratio	20	8 - 27	
Sodium, Serum	139 mmol/L	135 - 148	BN
Potassium, Serum	4.6 mmol/L	3.5 - 5.5	BN
Chloride, Serum	102 mmol/L	96 - 109	BN
Carbon Dioxide, Total	28 mmol/L	20 - 32	BN
Calcium, Serum	9.9 mg/dL	8.5 - 10.6	BN
Protein, Total, Serum	7.5 g/dL	6.0 - 8.5	BN
Albumin, Serum	4.5 g/dL	3.6 - 4.8	BN
Globulin, Total	3.0 g/dL	1.5 - 4.5	
A/G Ratio	1.5	1.1 - 2.5	
Bilirubin, Total	0.4 mg/dL	0.1 - 1.2	BN
Alkaline Phosphatase, Serum	76 IU/L	25 - 160	BN
AST (SGOT)	22 IU/L	0 - 40	BN
ALT (SGPT)	30 IU/L	0 - 55	BN
Testosterone, Serum			
Testosterone, Serum	217 L ng/dL	241 - 827	BN
Pat Name: STROUD, JOHN F			
Pat ID: 10396		Spec N: 362-277-0014.0	
		Seq #: 763	

Results are Flagged in Accordance with Age Dependent Reference Ranges
Continued on Next Page

PALMETTO

EMERGENCY DEPARTMENT RECORD

FIND MEDICAL PARK
COLUMBIA, S.C. 29203

PATIENT	UNIT RECORD	DATE	TIME	BIRTH DATE	AGE	MOTHER'S MARRIAGE	SEX	MR	MR	MR	MR	PATIENT NO.
	012182453	07/15/04	14:51	08/08/80	23Y							
	NAME ADDRESS	MIDDLE NAME, PHONE, EOC, EEC			FINANCIAL DATA			ADMIT BY				
	TRAUMA, M040632 X							RD 07/15/04 14:00				
	COLUMBIA SC 29202				REGULAR PHYSICIAN			REQUESTED PHYSICIAN				
	RESPONSIBLE PARTY	PHO						EMS, EMS				
	TRAUMA, M040632 X	Q						MODE OF ARRIVAL: HELICOPTER				
	COLUMBIA SC 29202							VALUABLES: ☐ YES ☐ NO WHERE?				
								BLOODWORK: ☐ HOME ☐ WITH PATIENT OTHER				
CHIEF COMPLAINT TRAUMA 811 BLUNT												
DATE OF LAST VISIT:												
LAST TENDON:												
TIME TO TREATMENT:												
NURSE'S SIGNATURE:												
TIME OUT:												
ALLERGIES:												
TIME												
LABS AND X-RAY												
C.T. Head												
C-SPIN												
Chest												
Hx/pulv												
Trauma Labs												
CXR												
ROS:												
REST OF ROS:												
PH / MEDS:												
PHYSICAL:												
CLINICAL IMPRESSION:												
TREATMENT:												
See trauma Hx P												
- David Pinner, MD												
DISPOSITIONSPECIAL PATIENT INSTRUCTIONS												
Aot												
EMS												
PRESENT AND REVIEWED WITH RESIDENT												
CONDITION OF DISCHARGE												
ADMIT ROOM												
TIME SEEN BY MD												

2609-600 def

[illegible][illegible]

HOURLY OUTPUT					
TIME	UPPER	NO EMISS	CT	CT	OTHER
0100	1600 1600				

REVISED TRAUMA SCORE			
GLASGOW COMA SCORE	SYNCLIC BP	RESPIRATORY RATE	CODE VALUE
13-15	> 90	10-20	4
9-12	75-90	> 20	3
6-8	50-75	6-9	2
4-5	1-40	1-5	1
3	0	0	0

TOTAL TRAUMA ROOM			
INTAKE		OUTPUT	
CRYSTALLOID		URINE	
COLLOID		NG	
		CHEST	
		EMESIS	
TOTAL ►		TOTAL ►	

[illegible]

TIME	TIME	TIME	X-RAYS	TIME	TIME
☐ C-SPINE	☐ ABDOMEN	☐ UPPER EXTREMITY	☐ SKULL	☐ CT SCAN	
☐ LATERAL	☐ PELVIS	☐ R _____	☐ FACIAL BONES	☐ HEAD	
☐ COMPLETION	☐ T-SPINE	☐ L _____	☐ RVP	☐ NECK	
☐ CHEST	☐ L-SPINE	☐ LOWER EXTREMITY			
☐ CLINIC					

TIME	NURSING OBSERVATIONS
1520	In Room #1 A+ox2, See Assistant Nurse, (K) placed, wear, SPO2
1530	placed as call, Trauma Team assessment of patient (1530) To 15 table
	a C-Spin maintained (1550) back to Rm 252. Unit
	to 90 (1600) should be (1610) ship pain (1615) plat, telkatic-
	device pain (1620) present R for C-collar. Vitals SKK-NSR 102.
	resp. regular, no labored. IV infusing 5% NEUMATE. (1700) pt
	to 90. Machine 25%, IV for pain relief. (1732) back
	to Rm. Rpt stable. NSR 102. (1745) trauma paged - 57 R
	trauma program (1750) trauma services area. Rpt 120
	(1755) trauma services called to see (1800) (1805) pt to
	xy for Flex (1810) view collar removed (1815) pt back to xy collar removed (1820) pt
	xy collar placed pt to well of collar feels much better, denies any need for pain med. (1825) pt
	(1830) Maint thick & web, per order to pain. (1835) depart to make PCU

TRAUMA NURSE SIGNATURE / INITIALS

[Handwritten Signature]
[Handwritten Signature]
[Handwritten Signature]

☐ See continued RN notes		☐ See ED/Resuscitation Page	
DISPOSITION	☐ DISCHARGE TIME:	☐ DIED TIME:	CORONER CALLED TIME:
	☐ ADMISSION TIME:	REPORT: ED NURSE Sush	RECEIVING NURSE Marken
	☐ TO OR TIME:	☐ AMA TIME:	TRANSFER TO: TIME:
ADMITTING BLD.	ROOM NO. 601	TIME LEFT ED	NURSE TRANSPORTING

Q. A. NO.

175

PATIENT COMPLAINT SIGNALS

Type of Incident

CORE DRUGS

SPECIAL PURPOSE / LOCAL OPTION DRUGS

TRAUMA

011 ABRASION/CONTUSION
012 AVULSION
013 LACERATION
014 PUNCTURE/STAB
015 GUNSHOT WOUND
016 BURN
017 HEMORRHAGE
018 ELECTROCUTION
019 CHEST INJURY
020 CRUSHING
021 AMPUTATION
022 DISLOCATION
023 FRACTURE
024 MULTITRAUMA/SHOCK
025 PATIENT TRAPPED
026 EYE INJURY
029 SPRAIN/STRAIN
030 HEAD INJURY
031 PARALYSIS
032 SPINAL INJURY
037 ANIMAL BITE
038 SNAKE BITE

RESPIRATORY

070 APNEA
071 AIRWAY OBSTRUCTION/
CHOKING
072 HYPERVENTILATION
073 PULMONARY EDEMA
074 RESPIRATORY DISTRESS
075 ANAPHYLACTIC TOXIN
SHOCK
076 NEAR DROWNING

OTHER

003 SEIZURE
004 DIABETIC REACTION
005 INSULIN SHOCK
006 POISONING
007 COMMUNICABLE DISEASE
008 UNCONSCIOUS
009 DEAD ON ARRIVAL-NO TRANS.
010 DEAD ON ARRIVAL-TRANS.
050 VOMITING
051 G.I. PROBLEMS
052 G.U. PROBLEMS
090 UNKNOWN COMPLAINT
091 TRANSPORT FOR EXAM
092 NONEMERGENCY TRANSPORT
093 NO TRANSPORT
094 CANCELLED CALL
095 FALSE CALL
102 SEXUAL ASSAULT
103 COLD/FLU
104 HEADACHE
105 WEAKNESS/DIZZINESS
106 PAIN
107 CANCER
108 DIALYSIS
109 MEDICAL DEVICE FAILURE
110 POST OPERATIVE
COMPLICATIONS
111 BED CONFINED
112 ALS MONITORING REQUIRED
113 BLS MONITORING REQUIRED
114 SPECIALTY CARE MONITORING

ENVIRONMENTAL

001 HEAT EXHAUSTION
002 HEAT STROKE
101 COLD EXPOSURE/
HYPOTHERMIA

BEHAVIORAL

040 Hysteria
041 Fainting
043 PSYCHIATRIC/
BEHAVIORAL
044 OVERDOSE
045 IMPAIRMENT SIMILAR TO
ALCOHOL
046 ALTERED MENTAL STATUS

OB/GYN

080 OB PRENATAL
081 OB POSTNATAL
082 OB EMERGENCY
083 OB ABORTION
084 GYN PROBLEM
085 OB DELIVERY

CARDIAC/STROKE

080 CORONARY PROBLEM
081 CONGESTIVE HEART
FAILURE
082 HYPERTENSION ON
083 CARDIAC ARREST
084 CVA/TIA/STROKE
085 HYPOTENSION
086 CHEST PAIN

GLASGOW

EYE OPENING:

SPONTANEOUS
TO VOICE
TO PAIN
NONE

VERBAL:

4 ORIENTED
3 CONFUSED
2 INAPPROPRIATE WORDS
1 INCOMPREHENSIBLE
NONE

MOTOR:

6 OBEYS COMMANDS
5 LOCALIZES PAIN
4 WITHDRAW (Pain)
3 FLEXION (Pain)
2 EXTENSION (Pain)
1 NONE

REVISED TRAUMA SCORE

GLASGOW COMA SCORE

13-15
9-12
6-8
4-5
3

SYSTOLIC BP

>89
76-89
50-75
1-49
0

RESPIRATORY RATE

10-29
>29
6-9
1-5
0

CODE VALUE

4
3
2
1
0

SELECTED ANATOMICAL INJURIES

1. ALL PENETRATING INJURIES TO HEAD, NECK, TORSO AND EXTREMITIES PROXIMAL TO ELBOW AND KNEE.
2. FLAIL CHEST.
3. COMBINATION TRAUMA WITH BURNS.
4. TWO OR MORE PROXIMAL LONG-BONE FRACTURES.
5. PELVIC FRACTURES.
6. LIMB PARALYSIS.
7. AMPUTATION PROXIMAL TO WRIST AND ANKLE

VITAL SIGNS

PUPILS

E = EQUAL
U = UNEQUAL
N = NO RESP.
C = CONSTR.
D = DILATED

LEVEL OF CONSCIOUSNESS

A = ALERT
V = VERBAL ST.
P = PAINFUL ST.
U = UNRESP.

LIST OF CODE NUMBERS OF S.C. COUNTIES

01 Abbeville	24 Greenwood
02 Aiken	25 Hampton
03 Allendale	26 Horry
04 Anderson	27 Jasper
05 Bamberg	28 Kershaw
06 Barnwell	29 Lancaster
07 Beaufort	30 Laurens
08 Berkeley	31 Lee
09 Calhoun	32 Lexington
10 Charleston	33 McCormick
11 Cherokee	34 Marion
12 Chester	35 Marlboro
13 Chesterfield	36 Newberry
14 Clarendon	37 Oconee
15 Colleton	38 Orangeburg
16 Darlington	39 Pickens
17 Dillon	40 Richland
18 Dorchester	41 Saluda
19 Edgefield	42 Spartanburg
20 Fairfield	43 Sumter
21 Florence	44 Union

Pel. Continue Maternal Medical

- ☐ Diabetes mellitus, poorly controlled
- ☐ Drug Overdose
- ☐ Infection that may cause premature birth:
 - ☐ Hepatitis
 - ☐ Influenza
 - ☐ Other: _____
- ☐ Pneumonia
- ☐ Pyelonephritis

Maternal: Surgical

- ☐ Acute abdominal injury, gestation less than 34 weeks, fetus less than 2000 gms
- ☐ Thoracic emergency, intensive care or surgery required.
- ☐ Trauma:
 - ☐ May cause premature onset of labor
 - ☐ Personnel/equipment not available locally

Neonatal Clinical Criteria

- ☐ Congenital malformation(s) requiring surgery or observation
- ☐ Gestation less than 34 weeks or weight less than 2000 gms
- ☐ Hemolytic disease
- ☐ Hypoglycemia
- ☐ Mother is: ☐ Diabetic ☐ Taking dangerous drugs
- ☐ Neonatal blood loss
- ☐ Neonatal cardiac disorder with persisting cyanosis
- ☐ Progressive respiratory distress syndrome
- ☐ Respiratory distress or metabolic acidosis persisting 2 hours after birth
- ☐ Seizures
- ☐ Sepsis, infection or meningitis
- ☐ Shock or asphyxia persisting beyond 2 hours
- ☐ Ventilatory support required more than 1 hour
- ☐ Other condition requiring more than routine care: _____

Pediatric Clinical Criteria

- ☐ Cardiopulmonary arrest and cardiopulmonary cerebral resuscitation
- ☐ Cardiovascular System: ☐ CHF
 - ☐ Shock
 - ☐ Other: _____
- ☐ Central Nervous System
 - ☐ Increased Intracranial Pressure
 - ☐ Meningitis
 - ☐ Status Epilepticus
 - ☐ Reyes Syndrome
 - ☐ Unconsciousness
- ☐ Hematologic Condition ☐ D/C
- ☐ Other: _____

Comments: _____

In my opinion, air transport is required for this patient for the reasons indicated above.

Date

Physician Signature

Print Full Name

- ☐ Metabolic and Electrolyte Imbalances:
 - ☐ Dehydration
 - ☐ Glucose, Ca++, K+, Na++, Mg++ derangement
- ☐ Multi-System Complication:
 - ☐ Acute poisoning
 - ☐ Asphyxia
- ☐ Pediatric team and/or specialized equipment required
- ☐ Respiratory failure or other respiratory condition:
 - ☐ Alveolar/Interstitial Disease
 - ☐ Lower Airway Obstruction
 - ☐ Upper Airway Obstruction
- ☐ Trauma, less than 14 years old (see trauma checklist)
- ☐ Condition complicated by congenital anomalies and/or chronic illness
- ☐ Other: _____

Trauma Clinical Criteria

- ☐ Age less than 14 or greater than 55 years
- ☐ Amputation or near amputation; requires rapid transport for replantation
- ☐ Blunt thoracic or abdominal injury with respiratory compromise or hemodynamic instability
- ☐ Burns:
 - ☐ More than 25% of body surface area
 - ☐ Major burns of face, hands, feet, or perineum
- ☐ Fall from height greater than 20 feet
- ☐ M.V.A.:
 - ☐ Associated fatalities
 - ☐ Patient ejected from vehicle
 - ☐ Extrication time greater than 15 minutes
 - ☐ Speed greater than 55 m.p.h.
 - ☐ Structural intrusion into victim's space
- ☐ Multiple orthopedic injuries
- ☐ Orofacial trauma requiring placement of airway
- ☐ Paralysis of extremities
- ☐ Pedestrian, struck by vehicle and thrown more than 15 feet
- ☐ Penetration injury, any part of body between mid-thigh and head
- ☐ Scalping or "degloving" injury
- ☐ Spinal immobilization and rapid, smooth transport necessary due to worsening motor sensory status
- ☒ Time by land to Trauma Center greater than 15 minutes
- ☐ Champion Trauma Score of 12 or less
- ☐ Glasgow Coma Score of 10 or less
- ☐ Other Serious Risk factor(s): _____
- ☐ Other: _____

ment Id L

CAREFORCE

Medical Necessity Form

Date: 2/15/24 Patient Name: Steven A. John Flight # 5513

From: Chesterfield General To: Richard Memorial

Requested by (name): Dr. Simpson DHEC # 450233 Initials FN/FM: JS/66

Complete For All Patients

General Criteria for Air Transport:

- ☒ Required therapeutic regimen must be initiated within limited time frame.
- ☒ Safe and legal transfer requires nurse and/or paramedic, at minimum.
- ☐ Land transport would be hazardous and delayed due to road and/or traffic conditions.
- ☐ Critical care/ALS environment required during transfer.
- ☒ Time of transfer between critical care units must be minimized.
- ☐ Complicated medical history requires transfer to patient's primary physician.
- ☒ Equipment and/or personnel to care for injury/illness not available.
- ☒ Patient required specialized interventions/tests not available at referring facility.
- ☐ Disaster/Triage decision.
- ☐ No other mode of transportation available.
- ☐ Other: _____

Adult Medical Criteria

- ☐ Acute poisoning: ☐ Carbon Monoxide
☐ Other: _____
- ☐ Cardiopulmonary arrest and cardiopulmonary cerebral resuscitation
- ☐ Cardiac Failure
 - ☐ Acute MI
 - ☐ Anticoagulation/TPA
 - ☐ Balloon pump
 - ☐ Dysrhythmias not responsive to standard therapies
 - ☐ Open heart surgery/PTCA
 - ☐ Unstable angina
- ☐ Central Nervous System illness, requires intracranial pressure monitor
- ☐ Hematologic Condition: ☐ DIC
☐ Other: _____
- ☐ Infectious Disease: _____
- ☐ Metabolic or Fluid and Electrolyte Imbalance:
 - ☐ Diabetic Ketoacidosis
 - ☐ Refractory Acidosis
 - ☐ Renal failure
- ☐ Multi-System failure:
 - ☐ Near Drowning
 - ☐ Septic Shock
- ☐ Respiratory failure, Pulmonary complications:
 - ☐ ARDS
 - ☐ Edema
 - ☐ COPD
 - ☐ Pulmonary emboli
- ☐ Other: _____

Adult Surgical Criteria

- ☐ Neurosurgical: space-occupying lesion
 - ☐ Diffuse cerebral edema
 - ☐ Surgery urgently required
- ☐ Replantation/Microsurgery
- ☐ Thoracic/abdominal aneurysm requiring repair
- ☐ Transplantation
- ☐ Other: _____

Perinatal Criteria

Maternal: Obstetrical

- ☐ Condition resulting in probable birthweight less than 2000 gm or gestation less than 34 weeks
 - ☐ Intrauterine growth retardation
 - ☐ Multiple gestation
 - ☐ Premature dilation of cervix
 - ☐ Rh iso-immunization
 - ☐ Severe pre-eclampsia
 - ☐ Other hypertensive complication
 - ☐ 3rd trimester bleeding
 - ☐ Other: _____
- ☐ Premature labor (expected birthweight less than 2000 gm or gestation less than 34 weeks)
- ☐ Premature rupture of membranes (as above)

(next page for Maternal Medical, Surgical, Neonatal Patient Trauma and Signature)



SSN 288-68-3216

179

PALMETTO RICHLAND MEMORIAL HOSPITAL

Trauma History & Physical Page 1 of 4

Date: 7-15-04
Time: 1503
Trauma M F#: _____
Name: Shoud, John

- ☐ Trauma Alert (911)
☐ Pediatric Trauma Alert (711)
☒ Trauma Notification (811)
☐ Pediatric Trauma Notification (611)
☐ Consult
☒ Transfer: Referring MD/Hospital
Chelton Gold
☐ Other: _____

TRAUMA, M040612
0419700929
MR 012182453 MORRISON, JAMES E
03/28/43 61Y M
ADDRJ _____

Team

Attending: Morrison
Fellow: _____
Senior Resident: Newcomb

Consultants

- ☐ Neurosurgery
☐ Orthopaedics
☐ Plastics
☐ Facial Trauma
☐ Pediatric Surgery
☐ Other: _____

I. PRE-HOSPITAL (MECHANISM OF INJURY, RESTRAINTS, AIRBAG, HELMET, MODE OF TRANSPORTATION, RTS, GCS, VITAL SIGNS, TREATMENT)

Backhoe Roll over, FLCL, @ Sholder pain

II. CONDITION ON ARRIVAL (VITAL SIGNS, RTS, GCS)

156/110, 100, 20, GCS-15

III. COMORBID FACTORS

ALLERGIES: ☐ NKDA PCN
MEDICATIONS: ☐ NONE 2 diabetes med.
PAST MEDICAL / SURGICAL HISTORY: Diabetes
Stomach ulcer
lost front - 127:30
@ smoker
occ elon
@ drugs

IV. PRIMARY SURVEY

- A. AIRWAY: (C-SPINE PROTECTION)
fulling @ Shoud
B. BREATHING: (BREATH SOUNDS/RESPIRATORY EFFORT)
clear - B, non-leak
C. CIRCULATION: (DISTAL PULSES, HEMORRHAGE CONTROL)
pulse x4 @ uncontrolled bleed
D. DISABILITY: (GCS, PUPIL RESPONSE, MOVEMENT OF EXTREMITY)
GCS-15, m.a.e
E. EXPOSE: (ENVIRONMENTAL CONTROL)
@ Gross Abdominal injury, @ extensive bleed

V. RESUSCITATION PHASE

- A. O₂ / PULSE OXIMETRY/INTUBATION:
B. IV ACCESS / FLUIDS
☒ PERIPHERAL ☐ SUBCLAVIAN ☐ FEMORAL ☐ IJ
☒ CRYSTALLOID (TYPE & VOLUME) _____ ☐ PACKED CELLS: TYPE SPECIFIC ☐ (VOLUME) _____
☐ FFP (VOLUME) _____ ☐ PLATELETS (VOLUME) _____
UNIVERSAL ☐ (VOLUME) _____

7-15-04 1510

7-15-04

A

Trauma History & Physical
Page 2 of 4

TRAUMA MD40632
0418700920
MR 012182453 MORRISON, JAMES E
03/28/43 61Y M
ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 03/28/00 BY 60322 UCBAW

TRAUMA M F #:

C. CARDIAC MONITOR/EKG:

S-tach - ~~0~~ euforic

D. GASTRIC DECOMPRESSION

☐ NG ☐ OG

N/A

E. RECTAL / URINARY MEATUS:

+ trace, N/A, post-void, ~~0~~ blood

F. CHEST TUBE:

N/A

G. FOLEY

~~0~~ blood

H. PATIENT'S RESPONSE TO RESUSCITATION:

remains ~~5~~ hypotensive or tachycardic

VI. SECONDARY SURVEY

A. HEENT: NC/AT ~~2~~ (R) temporal hematoma (in hair); PERL 4cm x 2cm; TMs
partly obscured by cerumen, but no blood in canals; nasals patent; OP clear

B. MAXILLOFACIAL: midface, maxillae, nasal bridge, orbits, mandible ~~5~~ tenderness
and all stable; ~~0~~ malocclusion

C. NECK: supple; ~~0~~ SQ emphysema; trachea midline; ~~0~~ JVD; ~~0~~ post
cervical tenderness

D. CHEST / LUNGS: tender over (R) clavicle; ~~4~~ tenderness over upper (R)
chest; CTA (R)

E. CARDIOVASCULAR: NSE/ST; S₁ & S₂; 2+/- radial, femoral
& OP pulses ~~0~~ bleeding identified

F. ABDOMEN: soft, NT; bowel sounds present; ~~0~~ bruising

G. BACK: TTP over (R) scapula; ~~0~~ spinous step-off; ~~0~~ other
tenderness

H. EXTREMITIES: (R) shoulder tender; ~~0~~ other areas of extremity pain; full
ROM in all other joints (R) proximal thigh pain

I. NEUROLOGIC: intact; GCS still 15; reflexes all active

J. SKIN: warm/dry; no other abrasions seen

Trauma History & Physical
Page 3 of 4

TRAUMA, MO40632
0418700929
MR012182453 MORRISON, JAMES E
03/28/43 61Y M
I 100 100 100 100 100 100 100 100 100 100

TRAUMA M F #: _____

K. GU: female; fly in place on arrival, & blood @
neatness

VII. SECONDARY DATA (RECORD RESULTS)

A. X-RAYS:

E. CAT SCAN

1. SPINE

HEAD:

A. CERVICAL:

2. ABDOMEN / PELVIS:

R. DORSAL:

3. SPINE:

C. LUMBAR:

① CERVICAL: ② clande fr

B. DORSAL:

4. CHEST:

C. LUMBAR:

5. PELVIS:

4. CHEST:

8. RADIOLOGY (OTHER):

5. ULTRASOUND:

☒ NO FLUID ☐ FLUID

7. EXTREMITIES:

A. UPPER EXTREMITY:

☐ PERICARDIUM

☐ MORRISON'S POUCH

B. LOWER EXTREMITY:

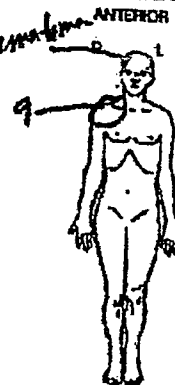
☐ **SPLENORENAL RECESS**

PELVIS

C. LABORATORY DATA:

VIII. PROBLEM LIST AND MANAGEMENT PLAN

- ① ④ LOC → head CT
- ② ⑤ shoulder pain, clavicle pain → imaging; assess consent ortho
- ③ mechanism of injury → CT C-spine & C-APP
- ④ DM → skull fracture p CTs; coronal SS1
- ⑤ ⑥ hip pain → XR of hip, femur
- ⑥ pelvic contusion, 3rd rib fx by CXR → CT

INJURIES:

LEGEND

1. ABRASION
2. AMPUTATION
3. BLEEDING
4. BURN
5. FRACTURE
6. GUNSHOT
7. INTERNAL INJURY
8. LACERATION
9. PAIN
10. PARALYSIS
11. PENETRATING WOUND
12. SPRAIN
- 13.

Trauma History & Physical
Page 4 of 4

TRAUMA, NO 49632
0419700929
MR 012182453 MORRISON, JAMES E
03/28/43 61Y M

TRAUMA M F #: _____

VII. Attending Physician Statement

I was present during this Evaluation and directed the decision making: ☒ Y ☐ N

Review of above Resident note: Crush Critical Care Time: In _____ Out _____

History: ± lo-to wt, back-lve pulled over. Blue
initiated level 2 outside ED, transfer report
2" palm cont. black VSS. alert
cc shoulder pain

Past Medical History: DM

Review of Systems: Orthopedic WBS DM

Allergies: PCN

DM Insulin penicillin Quinine cl 04

Social History: 0 by on work

Family History: normal

Examination: HEAD AT 7+ hyperextension neck - sup
PRN neck 1st
UPD low end M
WALK NO Brn W/acc & ink
HEAR - M (L) 15
CRACK NT

Laboratory Values/Diagnostic Studies:

CXR @ PM
@ thoracic rib crack

Plan of Care reviewed with the resident. Confirm or revise the resident's diagnosis/plan of care.

- 1) CMI 2 LAC 7 VCT Med
- 2) PRN 2-3-4 7 opni prn, ✓ X-rays
- 3) PRN 101 ✓ VCT Med ✓ H33
- 4) PRN 101 ✓ VCT
- 5) PRN 101 ✓ VCT
- 6) PRN 101 ✓ VCT

Discharge Admit to: Trauma Ortho Neuro Other

Disposition: PRN OR ICU PICU Floor Death HOME TRANSFER TO:

Addins	Bell	Brown	Bynoe	Glasser	Kerwin	Krantz	Manktelow	Nottingham	Reddy
252-1009	954-1590	954-1733	954-1541	252-1009	698-7157	954-7171	252-1009	698-7158	252-1009

15/15

PALMETTO HEALTH RICHLAND

5 Richland Medical Park Drive

Columbia, SC 29203

(803)434-7000

CONSULTATION REPORT

PATIENT: Trauma, M040632

MR #: 01-21-82-45-3

ADMITTED: 07/15/2004

DICT: Russell D. McMurry, ACNP

DOB: 03/28/1943

PT.LOC: PCU053401

DATE OF CONSULTATION: 07/15/2004

REQUESTING PHYSICIAN: James E. Morrison, MD

REASON FOR CONSULTATION: C7 transverse process fracture.

CHIEF COMPLAINT: Right posterior shoulder and scapular pain.

HISTORY OF PRESENT ILLNESS: This trauma male is a 61-year-old white male who is status post rollover of slow-moving (practically stationary) heavy machinery - said to be a backhoe-type machine. He admitted to loss of consciousness. He said that he was somewhat confused as to where he was when he awakened but then he was completely oriented. GCS score was 15 in the emergency department here at Richland Memorial Hospital. He is moving all extremities well and normal sensate. Neurosurgery has been asked to consult regarding a finding on CT scan of the cervical spine of a right C7 transverse process fracture.

PAST MEDICAL HISTORY: Significant for non-insulin-dependent diabetes mellitus.

REVIEW OF SYSTEMS: Complaints of right shoulder and scapular pain. Denies any chest pain, shortness of breath. Review of systems otherwise negative.

FAMILY HISTORY: Not applicable.

SOCIAL HISTORY: Negative for tobacco or ETOH abuse. He is married, lives in Cheraw.

ALLERGIES: PENICILLIN.

PHYSICAL EXAMINATION:

GENERAL: This is a white male who appears to be stated age and lying on an emergency room stretcher in no acute distress. He is well-developed, well-nourished appearing.

HEENT: Normocephalic, atraumatic. His has conjugate eye movements. He has no otonehea or rhinorrhea observed.

NECK: Cervical collar is in place. He has mild tenderness at the far distal aspect of the cervical spine in conjunction with his thoracic spine - it is also sore around his scapular bone.

CHEST: Clear to auscultation bilaterally.

HEART: Sinus rhythm per monitor. He has no abnormal heart tones.

PATIENT: Trauma, M040632

MR #: 01-21-82-45-3

Patient Type: IPR

CONSULTATION REPORT

Page 1 of 2

PALMETTO HEALTH RICHLAND
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

ABDOMEN: Non-acute.

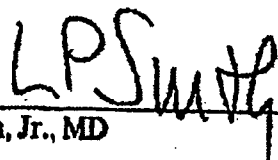
EXTREMITIES: No clubbing, cyanosis, or edema.

NEUROLOGIC: He is awake and alert, oriented x 3. He is conversant. He answers questions appropriately. His motor strength reveals that he is 5/5 all motor areas, slight weakness of 4/5 on the right deltoid area secondary to shoulder pain. Sensory exam is normal. Position sense normal.

LABORATORY DATA: CT scan of the head is negative. CT scan of the cervical spine shows a right C7 transverse process fracture. CT scan of the chest, abdomen, and pelvis shows a right first rib fracture with lucent lesions - nonspecific neoplasm not excluded. Bilateral renal cysts. No pneumothorax. No mediastinal hematoma. He had a right pleural effusion. PT 13.9, INR 1.1, PTT 28.4. White blood cells 15.4, hematocrit 44.3. Sodium 142, blood sugar 156. ETOH less than 10.

IMPRESSION: Distal right C7 transverse process fracture.

RECOMMENDATIONS: Discussed with Dr. Smith. This should be a stable fracture. We will get flexion and extension films of the cervical spine.



Lenwood P. Smith, Jr., MD

Dictated by: Russell D. McMurry, ACNP

RM:hs

D: 07/15/2004 7:33 P T: 07/16/2004 4:06 P

Job #: 000574698 T Job #: 219372 Doc #: 563629

cc: Physician EMS, MD

Russell D. McMurry, ACNP

James E Morrison, MD

Lenwood P Smith, Jr, MD

PATIENT: Trauma, M040632
MR #: 01-21-82-45-3
Patient Type: IPR

CONSULTATION REPORT
Page 2 of 2

PALMETTO HEALTH

Palmetto Health Richland
5 Richland Medical Park
Columbia, SC 29203

Patient Name: TRAUMA, M040632
Patient Address: 927 EAST BOULEVARD
CHESTERFIELD, SOUTH CAROLINA 29709
Patient Telephone: (843) 623-2591

Morrison MD, James E
2 RICHLAND MEDICAL PARK
SUITE 300
COLUMBIA, SC 29203

Date of Birth: 3/28/1943, Age: 61 Years
SSN: 238-68-3216
Medical Record Number: 012182453
Account Number: 0419700929
Location: R PCU, Patient Type: IPR-Inpatient
Room Number: 0534
Ordering Physician: Morrison MD, James E
CC:

RADIOLOGY SERVICES

Exam:
CT Head Without Contrast

Exam Date/Time:
7/15/2004 3:55:28 PM

Accession Number:
CT-04-053286

Ordering Physician:
Morrison MD, James E

Reason for Exam:
959.9-INJURY-SITE NOS

Findings:

CT HEAD SCAN WITHOUT CONTRAST:

CLINICAL INFORMATION: BLUNT TRAUMA TO THE HEAD.

Unenhanced CT head scan was performed and images reviewed in bone and brain windows.

On the bone windows, the paranasal sinuses and mastoids are clear and there are no calvarial lesions or skull fractures.

On the brain windows, the CSF spaces are normal with no midline shift or mass effect and no abnormal densities.

IMPRESSION:

Patient Name: TRAUMA, M040632
Medical Record Number: 012182453

Ordering Physician: Morrison MD, James E

R A D I O L O G Y S E R V I C E S

Exam:
CT Head Without Contrast

Exam Date/Time:
7/15/2004 3:55:28 PM

Accession Number:
CT-04-053286

Ordering Physician:
Morrison MD, James E

NORMAL UNENHANCED CT HEAD SCAN.

*** Final ***

Read by: Richmond MD, G Eddie
Released By: G E. Richmond
on: 07/16/2004 11:12

Transcriptionist: EMI
Trans Date/Time: 07/16/2004 09:06
Technologist: Brown, Steven

PALMETTO HEALTH RICHLAND
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

DISCHARGE SUMMARY

PATIENT:	Stroud, John	DICT:	Christopher Hydorn
MR #:	01-21-82-45-3		
ADMITTED:	07/15/2004	DOB:	03/28/1943
DISCHARGED:	07/19/2004	PT.LOC:	

DISCHARGE DIAGNOSES:

1. Status post 811 trauma.
2. Concussion.
3. Right clavicle fracture.
4. Right third rib fracture.
5. Right C7 transverse process fracture.
6. Pulmonary contusion.
7. Diabetes mellitus.

CONSULTATIONS: Neurosurgery with Dr. Smith and PT and OT.

HISTORY OF PRESENT ILLNESS: This is a 61-year-old gentleman who was involved in a backhoe rollover with positive loss of consciousness at the scene and right shoulder pain. His condition on arrival was blood pressure 156/110, pulse 100, GCS of 15.

PAST MEDICAL HISTORY: He is a diabetic with also a surgical history of previous skin grafts.

MEDICATIONS: Include diabetic medications which he was unable to recall.

ALLERGIES: PENICILLIN.

SOCIAL HISTORY: He denied smoking, occasional alcohol, no drugs.

PHYSICAL EXAMINATION: Patient was evaluated in the trauma bay using ATLS guidelines.

AIRWAY: He was talking with no stridor.

BREATHING: He was clear to auscultation bilaterally with equal chest wall movement.

CIRCULATION: He had pulses x4, no uncontrolled hemorrhage.

() He was GCS of 15. Pupils were equal and reactive to light and he was moving all extremities.

EXPOSURE: He was exposed with no obvious exsanguinating hemorrhage and covered with warm blankets.

HEENT: Normocephalic. He also had a right temporal hematoma, about 1 cm in size. Pupils equal, round and reactive to light and accommodation. They were approximately 4 cm. His tympanic membranes were partly

PATIENT: Stroud, John

MR #: 01-21-82-45-3

Patient Type: IPR

DISCHARGE SUMMARY

Page 1 of 3

PALMETTO HEALTH RICHLAND
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

obscured by cerumen but no blood in the canals. His nares were patent. His oropharynx was clear.

Maxillofacial/Midface: He was stable, no tenderness.

NECK: Supple, no subcutaneous emphysema. His trachea was midline. No JVD. No posterior cervical tenderness.

CHEST: His lungs were clear to auscultation bilaterally. He had tenderness over his right clavicle with some tenderness over the upper right chest.

CARDIOVASCULAR: Regular rate and rhythm, no murmurs, rubs or gallops. He had pulses x4. No acute bleeding.

ABDOMEN: Soft, nontender. Positive bowel sounds.

BACK: He had tenderness to palpation over the right scapula. No tenderness over the midline. He had no spinous stepoffs.

EXTREMITIES: He had right shoulder tenderness. He had full range of motion of all joints and his right proximal thigh tender.

NEUROLOGICAL: He was motor and sensory intact, GCS of 15, () throughout and he was able to move all extremities.

SKIN: Warm, dry and no other abrasions were seen.

GU: He was a normal male. He had a Foley in place arrival and no blood at the meatus. Urine was clear.

RECTAL: Positive tone, normal prostate with no blood.

LABORATORY DATA: In the trauma bay he had an x-ray of the chest as well as hip and femur which were all negative. He had a CT of the head which was negative. He had a CT of the abdomen and pelvis which was read as negative. He had a CT of the chest which was negative. He had a CT of the cervical spine which showed a right clavicle fracture. He had a FAST scan which showed no fluid.

This patient was resuscitated in trauma bay with crystalloid, peripheral IVs, and he responded well to resuscitation with no hypotension or tachycardia.

HOSPITAL COURSE: The patient was admitted to the PCU on July 15, 2004. He was evaluated secondary to his pulmonary contusions. He was then, while on the PCU, evaluated by Dr. Smith in Neurosurgery to evaluate his cervical spine fracture. Dr. Smith, Neurosurgery, found that there was no operative intervention needed at this time, that it was conservative treatment only. He was followed by physical therapy. His pain was well-controlled. He was moved to the trauma floor on July 16, 2004, where his pain was controlled. He was converted to oral medications and physical therapy was able to improve his ADL status and he was able to be discharged on July 19, 2004.

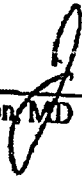
DISCHARGE INSTRUCTIONS: The patient was given followup with his primary care doctor, Dr. McCloud, with the phone number 834-537-9932, where he has an appointment for a walk-in on Friday. He was also given the number for the Trauma Clinic where he could followup as needed if he had any concerns. Activities were as tolerated. His diet was as tolerated. He was not to return to work or school until cleared by his followup appointment. He was given a prescription for Percocet 5/325, 1 to 2 tablets q.6h, p.r.n. pain, as well as Colace 100 mg b.i.d.

PATIENT: Stroud, John
MR #: 01-21-82-45-3

DISCHARGE SUMMARY
Page 2 of 3

PALMETTO HEALTH RICHLAND
5 Richland Medical Park Drive
Columbia, SC 29203
(803)434-7000

Patient was told to call the trauma resident on call at 434-6000 if he had any increased pain, increased bleeding, increased shortness of breath, or temperature over 101.


James E. Morrison, MD

Dictated by: Christopher Hydorn

CH:hs

D: 07/19/2004 12:55 P T: 07/20/2004 4:56 P

Job #: 000577157 T Job #: 287209 Doc #: 569115

cc: Christopher Hydorn
James E Morrison, MD

cc: Dr. McCloud Phone 834-537-9932

PATIENT: Stroud, John
MR #: 01-21-82-45-3

DISCHARGE SUMMARY
Page 3 of 3

Richland
5 MEDICAL PARK PRMH Columbia, SC 29202

Page: 1

Date: 07/23/04
Name: STROUD, JOHN
Sex: M
Birth Date: 03/28/43
Age: 61Y

Acct. #: 0419700929
Adm Date: 07/15/04

Financial Class: 72 - BLUE CROSS PPC
Disch Date: 07/19/04
LOS: 4

Attending Physician:
MORRISON, JAMES E
Coder: VJM

Discharge Status:
01 - 01-DIS HOME OR SELF CARE

NDC: 04 DISEASES/DISORDERS OF THE RESPIRATORY SYSTEM
DRG: 101 OTHER RESP DX, W CC MED

OUTLIER STATUS: N/A

DIAGNOSIS	DESCRIPTION	DIAGNOSIS	DESCRIPTION
1. (P) 807.01	FRACTURE ONE RIB-CLOSED	9.	593.2 CYST OF KIDNEY, ACQUIRED
2. C 805.07	FX C7 VERTEBRA-CLOSED		
3.	850.5 CONCUSSION W COMA NOS		
4.	860.0 TRAUM PNEUMOTHORAX-CLOSE		
5.	250.00 DMII WO CMP NT ST UNCNR		
6.	861.21 LUNG CONTUSION-CLOSED		
7.	E846 INDUS VEH ACC ON PREMISE		
8.	E849.8 ACCIDENT IN PLACE NEC		

PROCEDURE	DESCRIPTION	DATE	SURGEON NAME

STROUD, JOHN
012182453
07/23/04
01303431

ATTESTATION FORM

1

OrthoCarolina

1001 Blythe Blvd., Suite 200
Charlotte, NC 28203

432106

STROUD, JOHN F

971 NC ZOAR ROAD

CHERAW, SC 29520-0000

Home #: 843-263-2591

Work #:

DOB: 03/28/1943

Physician: Patrick Connor, M.D.

04/10/2005 Consultation

CMC

62 year old gentleman who was involved in a small airplane accident and was admitted to the trauma team. He is in quite critical condition and we have not been provided any clearance to manage his orthopaedic injuries which include closed right femur fracture, left acetabular fracture and an open left grade IV talus fracture dislocation. He was taken to the Emergency Room but again we weren't given clearance for management.

His extremity fractures he has a splint on the right side, a skeletal traction pin is placed on the right femur while he is in the trauma unit and no management for the left acetabular fracture at this time. He is monitored overnight and will be transferred to Dr. Kellam, I believe, and the CMC orthopaedic Trauma Service the next day. Patrick M. Connor, M.D./rss

c: coding

**CAROLINAS HEALTHCARE SYSTEM
HISTORY AND PHYSICAL**

PATIENT: Stroud, John

HISTORY NO: 000-485-90-16

DOB:

ATT. MD: TRAUMA SERVICES CMC, NONE

ADMIT DATE: 04/10/2005

ACC. NO:

LOCATION:

Stroud, John

000-485-90-16

The patient came in as an Adult Trauma Code 2, flown in by helicopter on 04/10/05.

HISTORY OF EVENT: This is a 62-year-old white male who crashed his ultralight airplane and sustained serious facial fractures as well as obvious right lower extremity injuries.

PAST MEDICAL HISTORY: Significantly only for diabetes which he reports he is on a medication pill which he is unsure of the name.

PAST SURGICAL HISTORY: Normal.

ALLERGIES: He reports being allergic to penicillin and codeine.

FAMILY HISTORY: Normal.

SOCIAL HISTORY: Negative for ETOH, smoking and drugs.

REVIEW OF SYSTEMS: The patient complains predominantly of pain in his right leg and denies any other major pain.

PRIMARY SURVEY:

The airway is obstructed due to the severe amount of edema in his face. There is no intervention. Cervical spine immobilization with a hard collar, back board and head roll. Breathing is spontaneous and mildly labored. There is a mask with 100% O₂ over his face.

Circulation: Skin is dry and warm, normal in color. External hemorrhage is seen in his face.

Disability: Patient is responsive to voice with a Glasgow Coma Scale score of 14. Right pupil is 4 mm and reactive; the left pupil is 7 mm and nonreactive.

INJURIES: There is substantial diffuse swelling of the face, predominantly the left side in the temporoparietal region. There is significant amount of blood from the patient's nares as well as mouth. The left orbit is swollen completely shut, and upon opening has dilated pupil to 7 mm. Other injuries: Right upper extremity, there is obvious deformity. Right medial ankle, there is an open dislocation.

SECONDARY SURVEY:

PT: Stroud, John

HIST #: 000-485-90-16

ROOM:

ATD: TRAUMA SERVICES CMC, NONE

ADM: 04/10/2005

Page 1 of 3

**CAROLINAS HEALTHCARE SYSTEM
HISTORY AND PHYSICAL**

PATIENT: Stroud, John

HISTORY NO: 000-485-90-16

DOB:

ATT. MD: TRAUMA SERVICES CMC, NONE

ADMIT DATE: 04/10/2005

ACC. NO:

LOCATION:

HEENT: See the above-mentioned injuries for external trauma. Pupils: Right is 4 mm reactive; the left is 7 mm and nonreactive. Gaze is conjugate. TMs: There is blood in the bilateral TMs. There is a significant amount of blood in the mouth. Extraocular movements on the right are intact, on the left is abnormal. Facial bones are difficult to assess due to the severe amount of edema, and there is some tenderness predominantly on the left side.

NECK: Veins are collapsed. Trachea is midline. There is no tenderness and no crepitus.

CHEST: No evidence of external trauma. Movement is symmetrical with slightly diminished breath sounds bilaterally. Heart sounds are regular rate and rhythm. No crepitus is felt. The patient denies any tenderness.

ABDOMEN: There is a right flank lesion that appears to be a burn. There is no tenderness. Mildly distended and dull to percussion.

PELVIS: Stable and nontender.

GU: The meatus is normal with Foley catheter placed with clear urine returned.

RECTAL: Normal sphincter tone, normal prostate and brown stool with no blood.

SPINE: Cervical, thoracic and lumbar spines are all nontender with no step-offs.

EXTREMITIES: There is a right ankle open dislocation and a right obvious femur deformity.

NEURO: Motor is intact in upper and lower bilateral extremities as well as sensory is intact in upper and lower bilateral extremities.

PULSES: 2+ radial, carotid, femoral, popliteal, posterior tibial and dorsalis pedis pulses are felt.

X-RAYS: FAST scan done in the Emergency Department was negative.

CT SCANS:

1. CT scan of the head was negative. This was read by Dr. Kravath.
2. CT scan of the face showed multiple facial fractures.
3. CT of cervical spine was read as negative by Dr. Kravath.
4. CT of the abdomen: There is some mesenteric stranding, a mild amount of fluid around the pancreatic head and a small right adrenal nodule.
5. CT pelvis: There appears to be a mild amount of active bleeding in the left pelvis. There is a right sacral fracture and a left acetabular fracture.

PT: Stroud, John

HIST #: 000-485-90-16

ROOM:

ATD: TRAUMA SERVICES CMC, NONE

ADM: 04/10/2005

Page 2 of 3

**CAROLINAS HEALTHCARE SYSTEM
HISTORY AND PHYSICAL**

PATIENT: Stroud, John

DOB:

ATT. MD: TRAUMA SERVICES CMC, NONE

ACC. NO:

HISTORY NO: 000-485-90-16

ADMIT DATE: 04/10/2005

LOCATION:

6. CT scan of the chest demonstrated a significant right pneumothorax and multiple rib fractures on the right as well as subcutaneous air. An L3 vertebral body fracture was noted; however, official thoracic and lumbar spine reconstructions have not been completed yet.

This films were all read by Dr. Kravath.

ASSESSMENT/PLAN: This is a 62-year-old white male who crashed his ultralight airplane with no loss of consciousness. He has severe facial fractures and swelling. The patient underwent an emergency cricothyroidotomy in the Emergency Department, and patient was then taken to the Operating Room for a revision tracheostomy. From the Emergency Department, the patient was taken to the CT scan.

1. Multiple facial fractures. Plastic Surgery will be consulted on this patient in the morning.
2. Multiple lower extremity fractures. Orthopedics has been consulted and will place the bilateral lower extremities in traction and will repair at a later time.
3. Right pneumothorax. A chest tube was placed in the right chest wall. There are also multiple rib fractures on the right.
4. Patient is admitted to the Trauma Intensive Care Unit on the ventilator and will be monitored closely.
5. Official thoracic and lumbar spines will be determined.
6. A complete tertiary survey will be performed as the patient is able to give a more accurate exam.



D: 04/10/2005 11:39 P TOM SCHMELZER, MD

T: 04/11/2005 8:47 A sim

cc: TRAUMA SERVICES CMC, NONE
TOM SCHMELZER, MD

PT: Stroud, John

ATD: TRAUMA SERVICES CMC, NONE

HIST #: 000-485-90-16

ROOM:

ADM: 04/10/2005

Page 3 of 3

PATIENT: Stroud, John F

NO: 000-485-90-16

PHYSICIAN: DAVID GEORGE JACOBS, M.D.

DATE: 04/11/2005

ROOM TIC 540101

Stroud, John F

000-485-90-16

TIME: 10:30 a.m.

CRITICAL CARE TIME: 55 minutes

The patient was seen this morning with the trauma and the ICU team. Agree with details and plans as outlined in the trauma resident note.

The patient remains critically ill and unstable after being involved in an ultralight plane crash yesterday in which he sustained multiple orthopaedic injuries as well as fractures of the face and some subarachnoid hemorrhage. He also has evidence of active bleeding on his CT scan in the region of the pelvis but has been too unstable to undergo angiography. This morning, he remains paralyzed and sedated on fentanyl, Versed and Norcuron and has been hemodynamically unstable requiring 90 mics per minute of Neo-Syneprine. Currently, his parameters would indicate that he is behind in volume. His hemoglobin has dropped from 11.6 to 9.4 over the last several hours. Will give him an additional 3 units of blood and try to wean him off of his pressors. We have been able to wean him down to 80% oxygen on high frequency ventilation. His chest x-ray shows extensive subcutaneous emphysema in the right chest but no focal infiltrates at this point. I & Os from yesterday 17 liters in and 1.3 liters out. He is a diabetic and is quite hyperglycemic this morning. We will attempt to control this with an insulin infusion.

He has not been febrile. His white count is normal. He is on no antibiotics at this point.

Our plan today is to continue resuscitation and to stabilize him sufficiently to get him to angiography for pelvic embolization.

OVERALL PROGNOSIS: Poor.



D: 04/11/2005 4:05 P DAVID GEORGE JACOBS, M.D.

T: 04/11/2005 4:31 P blw

000005145

cc:

PT: Stroud, John F

ATD: TRAUMA SERVICES CMC, NONE

HIST #: 000-485-90-16

ADM: 04/10/2005

ROOM: TIC 540101

DIS:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 04/18/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

ANESTHESIA: General via ET tube.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: 100 cc.

DESCRIPTION: After the induction of anesthesia, the leg was prepped and draped free. Because of significant full-thickness burn-like injuries to the lateral aspect of the thigh, an anterior antegrade nail was considered unwarranted. A retrograde nail could be placed, but medial to lateral screw insertion would be required distally for this.

We made a parapatellar incision. We identified the starting point in the intercondylar notch with image. We advanced a guide pin to the fracture site. We overreamed with a 13 mm reamer. After reducing the femur, a ball-tip guidewire was then placed into the proximal femur.

We then reamed. Following reaming, we placed a nail and noted that it was off angle. We removed the nail and placed a blocking screw. We then reinserted the nail and locked it both proximally and distally. We paid attention to both length and rotation.

Following the nailing, we inspected the tissues in the lateral aspect of the distal leg. Screws had been placed from medial to lateral because of the quality of the tissues. We found that the tissue represented a full-thickness burn, and all of the skin and fascia were removed down to muscle.

We then addressed the ankle. The patient was identified as having an open ankle fracture dislocation through 2 pin holes with very thinly stretched skin. We excised this tissue. We then designed an incision that would allow us to incorporate the posterior malleolus into an approach to fix the dislocated talus.

We found significant degloving of the skin. We debrided skin, subcutaneous tissue, and fascia.

We irrigated the wound copiously.

We then placed a K-wire at the talar neck. Using the K-wire, we were able to manipulate the fragment. Prior to reduction, we identified the posterior tibial nerve and the flexor digitorum. We then identified the nerve, artery,

PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 04/18/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

and vein. A vessel loop was placed around these. We removed invaginated fascia and capsule from the ankle joint. We removed soft tissues from the subtalar joint.

With distal traction, manipulation of the K-wire, and pushing on the talar head, we were able to reduce the talus into near anatomic position. Further manipulation of the talonavicular and subtalar joints was required until we anatomically reduced the talus into the ankle mortise. AP and lateral images showed adequate reduction. We then pinned the subtalar joint and then the talonavicular joint. Following this, the ankle was still unstable, so we placed a pin from the distal tibia that was exposed into the talar body, through the talar body, and out the calcaneus.

We then obtained images in the AP and lateral planes, and it appeared as though the ankle subtalar and talonavicular joints were appropriately reduced.

We then irrigated the wounds. We repaired the retinaculum to hold the posterior tibial tendon in place. We repaired the soft tissue over the neurovascular bundles. We repaired the anterior capsule and deltoid retinaculum.

We debrided a significant amount of necrotic tissue from the posterior aspect of this wound, where there was full-thickness loss. Following this, we placed a Wound VAC on both the thigh wound and the medial calcaneal heel wound. We then dressed with Xeroform gauze and sterile gauze, and the patient was placed into a posterior splint with the flexion given with the ankle pinning.

Final sponge and needle counts were correct. The patient was transported to the Recovery Room to recover from the anesthetic.

D: 04/18/2005 1:42 P MICHAEL J. BOSSE, M.D.
T: 04/19/2005 10:21 A sim

cc: MICHAEL J. BOSSE, M.D.

PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F.
ATT. MD:
SURGERY DATE:
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

Stroud, John F.

000-485-90-16

PROCEDURE:

1. Left subclavian line placement.

INDICATIONS: This patient's right subclavian malfunctioned, and there was no venous withdrawal on aspiration.

PHYSICIAN: Dr. Andrew J. Forgash

ANESTHESIA: The patient was on Fentanyl and Ativan drips at the time of line placement.

PROCEDURE: The patient was prepped out with Betadine solution and draped in the usual fashion. A left subclavian central venous catheter was placed via modified Seldinger technique without any difficulty. There was dark venous blood aspiration. This was done easily, as well as normal saline flush of all 3 ports. The patient tolerated the procedure well, and there were no complications.

D: 04/19/2005 12:45 A ANDREW J. FORGASH, III, MD
T: 04/19/2005 5:56 P sim

cc: ANDREW J. FORGASH, III, MD

cc: h.s. & Forgash

PT: Stroud, John F.
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

432106

CAROLINAS HEALTHCARE SYSTEM
OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, JohnF
ATT. MD:
SURGERY DATE: 04/20/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

RECEIVED
AUG 15 2005
Alpha Operations - DP15

Stroud, JohnF

000-485-90-16

PREOPERATIVE DIAGNOSES:

1. Perilunate dislocation, left wrist.
2. Suspected median nerve compression, left wrist.

POSTOPERATIVE DIAGNOSES:

1. Perilunate dislocation, left wrist.
2. Suspected median nerve compression, left wrist.

OPERATION PERFORMED:

1. Open reduction of perilunate dislocation, left wrist, with repair of scapholunate ligament.
2. Carpal tunnel release, left.

SURGEON: J R Boatright, M.D.

ASSISTANT: P Phadke, M.D.

ANESTHESIA: General.

DESCRIPTION OF PROCEDURE: The patient's left upper extremity was prepped with Betadine and draped as a sterile field. Pneumatic tourniquet was used at the upper arm level.

A longitudinal incision was made over the dorsal aspect of the left wrist, centered at the wrist joint and in line with the interval between the third and fourth extensor compartments. The subcutaneous tissue was bluntly dissected to expose and protect the extensor pollicis longus tendon. The interval between the third and fourth compartments was entered and the capsule divided longitudinally. The wrist joint was thus inspected. We found that the capitate and scaphoid are set dorsal to the lunate. The proximal pole of the capitate has only a minor contusion. There is no fracture of the scaphoid and no fracture of the triquetrum. We performed an open reduction of the lunate into the interval between the triquetrum and scaphoid, and then after verification of a satisfactory position, and being sure that the scapholunate angles are correct, a 0.062 inch diameter Kirschner wire was inserted from the triquetrum into the lunate, and another from the scaphoid into the lunate, and a third from the scaphoid into the capitate. We then placed a mini Mitek suture anchor into the dorsal distal aspect of the lunate and then repaired the scapholunate interosseous ligament dorsally as there was only a small time left on

PT: Stroud, JohnF
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

REPRINT

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, JohnF

ATT. MD:

SURGERY DATE: 04/20/2005

DOB:

HISTORY NO: 000-485-90-16

DATE:

LOCATION:

ACC. NO:

the scaphoid. We then thoroughly irrigated the wound with saline and closed the capsule with interrupted 3-0 Surgilon suture. The subcutaneous tissue was closed with 3-0 Vicryl suture and the skin was closed with staples.

A longitudinal incision was then made at the base of the left palm in the ray of the ring finger. Proximally, the median nerve was exposed and protected while the entire transverse carpal ligament was divided along its ulnar border. Care was taken to divide the distalmost fibers of the transverse carpal ligament in the palm and the distal fibers of the volar carpal ligament in the forearm. No abnormalities were found within the carpal canal.

We then irrigated the wound with saline and closed the skin with a running 4-0 nylon suture. Dry sterile dressings were applied along with a volar fiberglass splint. The patient was taken to recovery room in satisfactory condition with pink fingertips.

D: 04/21/2005 8:13 A JAMES R BOATRIGHT, M.D.

T: 04/22/2005 10:10 P jab

cc: JAMES R BOATRIGHT, M.D.
PARAG M. PHADKE, MD

PT: Stroud, JohnF
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

REPRINT

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F
ATT. MD:
SURGERY DATE: 04/26/2005
DOB: 03/28/1943

HISTORY NO: 000-485-90-16
DATE:
LOCATION: TIC 540101
ACC. NO:

A 3.5 mm open reduction clamp was placed on either side of the transverse fracture using the distraction mode. With this distractor, we were able to clean all of the callous from the transverse fracture. A Schanz pin was placed in the greater trochanter region. We then reversed the direction of the clamp and with the trochanter pulling laterally, we were able to anatomically reduce the fracture and we held it with the clamp. We then placed the 5 hole plate along the sciatic border to hold the reduction lag screws placed through this in the inferior fragment.

We then elevated the marginal impaction fracture and packed allograft behind it. We replaced the large osteochondral fragment. We then brought the posterior wall shell fragments on down and placed those in near anatomic position. These were provisionally held with K-wires.

Screw fixation of these multiple fragments would not work. We placed two spring plates and then placed a 3.5 plate to bridge these.

Images obtained intraoperatively showed excellent reduction of both the joint and the fragments. We imaged in all planes. One screw was replaced because it appeared to be too close to the joint.

Final images showed an excellent reduction.

The wound was then Water Pik'ed. Repaired the gluteus maximus with 0 Vicryl. The external rotators were repaired with 0 Vicryl sutures. 0 Vicryl sutures figure-of-eight were used to close the IT band and the gluteus maximus. We then used 2-0 Vicryl for the subcutaneous tissues and staples for the skin. A Hemovac drain was placed. Prior to closure, we used pulse lavage to irrigate the wound and inspected all muscles and debrided any muscles that were necrotic, specifically portions of the gluteus minimus. Final sponge and needle counts were correct. The patient was transported to the recovery room to recover from the anesthetic.

PT: Stroud, John F
540101
ATD:

HIST #: 000-485-90-16

ROOM: TIC

ADM: 04/10/2005

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F
ATT. MD:
SURGERY DATE: 04/26/2005
DOB: 03/28/1943

HISTORY NO: 000-485-90-16
DATE:
LOCATION: TIC 540101
ACC. NO:

D: 04/26/2005 1:07 P MICHAEL J. BOSSE, M.D.
T: 04/27/2005 2:06 A sim

cc: MICHAEL J. BOSSE, M.D.



PT: Stroud, John F
540101
ATD:

HIST #: 000-485-90-16

ROOM: TIC

ADM: 04/10/2005

CAROLINAS HEALTHCARE SYSTEM

DISCHARGE SUMMARY

PATIENT: Stroud, John F
DOB: 03/28/1943
ADMIT DATE: 04/10/2005

HIST. NO: 000-485-90-16
ACC. NO: 0100014567
DIS. DATE:

Stroud, John F

000-485-90-16

ATTENDING PHYSICIAN: Dr. Thomason

A 62-year-old male with a history of diabetes in which he was on Glucophage, renal stones and glaucoma. The patient's primary diagnosis is a plane crash (Ultralight)/trauma.

SECONDARY DIAGNOSES:

1. L3, L4 vertebral body fracture nonoperative, okay to mobilize.
2. Right sacral fracture.
3. Left acetabulum fracture.
4. Right pneumothorax status post chest tube.
5. Multiple rib fractures.
6. Fluid around pancreas and mesentery.
7. Right femur fracture.
8. Right ankle fracture which is a talar fracture with burns to that area.
9. Subarachnoid/right subdural.
10. Bilateral hypogastric embolization.
11. Complex midface fractures including the left LeFort III, right LeFort II and mandible fracture.
12. Left pleural effusion that was found on 4/22/05. *buildup of fluid 4w layers of tissue on lung/chest cavity*
13. Left temporal lobe infarct that was found on 4/22/05.
14. Follow-up head CT shows bilateral frontal hygromas and right parietal hygromas.

LUE (wrist) fx

HOSPITAL COURSE: The patient has emergent cricothyroidotomy but then was changed to a tracheostomy in the OR. At that time he also had a chest tube placed for history of pneumothorax and a right subclavian central venous line placed with a Swan catheter. The patient was admitted to the intensive care unit and initially was on vasopressors, was coagulopathic and a drop in his hemoglobin. He was transfused with packed red blood cells, fresh frozen plasma and transferred to CT and arteriogram. At this time the patient had bilateral hypogastric embolizations. He was transferred back to the intensive care unit, was hard to resuscitate secondary to a low hemoglobin and was transfused multiple times. He was placed on an oscillator. Even Life Share was contacted at one point. However, the patient progressively improved. He had a bronch on 4/14/05 that was negative. His chest tube DCD on 4/16/05. On 4/17 he was changed to a conventional ventilation and he went to OR with multiple procedures and at that time a Vacutainer dressing was applied to his right lower extremity. He had Dopplers bilaterally that showed no deep venous thrombosis and on 4/19/05 he had his left wrist ORIFd on 4/25/05 he went to OR with plastics in which they fixed multiple facial fractures. On 4/26/05 he had ORIF

PT: Stroud, John F
E11901

HIST #: 000-485-90-16

ROOM:EAC

ATD: TRAUMA SERVICES CMC, NONE
DIS:

ADM: 04/10/2005

CAROLINAS HEALTHCARE SYSTEM

DISCHARGE SUMMARY

PATIENT: Stroud, John F
DOB: 03/28/1943
ADMIT DATE: 04/10/2005

HIST. NO: 000-485-90-16
ACC. NO: 8100014567
DIS. DATE:

of the left acetabulum, on 4/28 the patient was started on trach collars. On 5/1 he was diagnosed with ventilated associated pneumonia which showed up Enterobacter and he was placed on antibiotics for that. On 5/2 he was transferred to progressive and he actually went back to the OR on that day for debridement of his ankle and right thigh. Eventually on 5/12 he was transferred to 11-A. On 5/13 he had another debridement of his abdominal burn and replaced wound VAC. Today on 5/17 he is felt okay to discharge to a nursing facility. He neuro wise will follow commands intermittently. He mouths words and he appears oriented at times. We give him a GCS of around 13 or 14. Respiratory wise he is on a trach collar at 30 percent O2 saturations are 100 percent. Cardiovascular wise he is within normal limits. Abdominal wise he has a wound VAC but he has a Dobhoff tube with TraumaCal at 60 and he has intravenous fluids going at 50. Renal wise he has a Foley to bedside drainage. We will try to change that to a condom cath today. He got out of bed today for the first time and did not tolerate as well secondary to deconditioning. He does get anxious at times. His Accu-Cheks are checked q.i.d. and they have been running from 110 to 190. He has a splint on the right lower extremity. On the right thigh has the wound VAC. On the right abdomen he has the normal saline dressing.

OPERATIONS AND PROCEDURES: On 4/18/05—

1. IM nail of the right femur.
2. I&D of the right ankle.
3. Open reduction/pinning of the right talus fracture.
4. Escharotomy at the right thigh.
5. Escharotomy at the right ankle.
6. Neurolysis at the posterior tibial nerve.

On 4/20 he had a left wrist open reduction internal fixation.

On 4/25/05—

1. A mandible fixation with arch bars.
2. Open reduction internal fixation of mandible.
3. Open reduction internal fixation of other facial fractures.

On 4/26/05 he had open reduction internal fixation of the left acetabulum.

On 5/2/05 he had debridement of the right ankle and thigh with Dr. Bosse.

On 5/13/05 he had debridement of abdominal wound with Dr. Thomason.

PT: Stroud, John F
E11901
ATD: TRAUMA SERVICES CMC, NONE
DIS:

HIST #: 000-485-90-16

ROOM:EAC

ADM: 04/10/2005

CAROLINAS HEALTHCARE SYSTEM

DISCHARGE SUMMARY

PATIENT: Stroud, John F

DOB: 03/28/1943

ADMIT DATE: 04/10/2005

HIST. NO: 000-485-90-16

ACC. NO: 8100014567

DIS. DATE:

DISCHARGE INSTRUCTIONS:

1. He is to follow-up with Dr. Hartman p.r.n.
2. Follow-up with Dr. Getz in two weeks.
3. Follow-up with Dr. Bosse in two weeks.
4. Wet-to-dry dressings b.i.d. to right ankle with Silvadene and to right abdomen.
5. Follow-up with trauma in two weeks.
6. VAC changed to right thigh three times per week.

DISCHARGE MEDICATIONS:

1. Atenolol 50 mg via tube every day.
2. Bacitracin ophthalmic ointment to eyelid b.i.d.
3. Clonidine 0.1 every day.
4. Colace b.i.d. 100 mg p.o.
5. Lovenox 30 mg subcu b.i.d.
6. NPH 35 units subcu q.12 which will eventually need to be changed over to Glucophage.
7. Accu-Cheks q.6h.
8. Cosopt eyedrops to both eyes b.i.d.
9. Accuzyme to wound VAC with dressing change only to areas of slough.

D: 05/17/2005 4:16 P ANGELA HOLT BLACKBURN, NP

T: 05/17/2005 6:44 P bmc

000008838

cc: ANGELA HOLT BLACKBURN, NP
TRAUMA SERVICES CMC, NONE

PT: Stroud, John F
E11901

ATD: TRAUMA SERVICES CMC, NONE
DIS:

HIST #: 000-485-90-16

ROOM:EAC

ADM: 04/10/2005

N 6302

207

Date	Time	Each Entry Requires Physician's Signature
5/19/05	PM 1:15	At seen/examined N.G. P # 2913162 <i>[Signature]</i> Diagnosis: Nutrition - Initial Assessment Problem: 1) Low ym adm 2 multiple Exs a plane: crash 4: PM 2. Rehydration to wants. H/o DM. Currently 2 DHT/TE Goals: 1) Tolerate TE 5 residual 2) Tight Glycemic Control. (SST Novolin Lantus) FPGS: 313, 213 3) Meet Nutrition Needs: 1950 - also Kool's (26-28 kg) + 98-113 g/lcm 4) Ht: 5'11" Wt: 110 lb (#) 75 kg, I BM: 172 lb 5% lean (1.3) 5) Labs WNL 6) Improve PAB, currently 13 Interventions: 1) Start Glucard. Start @ 80 ml/ to provide 1950 Kool's + 98 g/lcm 2) Monitor tolerance / Blood Sugars closely B. Cummings, RD, PhD

Physician's Progress Notes

N6302-T 11/88

٢٠٥١٢٤

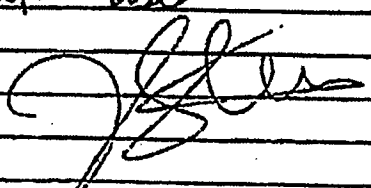
515 11 2 2 2

APRIL, APRIL KATIE

5/1F/ 5 II 62Y 23/28/43

ALCIN 6500770

REF 0000561

Date	Time	Each Entry Requires Physician's Signature	
5/19/05		Attach this Catheter Maintenance Guide to patient's chart. Bard Access Systems	
 Polyurethane PICC			
This patient has a PowerPICC Catheter inserted on: <u>5/19/05</u> (date) Lot No. <u>22DP4855</u> by: <u>Dr. G. L. Smith</u> (inserting clinician name)		<u>48cm</u>	
When cleaning the exit site: WARNING: - Do not wipe the catheter with acetone based solutions, or ointment. These can damage the polyurethane material it used over time. - Avoid prolonged or excessive contact with alcohol or alcohol containing antiseptics as these are known to degrade polyurethane catheters over time. DO: - Maintain according to hospital protocol. Avoid using acetone based solutions, or ointment. These substances are known to degrade polyurethane. - Use chlorhexidine gluconate and/or povidone iodine to clean the exit site around the catheter. - Allow all cleaning agents/antiseptic to dry completely before applying dressing.		New Important Information: - Contrast media should be warmed to body temperature prior to power injection. Warning: Failure to warm contrast media to body temperature prior to power injection may result in catheter failure. - Vigorously flush the PowerPICC catheter using a 10cc or larger syringe and sterile normal saline prior to and immediately following the completion of power injection studies. This will ensure the patency of the PowerPICC catheter and prevent damage to the catheter. Resistance to flushing may indicate partial or complete catheter occlusion. Do not proceed with power injection study until occlusion has been cleared. Warning: Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure. - Do not exceed the maximum flow rate of 5cc/sec. Warning: Power injector machine pressure limiting feature may not prevent over pressurization of an occluded catheter. Warning: Exceeding the maximum flow rate of 5cc/sec may result in catheter failure and/or catheter tip displacement. Warning: PowerPICC catheter indication for power injection of contrast media implies the catheter's ability to withstand the procedure, but does not imply appropriateness of the procedure for a particular patient. A suitably trained clinician is responsible for evaluating the health status of a patient as it pertains to a power injection procedure.	
Catheter Maintenance Flush the catheter with heparinized saline every 12 hours or after each use. Usually, one ml per lumen is adequate.		Power Injection Procedure: - Remove the injection/needleless cap from the PowerPICC catheter. - Attach a 10cc or larger syringe filled with sterile normal saline. - Aspirate for adequate blood return and vigorously flush the catheter with the full 10cc of sterile normal saline. Warning: Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure. - Detach syringe. - Attach the power injection device to the PowerPICC catheter per manufacturer's recommendations. - Complete power injection study taking care not to exceed the flow rate limits. Warning: Exceeding the maximum flow rate of 5cc/sec may result in catheter failure and/or catheter tip displacement. - Disconnect the power injection device. - Flush the PowerPICC catheter with 10cc of sterile normal saline, using a 10cc or larger syringe. - Replace the injection/needleless cap on the PowerPICC catheter.	
			
Bard Access Systems, Inc. 28425 West Amalia Eastern Drive Salt Lake City, UT USA 84116 801-225-0700 Central Mailing: 1-800-443-3325 Ordering: 1-800-845-0680		www.bardaccess.com www.powerpicc.com 0707857 / 0311R	
Ready for Use 		PATIENT IDENTIFICATION	

Date	Time	Each Entry Requires Physician's Signature
8/13/59		<u>Mr. CAPRA</u> ① Pt. follows up simple common. Reiterates any ② Pt. follows up simple common. Reiterates any ③ Pt. follows up simple common. Reiterates any ④ Pt. follows up simple common. Reiterates any ⑤ Pt. follows up simple common. Reiterates any ⑥ Pt. follows up simple common. Reiterates any ⑦ Pt. follows up simple common. Reiterates any ⑧ Pt. follows up simple common. Reiterates any ⑨ Pt. follows up simple common. Reiterates any ⑩ Pt. follows up simple common. Reiterates any ⑪ Pt. follows up simple common. Reiterates any ⑫ Pt. follows up simple common. Reiterates any ⑬ Pt. follows up simple common. Reiterates any ⑭ Pt. follows up simple common. Reiterates any ⑮ Pt. follows up simple common. Reiterates any ⑯ Pt. follows up simple common. Reiterates any ⑰ Pt. follows up simple common. Reiterates any ⑱ Pt. follows up simple common. Reiterates any ⑲ Pt. follows up simple common. Reiterates any ⑳ Pt. follows up simple common. Reiterates any ㉑ Pt. follows up simple common. Reiterates any ㉒ Pt. follows up simple common. Reiterates any ㉓ Pt. follows up simple common. Reiterates any ㉔ Pt. follows up simple common. Reiterates any ㉕ Pt. follows up simple common. Reiterates any ㉖ Pt. follows up simple common. Reiterates any ㉗ Pt. follows up simple common. Reiterates any ㉘ Pt. follows up simple common. Reiterates any ㉙ Pt. follows up simple common. Reiterates any ㉚ Pt. follows up simple common. Reiterates any ㉛ Pt. follows up simple common. Reiterates any ㉜ Pt. follows up simple common. Reiterates any ㉝ Pt. follows up simple common. Reiterates any ㉞ Pt. follows up simple common. Reiterates any ㉟ Pt. follows up simple common. Reiterates any ㊱ Pt. follows up simple common. Reiterates any ㊲ Pt. follows up simple common. Reiterates any ㊳ Pt. follows up simple common. Reiterates any ㊴ Pt. follows up simple common. Reiterates any ㊵ Pt. follows up simple common. Reiterates any ㊶ Pt. follows up simple common. Reiterates any ㊷ Pt. follows up simple common. Reiterates any ㊸ Pt. follows up simple common. Reiterates any ㊹ Pt. follows up simple common. Reiterates any ㊺ Pt. follows up simple common. Reiterates any ㊻ Pt. follows up simple common. Reiterates any ㊼ Pt. follows up simple common. Reiterates any ㊽ Pt. follows up simple common. Reiterates any ㊾ Pt. follows up simple common. Reiterates any ㊿ Pt. follows up simple common. Reiterates any
520	1400	Case mgmt: Admission Assessment completed. Do monitor classes in coordination & plan to ensure safe appropriate PC plan. 9/1/59

Date	Time	Each Entry Requires Physician's Signature
5/18/05		Glenn Seku @ 7am, taking TF well so far. For his wife. States he is hungry - will discuss adequate food 7pm. FSS-116718, 137 - back @ 10m last night X2. P. 7TF to good of 8am, Following tolerance / BG - 1.6mm / 1.1m
5-20-05		Chad removed from in tent of service + fever of 101.5. Admit complete medical, Resp. + 1.1m / 1.1m needs. Next revision scheduled for 5-23-05. (Signature)
		5/20/05 Hypertension on Zolten + Zolten Hx: NO Prr. Act. Tube feeds Anal. good output No. Sample crumb VSS Hy: 1.1m / 1.1m, 1.1m 1.1m / 1.1m 1.1m / 1.1m Ch. Ex. 1.1m
		(Signature)

PATIENT IDENTIFICATION

PT: DR. J. HN
 DR. SAFARI, ABUL KAGIM
 05/18/05 N 62Y 03/28/43

ACCT# 6500770

AK# 0002561

Physician's Progress Notes

N6302-T 11/98

NS302-T 11/98

At the time of the ...

Interdisciplinary Weekly Summary of Care

Date: 5-23-05

Patient Name: John Strand
7028

Physician: Dr. Gariba

* Sign and Date all Weekly Summaries

** Place N/A beside disciplines / therapies not utilized

Nursing: Alert. follows commands. +/- collar 35% mult. fx. left fx. Arch bar removal due Friday 5/27. PT getting up to chair wound vac to @ side → @ thigh. wound vac @ foot. deaf @ ear blind @ eye.

— Aul Bmm 5/24/05
1900

Nutrition:

TF = Promote & Fiber @ 75ml/100, tolerating TF well.
Blood Stools T, watching closely. Hgb=13. RBC=4.5

Physical Therapy:

① LE PROM, ② LE PROM & pt. in supine & emphasis on @ knee ROM. pt. & ventrally @ knee flexion & significant do pain. Rolling & mod @ xl.
OOB → stretch chair 1 hour & @ LE elevated. Susan Wojanowich, P.T.

Occupational Therapy: OT focus on cognition to carryover & ADLs and functional transfers. Amber

Speech Therapy:

ST is following to address basic cog/comm. Mod @ & orientation + max @ to recall info. from day to day. Providing family ed re: how to ↑ pt's orientation & recall. ↓ d vision noted. Will. out. to follow for cog/comm & will perform swallow eval when MD feels pt is ready. Jeff D. Johnson, M.D., CC-SLP

Interdisciplinary Weekly Summary of Care

Respiratory Care:

Pt remains on 28% T-cells E H₂O Shiley. Secretions are minimal to mod. @ times. SpO₂ stable. Will utilize PMR and V function pt tolerate and MD orders. All H₂O to be PRN — J. A. 7/27

Case Management / Social Services:

John Stroud - Lived at home with spouse prior to hospital admit. Scheduled for removal of Arch Bars in mouth on 5/27/05 0800 here in Main OR by Dr. Getz. F/U Appt. with Dr. Bosse' CMC Ortho Scheduled for 6/1/05 at 300pm. No d/c plans at present due to length of stay.

[Signature], Core mgmt

Pharmacy:

- ① Abx's - triple Abx Ointment added 5/19 BID
- ② DVT px - Lovenox 40mg SQ daily
- ③ Meds - Mucomyst as directed prn S₂O, A/A nets prn, Toradol IV prn S₂O, Demerol d/c'd S₂O. (CB)

Other:

Date	Time	Each Entry Requires Physician's Signature
5/29/05		Wood (Ck): 7p Chagrin disturbed from 5/19/05. (C) High #1-15.9 (W) x 5.5 (W) x 0.5 depth. moderate care. Long drainage, drape at hole, changed d. lid. and completed tamponade containing small amount of drape/leeches. (C) High #2-22.9 (W) x 0.8 (W) x 0.5; moderate care. Long drainage, 8 odor, drape/leeches removed from tubular and changed d. lid. and - width of tube ↑ d. drainage of tubular and drape/leeches. (C) abd. #1-11.4 (W) x 15.3 (W) x 0.5 depth; moderate care. Long drainage, 8 odor, 8 3/2 (W) infection, small amt. of drape/leeches. (C) abd. #2-8.5 (W) x 8.7 (W) x 1.4 depth; moderate care. Long drainage, 8 odor, 8 3/2 infection; (C) abd. #3-4.6 (W) x 5.1 (W) x 1.5 depth; moderate care. Long drainage, 8 odor, 8 3/2 infection. S. Barker, MD, Wood

Physician's Progress Notes

NE302-T 11/88

[illegible]

Date	Time	Each Entry Requires Physician's Signature
5/2/05		Care next (Kard) removed by infusion of Amic + fentanyl of ileus. Skin clean good Kardex next + relief care next revision scheduled for 5/2/05 Jore, fentanyl, care
5/2/05		Care next - Catha. f/a apppt scheduled 5-1-05 Wed. at 3:00 pm E. An. Dorse at CMC over. Can attend f/a. up appropriate transported to f/a, Chicago
5/2/05		Nutrition Monitor Fats @ 75ml, tolerating TF well so far. BS ↑ = 20, 182, 197, 195. This TF provides more protein, more CHO though. Mon. Monitoring Blood Sugars closely. VAPs for improvement B. BUNMs, MD, IDN
5/24/05	PM 11:45	3) RT % pain at R/Lt wound since VAC Δ; requests morphine as opposed to Demerol due to prior effectiveness in previous hospital; ask about repeat of head in progress
4.1		GENERAL: in chair; requesting to lay down HEENTIONS: (P) prop. sedative; (P) sup. trauma NECK: (P) trauma CV: PPR 3 ~ 12/6 9/10 BP 77 HR LUNGS: CHEST: STAB 77 RR ABDOMEN: (P) BS, soft, NT, d/t/R EXTREMITIES: blanching erythema around wound VAC R/Lt GU: (P) FOLEY, 11165 o. 1300
4.1	5/1	OTHER: PAIN: 1) R/Lt wound pain - (P) morphine as opposed; Demerol as per pt request 2) s/p ultra light plane crash & multiple injuries 3) leukocytosis - C/S MRSA @ wound culture. Ddx MRSA @ / Pseudomonas @ / isolation ABX + MRSA @ / oxacillin / ceftazidime

Physician's Progress Notes

N6302-T 11/05

Date	Time	Each Entry Requires Physician's Signature
5/28/85	10:00	1. ~~1. MC (Gastritis)~~ ~~2. 1st & 2nd complications~~ ~~3. over rule~~ ~~4. splenic bloods sample~~ ~~5. common~~ ~~6. 1st = 1st~~ ~~7. 2nd = 2nd~~ ~~8. 3rd = 3rd~~ ~~9. 4th = 4th~~ ~~10. 5th = 5th~~ ~~11. 6th = 6th~~ ~~12. 7th = 7th~~ ~~13. 8th = 8th~~ ~~14. 9th = 9th~~ ~~15. 10th = 10th~~ ~~16. 11th = 11th~~ ~~17. 12th = 12th~~ ~~18. 13th = 13th~~ ~~19. 14th = 14th~~ ~~20. 15th = 15th~~ ~~21. 16th = 16th~~ ~~22. 17th = 17th~~ ~~23. 18th = 18th~~ ~~24. 19th = 19th~~ ~~25. 20th = 20th~~ ~~26. 21st = 21st~~ ~~27. 22nd = 22nd~~ ~~28. 23rd = 23rd~~ ~~29. 24th = 24th~~ ~~30. 25th = 25th~~ ~~31. 26th = 26th~~ ~~32. 27th = 27th~~ ~~33. 28th = 28th~~ ~~34. 29th = 29th~~ ~~35. 30th = 30th~~ ~~36. 31st = 31st~~ ~~37. 32nd = 32nd~~ ~~38. 33rd = 33rd~~ ~~39. 34th = 34th~~ ~~40. 35th = 35th~~ ~~41. 36th = 36th~~ ~~42. 37th = 37th~~ ~~43. 38th = 38th~~ ~~44. 39th = 39th~~ ~~45. 40th = 40th~~ ~~46. 41st = 41st~~ ~~47. 42nd = 42nd~~ ~~48. 43rd = 43rd~~ ~~49. 44th = 44th~~ ~~50. 45th = 45th~~ ~~51. 46th = 46th~~ ~~52. 47th = 47th~~ ~~53. 48th = 48th~~ ~~54. 49th = 49th~~ ~~55. 50th = 50th~~ ~~56. 51st = 51st~~ ~~57. 52nd = 52nd~~ ~~58. 53rd = 53rd~~ ~~59. 54th = 54th~~ ~~60. 55th = 55th~~ ~~61. 56th = 56th~~ ~~62. 57th = 57th~~ ~~63. 58th = 58th~~ ~~64. 59th = 59th~~ ~~65. 60th = 60th~~ ~~66. 61st = 61st~~ ~~67. 62nd = 62nd~~ ~~68. 63rd = 63rd~~ ~~69. 64th = 64th~~ ~~70. 65th = 65th~~ ~~71. 66th = 66th~~ ~~72. 67th = 67th~~ ~~73. 68th = 68th~~ ~~74. 69th = 69th~~ ~~75. 70th = 70th~~ ~~76. 71st = 71st~~ ~~77. 72nd = 72nd~~ ~~78. 73rd = 73rd~~ ~~79. 74th = 74th~~ ~~80. 75th = 75th~~ ~~81. 76th = 76th~~ ~~82. 77th = 77th~~ ~~83. 78th = 78th~~ ~~84. 79th = 79th~~ ~~85. 80th = 80th~~ ~~86. 81st = 81st~~ ~~87. 82nd = 82nd~~ ~~88. 83rd = 83rd~~ ~~89. 84th = 84th~~ ~~90. 85th = 85th~~ ~~91. 86th = 86th~~ ~~92. 87th = 87th~~ ~~93. 88th = 88th~~ ~~94. 89th = 89th~~ ~~95. 90th = 90th~~ ~~96. 91st = 91st~~ ~~97. 92nd = 92nd~~ ~~98. 93rd = 93rd~~ ~~99. 94th = 94th~~ ~~100. 95th = 95th~~ ~~101. 96th = 96th~~ ~~102. 97th = 97th~~ ~~103. 98th = 98th~~ ~~104. 99th = 99th~~ ~~105. 100th = 100th~~ ~~106. 101st = 101st~~ ~~107. 102nd = 102nd~~ ~~108. 103rd = 103rd~~ ~~109. 104th = 104th~~ ~~110. 105th = 105th~~ ~~111. 106th = 106th~~ ~~112. 107th = 107th~~ ~~113. 108th = 108th~~ ~~114. 109th = 109th~~ ~~115. 110th = 110th~~ ~~116. 111st = 111st~~ ~~117. 112nd = 112nd~~ ~~118. 113rd = 113rd~~ ~~119. 114th = 114th~~ ~~120. 115th = 115th~~ ~~121. 116th = 116th~~ ~~122. 117th = 117th~~ ~~123. 118th = 118th~~ ~~124. 119th = 119th~~ ~~125. 120th = 120th~~ ~~126. 121st = 121st~~ ~~127. 122nd = 122nd~~ ~~128. 123rd = 123rd~~ ~~129. 124th = 124th~~ ~~130. 125th = 125th~~ ~~131. 126th = 126th~~ ~~132. 127th = 127th~~ ~~133. 128th = 128th~~ ~~134. 129th = 129th~~ ~~135. 130th = 130th~~ ~~136. 131st = 131st~~ ~~137. 132nd = 132nd~~ ~~138. 133rd = 133rd~~ ~~139. 134th = 134th~~ ~~140. 135th = 135th~~ ~~141. 136th = 136th~~ ~~142. 137th = 137th~~ ~~143. 138th = 138th~~ ~~144. 139th = 139th~~ ~~145. 140th = 140th~~ ~~146. 141st = 141st~~ ~~147. 142nd = 142nd~~ ~~148. 143rd = 143rd~~ ~~149. 144th = 144th~~ ~~150. 145th = 145th~~ ~~151. 146th = 146th~~ ~~152. 147th = 147th~~ ~~153. 148th = 148th~~ ~~154. 149th = 149th~~ ~~155. 150th = 150th~~ ~~156. 151st = 151st~~ ~~157. 152nd = 152nd~~ ~~158. 153rd = 153rd~~ ~~159. 154th = 154th~~ ~~160. 155th = 155th~~ ~~161. 156th = 156th~~ ~~162. 157th = 157th~~ ~~163. 158th = 158th~~ ~~164. 159th = 159th~~ ~~165. 160th = 160th~~ ~~166. 161st = 161st~~ ~~167. 162nd = 162nd~~ ~~168. 163rd = 163rd~~ ~~169. 164th = 164th~~ ~~170. 165th = 165th~~ ~~171. 166th = 166th~~ ~~172. 167th = 167th~~ ~~173. 168th = 168th~~ ~~174. 169th = 169th~~ ~~175. 170th = 170th~~ ~~176. 171st = 171st~~ ~~177. 172nd = 172nd~~ ~~178. 173rd = 173rd~~ ~~179. 174th = 174th~~ ~~180. 175th = 175th~~ ~~181. 176th = 176th~~ ~~182. 177th = 177th~~ <del>183. </del>

Physician's Progress Notes

NE302-T 11/98

ACCT# 4560776

ಹೊಸ ಮೂಲಕವು

Date	Time	Each Entry Requires Physician's Signature
5/26/05		Intubation Proximal Fiber @ 75mm Prealbumin Stable @ 13. FBS = 110, 242, 191, 228 P: Add 2 Tbs. Proteinex / Day = 127g / 100 (1.7g / 1kg) ? ↑ Labs for higher PB control P. B. M. A. R. I. N.
5/26/05	PM 13:30	3) no new complaints
5/26/05		GENERAL: W/O HEENT: ☒ eyes, ☒ ears, ☒ nose, ☒ throat NECK: ☒ thyroid CV: ☒ heart, ☒ lungs LONGSIGHT: C/A B-L DOMEN: ☒ B, ☒ L, ☒ NT, ☒ B/L, ☒ wound care ENTITIES: ☒ R/L wound care - 2 pitting edema (R) foot GU: ☒ FOLEY; I: 2100 O: 1450 OTHER:
10.0	10.8	11.9) 10.0 (10.8) 1) 5/10 intra light, have crash & multiple injuries s/p facial surgery (R/L B/L) 2) Near plane - wearing 3) Cont. wound care 4) Throat breathing 5) LTR 6) pre-op near CV, > 25 ppm / (pseudomonas) - CBC / BMP / mag (TBM) 4mg / Kg / loading dose Vancomycin - then pham D
		PATIENT IDENTIFICATION STANDARD PT. NAME: ABUL KAFIR DOB: 10/25/62 Y 63/28/63 ACCT: 6500770 MR# 0000561

Physician's Progress Notes

N6302-T 11/99

CAROLINAS HEALTHCARE SYSTEM
CHARLOTTE, NC

NAME: STROUD, JOHN F
MR#: 000-300-08-20
ACCT #: 0514700004
ATTENDING: STANLEY B. GETZ, JR., MD
SURGEON: STANLEY B. GETZ, JR., MD

ADMISSION DATE: 05/27/2005
DISCHARGE DATE: 05/27/2005
LOCATION: MORI
PATIENT TYPE: Outpatient
SURGERY DATE: 05/27/2005
M

OPERATIVE/PROCEDURE REPORT

STROUD, JOHN F

000-300-08-20

PREOPERATIVE DIAGNOSES:

1. Status post: severe facial fracture requiring arch bars and intermaxillary fixation.

POSTOPERATIVE DIAGNOSES:

1. Status post: severe facial fracture requiring arch bars and intermaxillary fixation.

OPERATIVE PROCEDURE PERFORMED: Removal of arch bars.

PRIMARY SURGEON: Stanley Getz, Jr., M.D.

ANESTHESIA: General endotracheal anesthesia.

DESCRIPTION OF OPERATIVE PROCEDURE: The patient was placed on the operative table in supine position. Following administration of an adequate general endotracheal anesthetic, the wires holding the mandibular and maxillary arch bars in place were untwisted, divided and removed. The arch bars were removed. The mouth was carefully checked for any evidence of retained metal and none was found. The patient was discharged to the recovery room in good condition.

D: 06/01/2005 7:50 A STANLEY B. GETZ, JR., MD

T: 06/01/2005.10:50 Asmi

Job #000009745 / Document #487047

cc: STANLEY B. GETZ, JR., MD
Department Of Plastic Surgery
2300 Randolph Road, Suite A
Charlotte NC 28207

Reprint

Operative Report
Page 1 of 1

Date	Time	Each Entry Requires Physician's Signature
5/17		Pharmacy Note: Gent dosing day #2 Patient started on Gent yesterday for Resp Co of Moderate Pseudomonas, using Levagran for double coverage. Will dose Gent using Hartford Nomogram @ 7mg/kg = 520mg q24h. Lab. due tomorrow: A/C. Patient is Allergic WBC = 10.9 & Neutrophils = 65%. Pharmacy will continue to follow. Michael Bolewicz, Pharm.D.
5/20/06		Nutrition Order to Fiber @ 75ml/p Spoke to A.S. wife in detail. Wt. on admission = 1164#, today's wt = 1564# ESR = 160, 242, 191, 228 Plan: ↑ TE to 80 ml/p, provides 1920 Kcals (25.6 Kcals/kg) + 134g protein & 2 Tbs. Vmeirex (1.78 g/TBW). Will obtain Wt. for baseline next week and follow closely. B. Brown, RD, LD
5/28		Cx: Gentamicin Day #3 1) Level = 2.1 this Am, per Nomogram dose at 24 hr interval appropriate. 2) Pseudomonas Resp Cx → Gent & LVG (double coverage) 3) Please note new urine culture growing. Enterobacter cloacae (multi-drug resistant) in this case the use of Gent & LVG may influence future sensitivities. Please advise on spectrum if UTI will be treated. Thanks, Alonzo D. Jones

Physician's Progress Notes

N6302-T 11/88

Date	Time	Each Entry Requires Physician's Signature
		<i>[Signature]</i>
		① New complications overall ② Hgb 10.7 - normal ③ Hct 32.5 - normal ④ HbA1c 7.8 - normal ⑤ Urine - negative ⑥ ECG - normal ⑦ CXR - normal ⑧ Labs - normal ⑨ Meds - as ordered ⑩ Overall - good
		① Ultra - left arm crack ② Urine - positive for protein ③ ECG - normal ④ Labs - normal ⑤ Overall - good
		① Ultra - left arm crack ② Urine - positive for protein ③ ECG - normal ④ Labs - normal ⑤ Overall - good
5/29/05		Rx: Amilorin (Day #1) 1) Utilizing Hartford nomogram 15 mg/kg/day. (wt = 74 kg) $\approx$ 1100 mg/day 2) Random level due tomorrow @ 06:00 am dosing adjustment if any pending results.
		Thanks, Maria V. Jones MD

Date	Time	Each Entry Requires Physician's Signature
4/20/15		Dr. [Signature] ① Pt. & new confessions. ② Pt. & new confessions. ③ Pt. & new confessions. ④ Pt. & new confessions. ⑤ Pt. & new confessions. ⑥ Pt. & new confessions. ⑦ Pt. & new confessions. ⑧ Pt. & new confessions. ⑨ Pt. & new confessions. ⑩ Pt. & new confessions. ⑪ Pt. & new confessions. ⑫ Pt. & new confessions. ⑬ Pt. & new confessions. ⑭ Pt. & new confessions. ⑮ Pt. & new confessions. ⑯ Pt. & new confessions. ⑰ Pt. & new confessions. ⑱ Pt. & new confessions. ⑲ Pt. & new confessions. ⑳ Pt. & new confessions. ㉑ Pt. & new confessions. ㉒ Pt. & new confessions. ㉓ Pt. & new confessions. ㉔ Pt. & new confessions. ㉕ Pt. & new confessions. ㉖ Pt. & new confessions. ㉗ Pt. & new confessions. ㉘ Pt. & new confessions. ㉙ Pt. & new confessions. ㉚ Pt. & new confessions. ㉛ Pt. & new confessions. ㉜ Pt. & new confessions. ㉝ Pt. & new confessions. ㉞ Pt. & new confessions. ㉟ Pt. & new confessions. ㊱ Pt. & new confessions. ㊲ Pt. & new confessions. ㊳ Pt. & new confessions. ㊴ Pt. & new confessions. ㊵ Pt. & new confessions. ㊶ Pt. & new confessions. ㊷ Pt. & new confessions. ㊸ Pt. & new confessions. ㊹ Pt. & new confessions. ㊺ Pt. & new confessions. ㊻ Pt. & new confessions. ㊼ Pt. & new confessions. ㊽ Pt. & new confessions. ㊾ Pt. & new confessions. ㊿ Pt. & new confessions.
5/30/15		Post KUB 0800 KO
6/30/15		RAIDING: Prob Hsp plane after
		PATIENT IDENTIFICATION

Physician's Progress Notes

N5302-T 11/98

3/18/55 62Y 1-43
 10074 4500776

April

Interdisciplinary Weekly Summary of Care

Date: 5-31-05

Patient Name: John Sprad
7028

Physician: Dr. Carlson

* Sign and Date all Weekly Summaries

** Place N/A beside disciplines / therapies not utilized

Nursing: Pt. denies Pain most of Day. Goal to keep Dobhoff in and prevent pt pulling out. Monitored to wife if possible she or some family member staying at night.

exp. finished

Nutrition:

Promote Fiber @ 8ml/° to 2 Tbs. Protein/Day.
PAB Stable @ 13. Tolerating TF well.
Prom. 110

Physical Therapy:

① UE ARM ROM c pt. in supine. ② UE ARM PROM c pt. in supine. Pt. c limited tolerance for ③ UE movement 2° to pain. Pt. able to roll ④ c min @ x 1. Rolling ⑤ c max @ x 1 2° to pt. not tolerating rolling onto ⑥ UE. ⑦ stretch chair x 1 hour c ⑧ UE elevated and do pain. Susan Wojcik, P.T.

Occupational Therapy:

OT focus on ① UE strengthening @ shld and prom (gentle) to ② hand/fingers to ↑ finger flexion. OT focus also on visual/percept skills c pt ability to identify items thru sense of touch and ③ eye (low vision). Will continue to address, limited OT tx 2° pt sedated. *Amber*

Speech Therapy:

Tx continues to focus on basic cog/com. @ x's, pain is an issue c ability to participate in tx. Pt. continues to have v/d orientation + to ability to recall events from day to day. Overall max ④ c recall, but @ x's has been min @ c orientation. Will cont. to follow for cog/com. *John J. Delaney, M.A., SLP*

Interdisciplinary Weekly Summary of CareRespiratory Care:

Pt cont on 28% T-cella. No downgrading yet - pt has
#6 Shiley - awaiting MD order. Tol PMV X 2-3h @ 2 time Good
strong prot cough. J. Stroud

Case Management / Social Services:

John Stroud- Lived at home with spouse prior to hospital admit. Had removal of Arch
Bars in mouth on 5/27/05 by Dr. Getz. F/U Appt. with Dr. Bosse' CMC Ortho Scheduled
for 6/1/05 at 300pm. Once decannulated will ask CIR to eval for poss. inpatient Rehab. VS
SNF. CM will follow and make referral to CIR when appropriate.

Pharmacy:

- John Stroud, Corent*
- ① ID - Amikacin new 5/29 for enterobacter UTI + pseudo resp ox
along with levofloxacin 500mg IV daily new 5/26 + 14 days
 - ② DVT px - Lovenox cont.
 - ③ Med Δ's - Vicodin prn spot, dilaudid prn spot (CB)

Other: Wound Care: Wounds continue to debride along/scar
along wound track on (L) thigh I & L, (L) Abdomen & (L) ankle I & L -
small amt. of new granulation tissue present in abdominal wound.

(H)

Date	Time	Each Entry Requires Physician's Signature
5/31/05	7:15 AM	① Pulled DHT again. Remain ② A lot of coherent back ③ Heart & lungs. Appropriate ④ RR - coarse ⑤ 4-4-4 MM. 13/16/11/16 ⑥ Soft, no sound ⑦ The rest of the ⑧ Pseudomonas to pneumonia ⑨ Cont. Pulmonary toilet. ⑩ 4/4 ultra light plane crash <i>[Signature]</i>
5/31/05	9:40	Tobacco tube placement in Radiology 0940 KO
5/31/05		Admission Patient: E. F. H. @ 0117. DHT pulled out. KUB confirmed placement. 100s: 136/101/16/1165 (ot 8.6) MA: 1.9 Phs: 4.0 FSES: 198, 2109, 171 43/32/5 WT=150#. Need baseline wt. ① Bed d'd out. ② Cont. TFC Prolinex for Protein repletion. ✓ wt. - D. Burn AD, MDN

Physician's Progress Notes

N6302-T 11/08

Date	Time	Each Entry Requires Physician's Signature
6/1/05		Pt will be scheduled for surgery in AM for debridement / Hb Removal (Rt) foot / Hold Levenox. [Signature] RNP
6-1-05 1730		Care note - Called Dr. Gaudin RE: above planned surgery 6-2-05. Orders for A/C home. Stop Tube Feeding + NPO & Omeprazole 6-2-05 Received. Dr. Gaudin E. Bob Simpson, R.D. [Signature] Care note
		PATIENT IDENTIFICATION 1 51 14 14 STE 14 2 14 ADULT MALE

Physician's Progress Notes

N6302-T 11/88

STP 10, 3 PM
PAC CORREA, ADOL ZARIN
6216/CS. 6 62Y C3/28/43

ACCT# 6500770

REF ID: A62561

Date	Time	Each Entry Requires Physician's Signature
6/1/05		Wound Care: (C) Thigh #1- 15.0(L) x 5.5(W) x 0.3 depth, moderate (C) long drainage, small ant. slash in heel, thick sl. graft. new ant. quadrilateral (C) thigh #2- 23.6(L) x 7.6(W) x 0.4 depth, moderate (C) long drainage, & odor, & 1/2 infection, thick sl. graft, thick & dough in heel; (C) abd wound #1(L) 15.0(W) x 0.4 depth, moderate (C) long drainage, & odor, & 1/2 infection, thick sl. graft & dough in heel, rubbing. Continuing to heal & Complication (C) ankle- area of foot (top) first- elevated, small ant. if, fluid from graft and introduced w/pt to let electro-flow when at appt. today; dimensions- 5.3(L) x 2.7(W) x 1.4 depth, moderate (C) long drainage, & odor, & 1/2 infection at wound site, tendon graftable & some slash in heel, very painful; (C) ankle #2- 4.5(L) x 5.0(W) x 1.4 depth, moderate (C) long drainage, & odor, & 1/2 infection, slash at heel, healing daily. <i>Dr. Carter, M.D., M.C.</i>

Date	Time	Each Entry Requires Physician's Signature
10/10/09	4:17 PM	① Pt. & new complications - to have TTT & inserted ② TTT & inserted ③ TTT & inserted ④ TTT & inserted ⑤ TTT & inserted ⑥ TTT & inserted ⑦ TTT & inserted ⑧ TTT & inserted ⑨ TTT & inserted ⑩ TTT & inserted ⑪ TTT & inserted ⑫ TTT & inserted ⑬ TTT & inserted ⑭ TTT & inserted ⑮ TTT & inserted ⑯ TTT & inserted ⑰ TTT & inserted ⑱ TTT & inserted ⑲ TTT & inserted ⑳ TTT & inserted ㉑ TTT & inserted ㉒ TTT & inserted ㉓ TTT & inserted ㉔ TTT & inserted ㉕ TTT & inserted ㉖ TTT & inserted ㉗ TTT & inserted ㉘ TTT & inserted ㉙ TTT & inserted ㉚ TTT & inserted ㉛ TTT & inserted ㉜ TTT & inserted ㉝ TTT & inserted ㉞ TTT & inserted ㉟ TTT & inserted ㊱ TTT & inserted ㊲ TTT & inserted ㊳ TTT & inserted ㊴ TTT & inserted ㊵ TTT & inserted ㊶ TTT & inserted ㊷ TTT & inserted ㊸ TTT & inserted ㊹ TTT & inserted ㊺ TTT & inserted ㊻ TTT & inserted ㊼ TTT & inserted ㊽ TTT & inserted ㊾ TTT & inserted ㊿ TTT & inserted

Physician's Progress Notes

N6302-T 11/80

[illegible]

Date	Time	Each Entry Requires Physician's Signature
6-1-05		Carry out - Check name of patient of genius - Henry of Illinois. Stay patient qualified - Can't see what we need - next exam is scheduled 6-6-05. <i>[Signature]</i>
6/2/05		Re amikacin dosing: Daily Amikacin 100 mg IV q 24 hrs. Ser. Gentamicin exp. or + Gentamicin UTI. Ser. Strept. @ ~ 0.6. Last level 5/20/05 = 2.1 which is appropriate for q 24 dosing per Hartford nomogram. No renal level indicated at this time. Pharmacy will continue follow. <i>[Signature]</i> PharmD
6/2/05	PM 17:40	as per Dr. Bost Pt kept at CMC for RBE infection; had gone over for pin removal in R ankle. DC ~~exam~~ distal #242 53P2 8/10 <i>[Signature]</i>
		PATIENT IDENTIFICATION
		Stroud John.

Physician's Progress Notes

N6302-T 11/98

A. APUL KATY

62Y 11/22/61

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 06/02/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

Stroud, John

000-485-90-16

PREOPERATIVE DIAGNOSES:

1. Status post severe injury to left ankle with ankle and subtalar dislocation requiring pinning of the subtalar joint and pinning of the ankle joint. The patient developed full-thickness loss on the medial side of his ankle and was treated with a Wound-Evac.

POSTOPERATIVE DIAGNOSES:

1. Status post severe injury to left ankle with ankle and subtalar dislocation requiring pinning of the subtalar joint and pinning of the ankle joint. The patient developed full-thickness loss on the medial side of his ankle and was treated with a Wound-Evac.
2. Necrosis of the posterior tibial tendon, flexor digitorum hallucis tendon, and infection of the ankle joint and subtalar joint with necrosis of all ligaments in the region.

OPERATION PERFORMED:

1. Debridement of wound, right ankle, with removal of necrotic skin, subcutaneous tissues, multiple tendons, and debridement of talar and subtalar joints.
2. Removal of hardware, deep and superficial.
3. Manipulation of knee secondary to stiffness.

SURGEON: M Bosse, M.D.

ASSISTANT: M Harris, M.D.

ANESTHESIA: General.

SPECIMENS: Deep cultures.

DESCRIPTION OF PROCEDURE: After induction of anesthesia, the leg was prepped and draped free. The patient's skin graft site up by the knee was evaluated and found to be clean. We evaluated the knee. The patient had a range of motion of only 30 degrees. I manipulated his knee and was able to get 90 degrees of flexion.

PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 06/02/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

Next, exploration of the foot was performed. We removed the pins and following pin removal we explored the medial side. The patient had significant infection in the area with necrosis of the major tendons. Essentially, we removed all tendons anterior to the posterior tibial nerve.

The ligaments of the ankle joint and the subtalar joint were all necrotic. The patient had pus in the subtalar joint. He had dead muscle posteriorly.

We debrided all tissues back to viable tissue. We let the tourniquet down to check for bleeding. The foot looked viable. A Plastic Surgery consult was obtained intraoperatively. At minimum, this patient will require a free tissue transfer.

Based on the observation of the severe tissue damage, infection, and instability of the joint, and the requirements for a free tissue transfer and likely, at best, an ankle and subtalar fusion, it is my impression that the patient would be better served by amputation. I will speak with him and his family about this and proceed on their desires.

D: 06/02/2005 4:07 P MICHAEL J. BOSSE, M.D.
T: 06/03/2005 1:15 A jab



cc: MICHAEL J. BOSSE, M.D.
MIKE HARRIS, MD

PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

CONSULTATION REPORT

PATIENT: Stroud, John F	HISTORY NO: 000-485-90-16
ATT. MD: MICHAEL J. BOSSE, M.D.	DATE: 06/03/2005
DOB: 03/28/1943	ACCOUNT NO: 0515301007
REQUESTING MD:	LOCATION: EAC E11301

Stroud, John F

000-485-90-16

ADDENDUM ADDED

CONSULTING PHYSICIAN: David Weinrib, M.D.

REFERRING PHYSICIAN: Dr. Michael Bosse.

QUESTION: Antibiotic management for staphylococcal right ankle infection status post trauma.

HISTORY: The patient is a 62-year-old white male who was in a light aircraft plane crash on 4/10/05. He experienced multiple traumas including a subarachnoid and right subdural hematoma, left ocular injury and skull injury requiring plastic reconstruction, L3/4 vertebral body fracture that did not require surgical fixation, pneumothorax on the right side and multiple rib fractures, right femur and ankle fractures, and multiple burns. He had a complicated hospital course that included at least one bacteremic episode with Enterobacter.

He was transferred to the LTAC facility at Mercy Hospital on 5/18/05. There swab cultures were performed on the burn wounds that revealed MRSA at the right ankle and right thigh and Pseudomonas aeruginosa at the abdominal burn. No antibiotics were prescribed as he was afebrile and free of elevated white count.

I spoke by telephone with Dr. Garuba who supervised his therapy there. He reports starting Amikacin for an Enterobacter multidrug resistant urinary tract infection around 5/27. Levofloxacin was also prescribed, but that Enterobacter was not susceptible to it. I did not ask Dr. Garuba why Levaquin was used, but he also coincidentally did grow Pseudomonas aeruginosa from a tracheostomy aspirate also sensitive to that organism. However, chest x-ray 5/27 did not show any pneumonia.

He was transferred to this hospital for further management of purulence from the right ankle on those two antibiotics. Dr. Garuba and the patient's wife both confirm that there was no fever at that hospitalization in the last week or more.

On questioning, the patient is extremely hard of hearing, which was a problem prior to the plane crash. The wife did speak to the patient loudly closely to his ear and he indicated yes and no answers to certain questions. Much of the history was obtained from the chart and in talking to the wife.

The patient denies any pain right now in the right ankle. He does have some sensation in the right foot. The right leg is casted currently. His best functional status at Mercy was that with a lot of assistance he would get up

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-485-90-16
ADM: 06/02/2005

ROOM: EAC E11301

CAROLINAS HEALTHCARE SYSTEM

CONSULTATION REPORT

PATIENT: Stroud, John F	HISTORY NO: 000-485-90-16
ATT. MD: MICHAEL J. BOSSE, M.D.	DATE: 06/03/2005
DOB: 03/28/1943	ACCOUNT NO: 0515301007
REQUESTING MD:	LOCATION: EAC E11301

from the bed to a cardiac recliner chair and sit semi-upright. He's not ambulatory. He can speak through the tracheostomy when it's capped, and expresses wishes. He knows he's at a hospital.

ALLERGIES: Penicillin reaction in the military as a young adult caused "rash and swelling" according to the wife. He's also intolerant of Demerol and codeine.

MEDICATIONS: Currently on -

1. Levofloxacin 500 mg IV q.24 hours.
2. Amikacin 1100 mg IV q.24 hours.
3. Colace.
4. Sliding scale insulin.
5. Diltiazem 30 mg q.8 hours via tube.
6. Protonix 40 mg q. day via tube.
7. Clonidine 0.1 mg q.12 hours.
8. Was on Silvadene cream topically b.i.d. to the wounds, which has been discontinued and substituted for Biatain foam.
9. PRN morphine for pain.
10. Potassium chloride supplements.

PAST SURGICAL HISTORY: Includes removal of a lipoma from the shoulder in the remote past. He required multiple procedures during the recent hospitalization for trauma including 4 K-wires placed in the right ankle. He had plastic surgery to the left skull.

PAST ILLNESSES: Include six years of type 2 diabetes on oral Glucophage therapy as an outpatient, glaucoma requiring eyedrops, kidney stones, but no infectious disease history like tuberculosis, viral hepatitis, or significant bacterial infections prior to this admission.

SOCIAL HISTORY: Lives in Cheraw, SC, married, was working as an independent contractor for construction prior to the injury. Did not question the wife about a history of substance abuse.

FAMILY HISTORY: Negative for TB, otherwise noncontributory for infectious disease problems.

REVIEW OF SYSTEMS: Otherwise noncontributory.

PHYSICAL EXAMINATION:

GENERAL: White male, alert, cooperative with exam and in no acute distress.

PT: Stroud, John F

ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-485-90-16

ADM: 06/02/2005

ROOM: EAC E11301

CAROLINAS HEALTHCARE SYSTEM

CONSULTATION REPORT

PATIENT: Stroud, John F	HISTORY NO: 000-485-90-16
ATT. MD: MICHAEL J. BOSSE, M.D.	DATE: 06/03/2005
DOB: 03/28/1943	ACCOUNT NO: 0515301007
REQUESTING MD:	LOCATION: EAC E11301

VITAL SIGNS: No fever since hospitalization, temperature max 98.4, currently 97.6, current BP 108/70, pulse 108, respiratory rate 18, weight not measured, O2 sat 100%.

SKIN: Has a nicely healing burn with good regrowth of semi-epithelized skin on the right side of the abdominal wall. The whole right leg was casted so I could not inspect the burns or the surgical wound. Did not inspect the backside for decubitus sores, but none apparent on the left leg. Well healed surgical scars on the scalp.

HEAD/NECK: Left eyelid does not open spontaneously by the patient. Did not assess visual acuity, but I'm told he has less vision in the left eye. Right eye good range of motion. Mouth no thrush. Tracheostomy is in place.

LUNGS: Relatively clear, no wheezes or crackles.

HEART: Regular, no murmur or gallop.

ABDOMEN: Soft, nontender, Dobhoff tube is in the nostril to the duodenum.

GENITOURINARY: Circumcised penis without lesions.

RECTAL: Anal exam omitted.

NEUROLOGIC: Omitted. He does have sensation in the right foot distal to the cast.

LABORATORY: From the outside hospital 6/2/05, WBC count: 8400, hemoglobin 9.6, hematocrit 27%, platelets 533,000. Glucose 191, BUN 14, creatinine 0.6, bicarbonate 31, other electrolytes normal.

RADIOLOGY: X-ray 6/1/05 right femur two views shows an interlocked IM nail with anatomic alignment of the fracture with some bridging callus formation at the fracture site. Hip appears normal.

6/1/05 pelvis three views shows moderate fecal load in the colon. He has reconstruction plates on the posterior column of the left acetabulum onto the lower left ischial region. Joint spaces are maintained. Normal healing changes are identified. Femoral head appears normal.

6/105 x-ray right ankle two views shows quadruple K-wire fixation stabilization of the subtalar, tibiotalar articulation with good alignment and there are bone fragments in that area.

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-485-90-16
ADM: 06/02/2005

ROOM: EAC E11301

CAROLINAS HEALTHCARE SYSTEM

CONSULTATION REPORT

PATIENT: Stroud, John F	HISTORY NO: 000-485-90-16
ATT. MD: MICHAEL J. BOSSE, M.D.	DATE: 06/03/2005
DOB: 03/28/1943	ACCOUNT NO: 0515301007
REQUESTING MD:	LOCATION: EAC E11301

Last chest x-ray was on 5/26/05 showing multiple right-sided rib fractures, none in the thorax. There is mild volume loss in the right lung base but no mention of infiltrate.

MICROBIOLOGY: Surgical swab specimen from 6/2/05 shows no PMNs and 1+ gram-positive cocci in pairs. Culture has moderate *Staphylococcus aureus*, susceptibilities pending.

ASSESSMENT AND PLAN:

1. History of significant trauma in early April 2005 including burns to the right leg and fracture to the right femur and ankle.
2. Known methicillin resistant *Staphylococcus aureus* colonization of these wounds.
3. Status post incision and drainage of the right ankle and I believe, but need to confirm, that he may have had removal of the K-wire fixation from the ankle. In speaking to the wife, it sounds like they are deliberating on the options of below knee amputation versus extensive plastic surgery with the aim of limb salvage. For now, start vancomycin 1 gm q.12 hours. Because he's over 60 years of age, he may have a creatinine clearance that approaches 50 ml per minute and so we will check vancomycin levels at the fifth dose and adjust if needed. I will reserve judgment on whether rifampin needs to be added until we have full susceptibility report and understand the plan. He is not on any Coumadin or any other drug that's a clear contraindication to rifampin.
4. Urinary infection with a multidrug resistant *Enterobacter*. He's had eight days of antibiotics. Stop Amikacin and Levaquin. Recheck urine culture 2-3 days off antibiotics to demonstrate cure.

Dr. Lovell will check culture results this weekend. Thanks for the consultation.



D: 06/03/2005 12:33 P DAVID A. WEINRIB, M.D.
T: 06/03/2005 1:13 P miru (and addendum, vital signs added)
000000138/000000157

cc: MICHAEL J. BOSSE, M.D.
ABDUL K. GARUBA, MD
DAVID A. WEINRIB, M.D.

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-485-90-16
ADM: 06/02/2005

ROOM:EAC E11301

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 06/07/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

Stroud, John

000-485-90-16

PREOPERATIVE DIAGNOSES:

1. Infected right ankle and subtalar joint.

POSTOPERATIVE DIAGNOSES:

1. Infected right ankle and subtalar joint.

OPERATION PERFORMED:

1. Debridement of skin and subcutaneous tissue with talectomy of the ankle.

SURGEON: M Bosse, M.D.

ASSISTANT: R J Morgan, M.D.

ANESTHESIA: General endotracheal.

COMPLICATIONS: None.

INDICATIONS FOR PROCEDURE: The patient has continued infection.

DESCRIPTION OF PROCEDURE: After induction of anesthesia, the leg was prepped and draped. We debrided necrotic skin, fascia, tendon, subcutaneous tissue and muscle. We explored the subtalar joint. It was obvious that the subtalar joint was wide open and there were minimal soft tissue attachments.

With a hemostat placed on the opposite side of the talus, it easily extruded itself from the wound and was discarded. It was completely avascular and infected. We debrided the tissues behind it and then packed and closed, and placed in a splint.

IMPRESSION: This patient needs an amputation. I will attempt to schedule this tomorrow if the family permits.

PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John
ATT. MD:
SURGERY DATE: 06/07/2005
DOB:

HISTORY NO: 000-485-90-16
DATE:
LOCATION:
ACC. NO:

D: 06/07/2005 2:26 P MICHAEL J. BOSSE, M.D.
T: 06/08/2005 2:35 P jab

cc: MICHAEL J. BOSSE, M.D.
ROBERT J. MORGAN, MD



PT: Stroud, John
ATD:

ADM:

HIST #: 000-485-90-16

ROOM:

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F
ATT. MD: MICHAEL J. BOSSE, M.D.
SURGERY DATE: 06/08/2005
DOB: 03/28/1943

HISTORY NO: 000-485-90-16
DATE:
LOCATION: EAC E11301
ACC. NO: 0515301007

Stroud, John F

000-485-90-16

PREOPERATIVE DIAGNOSES:

1. Infection right ankle status post tyelectomy for necrosis.
2. Full thickness burns right thigh and abdomen.

POSTOPERATIVE DIAGNOSES:

1. Infection right ankle status post tyelectomy for necrosis.
2. Full thickness burns right thigh and abdomen.

OPERATIONS PERFORMED:

1. Below-knee amputation with primary closure.
2. Split thickness skin graft to thigh and abdominal areas after prepping of the burn sites.

OPERATING SURGEON: Dr. Michael J. Bosse.

ASSISTANT SURGEONS: Dr. Bobby Morgan, and Dr. Josh Patt.

ANESTHESIA: General via ET tube, (tracheostomy tube).

ESTIMATED BLOOD LOSS: 40 cc.

SPECIMENS: Amputated leg.

INDICATIONS: The patient is status post an all terrain accident. He had a dislocation of his talus. The patient developed a full thickness eschar on the medial side and was treated with a wound VAC by the Plastic Surgery Service. He developed a deep infection and it resulted in removal of all tendons and soft tissues of the medial side, and had surgery yesterday. He was found to have a completely devascularized and loose talus that extruded from the wound. He had deep infection below that. The patient is a diabetic. There was no salvage option other than the below-knee amputation in my opinion.

DESCRIPTION: After induction of anesthesia, the leg was prepped and draped free. Tourniquet was placed and was used for about a 1/2 hour during the case.

PT: Stroud, John F
E11301

HIST #: 000-485-90-16

ROOM:EAC

ATD: MICHAEL J. BOSSE, M.D.

ADM: 06/02/2005

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F
ATT. MD: MICHAEL J. BOSSE, M.D.
SURGERY DATE: 06/08/2005
DOB: 03/28/1943

HISTORY NO: 000-485-90-16
DATE:
LOCATION: EAC E11301
ACC. NO: 0515301007

We covered up the distal ankle to prevent contamination as much as possible from the surgical site.

We fashioned a long posterior flap. We made a standard below-knee amputation. We sectioned the tibia one handbreadth below the tibial tubercle and sectioned the fibula 1 cm more proximal. We beveled and smoothed the bone edges. We had sectioned the anterior and lateral compartments and the deep posterior compartment. A long gastroc based posterior flap was maintained.

We identified all of the nerves and retracted those and section applied. We identified all of the vessels and ligated those with both nylon and Hemoclip ligatures.

We trimmed excess tissue off the bottom end of the flap as it was redundant when we tried provisional closure.

After debridement and appropriate clipping of all vessels, we Water Pik'ed with pulse lavage. Following that, we let the tourniquet down and checked hemostasis. We found one area where we still had some ooze and controlled that with an additional ligature. We bovied some muscle bleeders. At the end of the hemostasis phase, the patient was normotensive and there was no significant bleeding.

We then initiated closure. We closed the fascia of the gastroc to the periosteum anteriorly using O Vicryl suture. We then closed skin with 2-0 Vicryl suture subdermally and nylon suture for the skin. A Hemovac drain was placed.

The specimen was taken to a separate back table. A dermatome was available. We had previously shaved the specimen during the prep. We then obtained all of the skin graft off of the amputated leg in order to provide split thickness skin grafting to the patient's thigh and abdominal areas.

Areas that were 7 by 23 and a second area that was 4 by 15 cm on the thigh proximally and then about the knee were prepared by debriding the granulation tissue and exposed necrotic fascia. Once we were down to clean tissues, we took the skin graft that we had salvaged from the amputated part and meshed it to 1:1.5. We then placed the skin graft on this area and got excellent coverage.

At the end of the procedure, we then undraped the abdomen. The patient had a 4 by 10 cm full thickness from the abdomen that was being allowed to granulate. We again prepped the recipient site, and after that, we skin grafted

PT: Stroud, John F
E11301

HIST #: 000-485-90-16

ROOM: EAC

ATD: MICHAEL J. BOSSE, M.D.

ADM: 06/02/2005

CAROLINAS HEALTHCARE SYSTEM

OPERATIVE/PROCEDURE REPORT

PATIENT: Stroud, John F
ATT. MD: MICHAEL J. BOSSE, M.D.
SURGERY DATE: 06/08/2005
DOB: 03/28/1943

HISTORY NO: 000-485-90-16
DATE:
LOCATION: EAC E11301
ACC. NO: 0515301007

it. Skin graft was held in place at all sites with staples. We then covered it with Vaseline gauze, wet cotton balls and compressive dressings.

We then placed the patient's lower extremity in extended wraparound plaster splint. This was done after first putting a contouring compressive dressing over the amputation area.

Final sponge and instrument counts were correct. The patient was transported to the recovery room to recover from the anesthetic.

D: 06/08/2005 9:55 A MICHAEL J. BOSSE, M.D.
T: 06/08/2005 11:16 A sim

cc: MICHAEL J. BOSSE, M.D.

PT: Stroud, John F
E11301
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-485-90-16

ROOM:EAC

ADM: 06/02/2005

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN

Patient Location: CMAJ, ER MAJOR

Exam: 7304, DX FEMUR R/P/E

Clinical Information: 1 APPLE TRAUMA; ;TRAUMA

MRN: 0004859016

Patient Type QER

Accession #: 10512884

Visit #: 8100014567

Completed 4/10/05 9:13 pm

Requesting Provider: CMC, TRAUMA SERVICE, DEFAULT
CMC MEDICAL EDUCATION BUILDING A,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: RIGHT FEMUR TWO VIEWS
DATE OF SERVICE: 04/10/2005, 2037 HOURS

HISTORY: Trauma.

There is a comminuted bending wedge fracture of the distal third of the femoral shaft with an 11 cm long anterior butterfly fragment, posterior displacement of the distal shaft by about 50% and about 40% lateral and 25% anterior angulation. No significant shortening is seen at the fracture site. The proximal and distal ends of the femur are intact.

D: 04/11/2005 00:09 SC: 119

Dictated By: Peter Hindel, M.D.

Transcribed By: DIANE BIRRER

Signed By: PETER HINDEL M.D.

Monday, April 11, 2005 6:35:28AM

Tuesday, April 12, 2005 1:50:18AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
 Carolinas HealthCare System

Patient Name: STROUD, JOHN

Patient Location: CMAJ, ER MAJOR

Exam: 7328, DX ANKLE R/P/E

Clinical Information: 1 APPLE TRAUMA; TRAUMA

MRN: 0004859016

Patient Type: QER

Accession #: 10512912

Visit #: 8100014567

Completed: 4/10/05 8:55 pm

Requesting Provider: CMC, TRAUMA SERVICE, DEFAULT
 CMC MEDICAL EDUCATION BUILDING A,
 CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT ANKLE TWO VIEWS

DATE OF SERVICE: 04/10/2005, 2047

There is a comminuted fracture/subluxation of the talus. The talar body is rotated nearly 90 degrees externally and adducted such that its lateral corner rests again the plafond. Multiple small comminuted fragments are seen in the lateral joint space. The lateral view demonstrates a sliver-like fragment of the anterior process of the talus which remains articulating with the navicular. This would suggest a fracture through at least a portion of the anterior process or neck of the talus. The distal fibula appears grossly intact.

D: 05/11/2005 0006 SC: 119

Dictated By: Peter Hindel, M.D.

Transcribed By: DEBRA DELORME

Signed By: PETER HINDEL M.D.

Monday, April 11, 2005 6:31:03AM

Tuesday, April 12, 2005 1:50:07AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**Patient Location: CMAJ, ER MAJOR****Exam: 7078, CT HEAD SCAN W/O CONTRAST E****Clinical Information: 1 APPLE TRAUMA; ;TRAUMA****MRN: 0004859016****Patient Type QER****Accession #: 10512899****Visit #: 8100014567****Completed 4/10/05 10:34 pm**

Requesting Provider: CMC, TRAUMA SERVICE, DEFAULT
CMC MEDICAL EDUCATION BUILDING A,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: HEAD CT WITHOUT CONTRAST
DATE OF SERVICE: 04/10/2005

COMMENT: Axial CT evaluation of the brain was performed without intravenous contrast.

There is marked soft tissue swelling in the frontal scalp on the left. There is subtle subarachnoid blood in the right sylvian fissure. There is a very thin low density collection over the right convexity which may represent a subdural hygroma. There is no mass effect or midline shift. Please see separate dictation of face CT describing multiple facial fractures. There is air along the medial roof of the left orbit and posterior to the left frontal sinus. Some of this air appeared to be intracranial.

IMPRESSION:

1. Small amount of right sylvian subarachnoid blood. Very thin right convexity low density subdural collection. No mass effect.
2. Small amount of intracranial air associated with left orbit and frontal sinus fractures.

D: 04/11/2005 07:49 SC: 141**Dictated By: Robert Mittl, M.D.****Transcribed By: DIANE BIRRER****Signed By: ROBERT MITTL, M.D.****Monday, April 11, 2005 8:47:13AM****Monday, April 11, 2005 9:40:57AM**

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**MRN: 0004859016****Accession #: 10513171****Patient Location: 5401-01, 5401-01 TIC****Patient Type IP****Visit #: 8100014567****Exam: 7306, DX FOOT R/P****Completed 4/11/05 10:53 am****Clinical Information: 1 APPLE TRAUMA; ;ORDERS****Requesting Provider: MANN, CHRISTOPHER H****PO BOX 32861,****CHARLOTTE, NC 28232****FINAL REPORT****EXAM: RIGHT FOOT, THREE VIEWS****DATE OF SERVICE: 04/11/2005**

No comparison studies are available at this time.

FINDINGS: Bony detail is obscured by overlying cast material. There does however appear to be some talar dislocation possible fracturing in the talas. This could be further assessed with CT scanning if clinically indicated. Also, the alignment of the tibiotalar joint appears to be offset suggesting dislocation in this area as well.

D: 04/11/2005 1202 SC: 151**Dictated By: W. Carey Werthmuller, M.D.****Transcribed By: TAMMY RICHBERG****Monday, April 11, 2005 2:50:28 PM****Signed By: WILLIAM WERTHMULLER M.D.****Tuesday, April 12, 2005 7:50:57AM**

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**MRN: 0004859016****Accession #: 10513170****Patient Location: 5401-01, 5401-01 TIC****Patient Type IP****Visit #: 8100014567****Exam: 9855, DX PELVIS 3 VIEWS P****Completed 4/11/05 10:53 am****Clinical Information: 1 APPLE TRAUMA; ;ORDERS****Requesting Provider: MANN, CHRISTOPHER H****PO BOX 32861,****CHARLOTTE, NC 28232****FINAL REPORT****EXAM: TWO VIEW EXAMINATION OF THE PELVIS****DATE OF SERVICE: 04/11/2005**

Correlation is made with the previous exam earlier in the day.

Left acetabular fracture is again noted without significant interval change. Mild caudal off set of the left parasymphseal region with respect to the right is noted. The rest of the visualized bony structures are grossly intact.

D: 04/11/2005 1159 SC: 151**Dictated By: W. Carey Werthmuller, M.D.****Transcribed By: WENDY SYKES****Tuesday, April 12, 2005 4:25:59 PM****Signed By: WILLIAM WERTHMULLER M.D.****Tuesday, April 12, 2005 5:05:06 PM**

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01 TIC

Exam: **7328, DX ANKLE R/P**

Clinical Information: 1 APPLE TRAUMA; ;ORDERS

MRN: **0004859016**

Patient Type IP

Accession #: **10513172**

Visit #: **8100014567**

Completed **4/11/05 10:54 am**

Requesting Provider: **MANN, CHRISTOPHER H**

PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: THREE-VIEW EXAMINATION OF THE RIGHT ANKLE

DATE OF SERVICE: 4/11/2005

Correlation is made to the foot exam performed at the same time.

Fracture dislocation at the tibiotalar articulation and subtalar articulation is again noted. Bony detail is obscured by overlying cast material.

D: 4/11/05 1203 SC: 151

Dictated By: W. Carey Werthmuller, M.D.

Transcribed By: DENISE HARVEY

Signed By: WILLIAM WERTHMULLER M.D.

Monday, April 11, 2005 2:56:20 PM

Tuesday, April 12, 2005 7:51:06AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

MRN: **0004859016**

Accession #: **10513173**

Patient Location: **5401-01, 5401-01 TIC**

Patient Type **IP**

Visit #: **8100014567**

Exam: **7231, DX LOWER LEG R/P**

Completed **4/11/05 10:55 am**

Clinical Information: **1 APPLE TRAUMA; ;ORDERS**

Requesting Provider: **MANN, CHRISTOPHER H**

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: TWO VIEWS TIBIA AND FIBULA

DATE OF SERVICE: 04/11/2005

Correlation is made to the ankle exam performed at the same time.

FINDINGS: Fracture and dislocation of the ankle is seen. Traction pin projects over the proximal tibia.

D: 04/11/2005 1203 SC; 151

Dictated By: W. Carey Werthmuller, M.D.

Transcribed By: TAMMY RICHBERG

Signed By: WILLIAM WERTHMULLER M.D.

Monday, April 11, 2005 2:53:03 PM

Tuesday, April 12, 2005 7:51:00AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01 TIC

Exam: **9855, DX PELVIS 3 VIEWS P**

Clinical Information: **1 APPLE TRAUMA; ;ORDERS**

MRN: **0004859016**

Patient Type **IP**

Accession #: **10513169**

Visit #: **8100014567**

Completed **4/11/05 10:52 am**

Requesting Provider: **MANN, CHRISTOPHER H**

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: PELVIS, THREE VIEWS

DATE OF SERVICE: 04/11/2005

Correlation is made to the previous exam on 04/10/2005.

FINDINGS: Left acetabular fracture is again noted grossly stable in position and alignment as compared to the prior study. Extensive subcutaneous emphysema projects over the lower pelvis. There is mild caudal offset of the parasymphyseal region with respect to the right. The rest of the visualized bony structures are grossly intact.

D: 04/11/2005 1158 SC: 151

Dictated By: W. Carey Werthmuller, M.D.

Transcribed By: TAMMY RICHBERG

Signed By: WILLIAM WERTHMULLER M.D.

Monday, April 11, 2005 2:47:45 PM

Tuesday, April 12, 2005 7:50:53AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01 TIC

Exam: **7311, DX KNEE R/P**

Clinical Information: 1 APPLE TRAUMA; ;ORDERS

MRN: 0004859016

Patient Type IP

Accession #: 10513174

Visit #: 8100014567

Completed 4/11/05 10:56 am

Requesting Provider: **MANN, CHRISTOPHER H**

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: TWO VIEWS RIGHT KNEE

DATE OF SERVICE: 04/11/2005

No comparison studies are available at this time.

FINDINGS: Traction pin projects over the proximal tibia. A comminuted dislocated femoral diaphyseal fracture seen with anterior angulation. 1/4 shaft width lateral translation of the distal shaft with proximal shaft at fracture site is seen.

D: 04/11/2005 1204 SC: 151

Dictated By: W. Carey Werthmuller, M.D.

Transcribed By: TAMMY RICHBERG

Signed By: WILLIAM WERTHMULLER M.D.

Monday, April 11, 2005 2:54:35 PM

Tuesday, April 12, 2005 7:51:03AM

Carolinas HealthCare System
1000 BLYTHE BLVD CHARLOTTE, NC 28203
Radiological Services
CAROLINAS MEDICAL CENTER

Patient Name: STROUD, JOHN

MRN: 0004859016

DOB: 3/28/43

Age: 62 Y

Sex: M

Patient Status: I

Patient Type: IP

Visit #: 8100014567

Patient Location: 3401-01, 5401-01 TIC

Exam: 7371, SP ANGIO PELVIS W & W/O SELECTIVE

Accession #: 10514244

Completed: Monday, April 11, 2005 02:35:00 PM

History (Reason for exam): TRAUMA

Requesting Provider:

CMC, TRAUMA SERVICE, DEFAULT
CMC MEDICAL EDUCATION BUILDING A
CHARLOTTE, NC 28232

Admitting Provider: CMC, TRAUMA SERVICE, DEFAULT

FINALIZED

EXAM: PELVIC ARTERIOGRAM AND SELECTIVE HYPOGASTRIC ARTERIOGRAM

DATE OF SERVICE: 04/11/2005

HISTORY: Status post pelvic trauma with persistent hemodynamic instability and active bleeding on CT scan.

The patient was placed on the angiography table in the supine position. The right groin was prepped and draped in the usual sterile fashion. The skin and subcutaneous tissues of the right groin were anesthetized with 10 cc of Lidocaine.

The right common femoral artery was accessed with a 19-gauge needle and a Schneider wire. The needle was exchanged for a 5-French Pinnacle sheath. A 5-French Omniflush catheter was placed through the sheath and positioned at the aortic bifurcation.

A single DSA run of the pelvis was performed with the catheter in this location.

The catheter was exchanged for a 5-French C2 catheter which was used to select the left internal iliac artery over a 0.035 guidewire. Two DSA runs were performed with the catheter in this location.

A Waltman loop was formed with the C2 catheter which was then used to select the right internal iliac artery. Two DSA runs were performed with the catheter in this location.

FINDINGS:

1. No evidence of contrast extravasation to suggest active arterial bleeding.

NAME: STROUD, JOHN

CAROLINAS MEDICAL CENTER: RADIOLOGY REPORT

Accession #: 10514244

MRN# 0004859016

SP ANGIO PELVIS W & W/O SELECT

ACCT #: 8100014567

Monday, April 11, 2005

Carolinas HealthCare System
1030 BLYTHE BLVD CHARLOTTE, NC 28203
Radiological Services

CAROLINAS MEDICAL CENTER**Patient Name: STROUD, JOHN****MRN: 0004859016****DOB: 1/28/43****Age: 62 Y****Sex: M****Patient Status: 1****Patient Type: IP****Visit #: 8100014567****Patient Location: 5401-01, 5401-01 TIC****Exam: 7371, SP ANGIO PELVIS W & W/O SELECTIVE****Accession #: 10514244****Completed: Monday, April 11, 2005 02:35:00 PM****History (Reason for exam): TRAUMA**

2. Abnormal appearing internal iliac artery branches bilaterally likely representing spasm.
3. At least one truncated superior gluteal artery branch on the right consistent with injury and thrombosis or tamponade.

The patient tolerated the procedure well. There were no immediate complications. Both internal iliac arteries were embolized with gelfoam through the 5-French C2 catheter. Embolization will be dictated under a separate accession number.

IMPRESSION:

1. No evidence of contrast extravasation to suggest active arterial bleeding.
2. At least one truncated right superior gluteal artery branch consistent with injury and thrombosis or tamponade.

D: 04/13/2005 0953 SC: 121**Dictated by: Jeffrey Stein, M. D.****Transcribed By: PHILLIPS, NANCIE****Verified By: STEIN MD, JEFFREY****Wednesday, April 13, 2005 10:00:16AM****Friday, April 15, 2005 11:51:41AM****(R)**

36240 75736
36246 75736 LT
36245 75736 RT

NAME: STROUD, JOHN
Accession #: 10514244**CAROLINAS MEDICAL CENTER: RADIOLOGY REPORT**
MRN# 0004859016
SP ANGIO PELVIS W & W/O SELECTI**ACCT #: 8100014567**
Monday, April 11, 2005

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01

Exam: 7304, DX FEMUR R/P

Clinical Information: 1 APPLE TRAUMA; EVAL FX FEMUR

MRN: 0004859016

Patient Type IP

Accession #: 10518741

Visit #: 8100014567

Completed 4/12/05 4:33 pm

Requesting Provider: **KELLAM, JAMES**

CAROLINAS MED CTR DEPT OF ORTH, PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT FEMUR, TWO VIEWS SUBMITTED PORTABLY

DATE OF SERVICE: 04/12/2005

Femoral head itself is smooth in contour and well seated with reference to the acetabular cavity. The joint space appears concentrically maintained. Soft tissue injury at the level of the hip is seen. There is a comminuted distal third diaphyseal fracture of the right femur with anterolateral butterfly fragment noted. There is also significant anterior angulation of the distal fracture fragment. No intraarticular extension is seen.

CONCLUSION: Significant soft tissue injury involving principally the soft tissues about the right iliac crest and hip.

Comminuted distal third diaphyseal fracture of the right femur without intraarticular extension and with significant anterior angulation of the distal fracture fragment.

D: 04/13/2005, 0840 **SC:** 151

Dictated By: James Coumas, M.D.

Transcribed By: LINDA WHELAN

Signed By: JAMES COUMAS M.D.

Wednesday, April 13, 2005 9:45:47AM

Tuesday, April 26, 2005 12:58:28 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN

Patient Location: 5401-01, 5401-01 TIC

Exam: 7202, US PERIPHERAL VENOUS LEGS P

Clinical Information: 1 APPLE TRAUMA; LOWER EXT DOPPLERS EVAL DVT

MRN: 0004859016

Patient Type IP

Accession #: 10520056

Visit #: 8100014567

Completed 4/13/05 3:06 pm

Requesting Provider: PATON, BEVERLY L

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: PERIPHERAL VENOUS US BILATERAL LOWER EXTREMITIES

DATE OF SERVICE: 04/13/2005

CLINICAL HISTORY: Lower extremity edema.

FINDINGS: There is normal gray scale, color Doppler, and waveform appearance of the bilateral femoral and popliteal veins. Incidental note is made of subcutaneous edema in the lower extremities bilaterally.

IMPRESSION: No sonographic evidence of deep venous thrombosis in either lower extremity.

D: 04/13/2005 1524 SC: 131

Dictated By: David Pellei, M.D.

Transcribed By: TAMMY RICHBERG

Signed By: DAVID PELLEI M.D.

Wednesday, April 13, 2005 5:07:13 PM

Wednesday, April 13, 2005 5:25:16 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**Patient Location: 5401-01, 5401-01 TIC****Exam: 7819, CT LOWER EXTREMITY W/O R****Clinical Information: 1 APPLE TRAUMA; ;FOR SURGERY****MRN: 0004859016****Patient Type IP****Accession #: 10530718****Visit #: 8100014567****Completed 4/17/05 4:44 pm**

Requesting Provider: PATON, BEVERLY L**PO BOX 32861,****CHARLOTTE, NC 28232**

FINAL REPORT

EXAM: CT RIGHT ANKLE WITHOUT CONTRAST WITH 2D & 3D REFORMATATIONS**DATE OF SERVICE: 04/17/2005****HISTORY: 62 year old male with trauma**

Helical 2 mm thick sections are taken through the right ankle. 2D and 3D reformations are then performed to exclude pathology in the plane of data acquisition.

There is a comminuted fracture dislocation of the talus. Three dimensional reformations best demonstrate the posteromedial dislocation of the talus from the ankle joint with a small in situ fragment of the anterior process of the talus articulating with the lateral margin of the navicular. This fragment measures about 2.6 cm AP and 1.9 cm transverse and about 2 cm vertical. It articulates with about 55% of the talonavicular joint.

There is moderate comminution of the lateral cortex of the displaced talus with small fragments in the tibiotalar joint ranging from several mm to about 1.5 cm in length. There is a vertical fracture extending into the lateral corner of the talar dome but the remainder of the talar dome is intact with its articular surface pointed medially. The anterior surface of the displaced talar dome abuts the posteromedial surface of the tibia. I do not see any definite distal tibial fractures. The calcaneus is intact and the navicular also intact. There is a 4 x 2 mm avulsion fragment arising from the posterior cortex of the distal fibula.

IMPRESSION: Comminuted fracture dislocation of talus with posteromedial displacement of the talar dome and body and an in situ fragment of the anterior process of the talus articulating with the lateral one-half of the talonavicular joint.

D; 04/18/2005 0845 SC: 151**Dictated By: Peter Hindel, M.D.****Transcribed By: DEBRA DELORME****Signed By: PETER HINDEL M.D.****Monday, April 18, 2005 11:17:49AM****Tuesday, April 19, 2005 10:05:58AM**

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN

Patient Location: 5401-01, 5401-01 TIC

Exam: 7311, DX KNEE OR/R

Clinical Information: 1 APPLE TRAUMA;

MRN: 0004859016

Patient Type PRO

Accession #: 10532809

Visit #: 8100014567

Completed 4/18/05 12:40 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: RIGHT KNEE, TWO VIEWS

DATE OF SERVICE: 04/18/2005

Distally inserted intramedullary nail in the femur. The joint is grossly intact.

D: 04/18/2005 1445 SC: 151

Dictated by: William B. Guilford, M.D.

Transcribed By: SUZANNE UPTON

Signed By: WILLIAM GUILFORD M.D.

Monday, April 18, 2005 9:21:15 PM

Tuesday, April 19, 2005 9:50:12AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN
Patient Location: 5401-01, 5401-01 TIC
Exam: 7328, DX ANKLE OR/R
Clinical Information: 1 APPLE TRAUMA;

MRN: 0004859016
Patient Type PRO

Accession #: 10532951
Visit #: 8100014567
Completed 4/18/05 1:20 pm

Requesting Provider: BOSSE, MICHAEL
CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: RIGHT ANKLE TWO VIEWS INTRAOPERATIVE
DATE OF SERVICE: 04/18/2005

Fluoroscopic spot views demonstrate longitudinal K-wire transfixion and vertical transcalcaneal K-wire stabilization of the subtalar joint with maintenance of joint alignment in neutral posture.

D: 04/19/2005 08:50 SC: 151

Dictated By: Brian Howard, M.D.

Transcribed By: DIANE BIRRER
Signed By: BRIAN HOWARD M.D.

Tuesday, April 19, 2005 12:39:22 PM
Tuesday, April 19, 2005 5:25:16 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

MRN: 0004859016

Accession #: 10533825

Patient Location: 5401-01, 5401-01 TIC

Patient Type IP

Visit #: 8100014567

Exam: 7304, DX FEMUR R/P

Completed 4/18/05 7:59 pm

Clinical Information: 1 APPLE TRAUMA; ;X-RAY RIGHT FEMUR AP/LAT

Requesting Provider: PATT, JOSHUA C.

PO BOX 32861-CMC-ORTHOPEDIS DEPARTMENT,
CHARLOTTE, NC 28232**FINAL REPORT****EXAM: RIGHT FEMUR, TWO VIEWS****DATE OF SERVICE: 04/18/2005**

Retrograde interlocked intramedullary nail fixation of spiral mid third distal third junctional fracture with near anatomic alignment. Hip joint and knee joint appear unremarkable. Femoral central line catheter noted. Mildly displaced anterior medial wedge fragment present. Fracture margins appear opposed. No significant angular deformity identified. Segmental views prevent assessment of knee hip rotational alignment.

D: 04/19/2005 0851 SC: 151

Dictated by: Brian Howard, M.D.

Transcribed By: CAROL MILLER

Signed By: BRIAN HOWARD M.D.

Tuesday, April 19, 2005 11:56:56AM

Tuesday, April 19, 2005 5:24:54 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01 TIC

Exam: 7328, DX ANKLE R/P

Clinical Information: 1 APPLE TRAUMA; ;X-RAY RIGHT ANKLE (3 VIEWS)

MRN: 0004859016

Patient Type IP

Accession #: 10533838

Visit #: 8100014567

Completed 4/18/05 8:00 pm

Requesting Provider: **PATT, JOSHUA C.**

PO BOX 32861-CMC-ORTHOPEDIS DEPARTMENT,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT ANKLE, THREE VIEWS

DATE OF SERVICE: 04/18/2005

The mortise is congruent. Multiple triple transcalcaneal vertical K-wires stabilize the subtalar and tibiotalar articulation with a single oblique talonavicular K-wire stabilizing the mid-foot articulation. Joints remain congruent. Bulky plaster cast obscures underlying detail of the bony trabecular assessment.

D: 04/19/2005 0853 SC: 151

Dictated by: **Brian A. Howard, M.D.**

Transcribed By: **PAMELA BAKER**

Signed By: **BRIAN HOWARD M.D.**

Tuesday, April 19, 2005 12:05:21 PM

Tuesday, April 19, 2005 5:25:08 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

MRN: 0004859016

Accession #: 10533835

Patient Location: 5401-01, 5401-01 TIC

Patient Type IP

Visit #: 8100014567

Exam: 7306, DX FOOT R/P

Completed 4/18/05 8:00 pm

Clinical Information: 1 APPLE TRAUMA; ;X-RAY RIGHT FOOT (3 VIEWS)

Requesting Provider: PATT, JOSHUA C.

PO BOX 32861-CMC-ORTHOPEDIS DEPARTMENT,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT FOOT, THREE VIEWS

DATE OF SERVICE: 04/18/2005

Views of the forefoot demonstrate neutral alignment. Bulky overlying plaster cast obscures underlying detail and assessment of bony structure. Quadruple threaded K-wire transfixion stabilization of the talonavicular, tibiotalar and subtalar articulation with neutral posture.

D: 04/19/2005 0852 SC: 151

Dictated by: Brian Howard, M.D.

Transcribed By: CAROL MILLER

Signed By: BRIAN HOWARD M.D.

Tuesday, April 19, 2005 11:59:20AM

Tuesday, April 19, 2005 5:25:00 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

Patient Location: 5401-01, 5401-01 TIC

Exam: 7202, US PERIPHERAL VENOUS LEGS P

Clinical Information: 1 APPLE TRAUMA; ;ULTRASOUND DOPPLER LOWER EXT

MRN: 0004859016

Patient Type IP

Accession #: 10531919

Visit #: 8100014567

Completed 4/18/05 9:14 pm

Requesting Provider: **PATON, BEVERLY L**

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION:

DATE OF SERVICE:

BILATERAL LOWER EXTREMITY COLOR DOPPLER VENOUS ULTRASOUND
04/18/2005 AT 21:08

HISTORY:

Trauma.

COMPARISON:

None available.

FINDINGS:

Both common femoral veins and superficial femoral veins demonstrate normal compressibility, waveform, and augmentation. Neither popliteal vein is visualized.

IMPRESSION:

No gross evidence of DVT.

D: 04/18/2005 21:29 SC: 119

Dictated By: **Rajiv Sharma, M.D.**

Transcribed By: **DIANE BIRRER**

Signed By: **RAJIV SHARMA M.D.**

Tuesday, April 19, 2005 8:57:14AM

Tuesday, April 19, 2005 10:27:30AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**
Patient Location: 5401-01, 5401-01 TIC
Exam: **7078, CT HEAD SCAN W/O CONTRAST**
Clinical Information: 1 APPLE TRAUMA; ;ORDERS

MRN: **0004859016**
Patient Type IP

Accession #: **10543876**
Visit #: **8100014567**
Completed **4/22/05 11:05 am**

Requesting Provider: **PATON, BEVERLY L**
PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: **CT BRAIN WITHOUT ENHANCEMENT**

DATE OF SERVICE: **04/22/2005**

CLINICAL HISTORY: **Trauma.**

PROCEDURE: **Sections cover from the base to the high convexity region.**

FINDINGS: **The study is compared to the prior CT of 04/10/2005.**

The study shows a moderate-sized area of low-attenuation involving the left temporal lobe. This may represent an area of post traumatic edema or infarct. A definite abnormality was not seen in this region on the prior CT from 04/10/2005. The ventricles are of normal size and configuration. There is a small right frontal convexity subdural hygroma that was not seen on the prior study. This maximally measures about 7 mm in thickness. There is a small anterior left frontal subdural hygroma or focally widened subarachnoid space. This is a little more prominent than was seen on the prior scan. There is a small amount of blood superficially in the right parietal area. This was not seen on the prior scan. An area of low-attenuation involves the anterior right frontal lobe that was not seen previously. There is no midline shift or hydrocephalous. Multiple bilateral facial fractures are seen. There is extensive paranasal sinus opacification.

IMPRESSION: **There has developed since the prior CT a moderate-sized area of low-attenuation in the left temporal lobe that may represent post traumatic edema or infarct. There is a right frontal convexity subdural hygroma. Other findings are described above.**

D: **04/22/2005 1116 SC: 141**

Dictated By: **Gary DeFilipp, M.D.**

Transcribed By: **TAMMY RICHBERG**
Signed By: **GARY DEFILIPP M.D.**

Friday, April 22, 2005 8:13:28 PM
Monday, April 25, 2005 4:46:41 PM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

MRN: 0004859016

Accession #: 10546422

Patient Location: 5401-01, 5401-01 TIC

Patient Type IP

Visit #: 8100014567

Exam: 7078, CT HEAD SCAN W/O CONTRAST

Completed 4/23/05 3:33 am

Clinical Information: 1 APPLE TRAUMA; ;R/O CHANGE FROM PRIOR CT

Requesting Provider: CMC, TRAUMA SERVICE, DEFAULT

CMC MEDICAL EDUCATION BUILDING A,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: HEAD CT WITHOUT CONTRAST

DATE OF SERVICE: 04/23/2005

COMMENT:

Axial CT evaluation of the brain was performed without intravenous contrast and compared to a study from 04/22/2005.

There is edema in the left temporal lobe compatible with a subacute contusion. There is a thin right frontal low-density extra-axial collection compatible with a subdural hygroma and superior right frontal edema. All these findings are stable. There is a tiny amount of residual subarachnoid blood. The ventricles are within normal limits. Sulci are mildly prominent.

IMPRESSION:

Stable appearance of the brain from 04/22/2005 with contusions and collections as described above.

D: 04/23/2005 0818 SC: 148

Dictated By: Robert Mittl, M.D.

Transcribed By: **CAROLE ROCKWELL**

CAROLE ROCKWELL

Signed By: **ROBERT MITTL M.D.**

Saturday, April 23, 2005 7:12:08 PM

Saturday, April 23, 2005 7:12:08 PM

Sunday, April 24, 2005 11:04:48AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN	MRN: 0004859016	Accession #: 10551259
Patient Location: 5401-01, 5401-01 TIC	Patient Type IP	Visit #: 8100014567
Exam: 7077, CT FACE AX W/O		Completed 4/26/05 5:27 am
Clinical Information: 1 APPLE TRAUMA; ;CT FACE W/ 3D RECONS S/P ORIF FAC		

Requesting Provider: CMC, TRAUMA SERVICE, DEFAULT
CMC MEDICAL EDUCATION BUILDING A,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: CT OF THE FACE WITH 2D CORONAL MULTIPLANAR RECONSTRUCTION IMAGES AND 3D CT RECONSTRUCTION IMAGES PERFORMED WITHOUT CONTRAST

DATE OF SERVICE: 04/26/2005

CLINICAL HISTORY: Facial fractures, postop.

COMPARISON: CT brain 04/23/2005.

PROCEDURE: Thin section axial images are obtained from the tip of the chin to the low forehead. 2D coronal multiplanar reconstruction images and 3D CT reconstruction images are performed to better assess the patient's fractures and displacements. No contrast is given.

Portions of the brain are included in the study and again show a subdural hygroma over the right frontal convexity with a very slight midline shift to the left. There is a prominent low density area in the left temporal lobe. There is a subtle low density in the inferior left cerebellar hemisphere. No new intracranial lesion is observed.

There are bilateral mandibular condylar neck fractures. The condylar heads are located within the temporal fossae. The left condylar head is in normal position. The right condylar head is rotated inward, with slight outward bowing at the condylar neck fracture site. On the left, there is a slight shortening of the mandibular ramus and condyle length due to an overlap of the fracture fragments. The teeth are wired together approximating a normal dental occlusion. There is a single plate and screw system across the chin fracture. There is a very slight distraction of the fracture. A second plate is not identified.

The bridge of the bony nose is slightly off midline toward the left but relatively straight. The glabella remains depressed into the frontoethmoidal air cells. It's unclear whether this will obstruct drainage of the frontal sinuses which are fully opacified at the moment. The depression of the glabella is slightly greater on the left than the right. There is a titanium-type mesh reconstituting the left orbital floor. This is fairly lower in position than the right orbital floor. In addition, the left malar eminence is displaced laterally and rotated inward. The plate and screw applied to the left zygomatic arch does not firmly anchor the posterior aspect of the arch, and there's a slight bowing deformity of the arch on the left when compared to the right. Left infraorbital rim has a small bony gap in its midportion. There are also fractures at the site of both medial canthal attachments. The globes appear to be intact. The left nasal process of the maxilla is somewhat lateral in position. This displaces the left globe slightly forward, but overall the left orbital volume is enlarged when compared to the right. On the right, there is a fractured orbital floor which approximates normal position. The other orbital bony walls are basically intact and in normal position.

CAROLINAS MEDICAL CENTER 1000 BLYTHE BLVD, CHARLOTTE, NC 28203 (704) 355-2270

Patient Name: STROUD, JOHN	DOB: 03/28/1943	Age: 62

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**MRN: 0004859016****Accession #: 10551259****Patient Location: 5401-01, 5401-01 TIC****Patient Type IP****Visit #: 8100014567****Exam: 7077, CT FACE AX W/O****Completed 4/26/05 5:27 am****Clinical Information: 1 APPLE TRAUMA; CT FACE W/3D RECONS S/P ORIF FAC**

There are fractures of the hard palate, with approximation of normal anatomic alignment. There is diffuse opacification of the paranasal sinuses and mastoid air cells. A Dobbhoff type tube passes through the right nasal air passage.

SUMMARY:

1. The patient's extensive facial and mandibular fractures have been surgically reduced and stabilized as described in detail above. The patient's right subdural hygroma and low density change in the left temporal lobe are stable and unchanged when compared to the brain CT of 04/23/2005.
2. The glabella remains depressed into the frontoethmoidal area, and this depressed bone may obstruct drainage of the frontal sinuses.
3. The orbital volume on the left is enlarged due to a depressed position of the titanium mesh in the left orbital floor area, and the lateral displacement of the left malar eminence as described in detail above.

D: 04/26/2005 08:20 SC: 141**Dictated By: Christopher Ullrich, M.D.****Transcribed By: DIANE BIRRER****Signed By: CHRISTOPHER ULLRICH M.D.****Tuesday, April 26, 2005 12:50:48 PM****Tuesday, April 26, 2005 6:35:05 PM**

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: **STROUD, JOHN**

MRN: **0004859016**

Accession #: **10554293**

Patient Location: **5401-01, 5401-01 TIC**

Patient Type **PRO**

Visit #: **8100014567**

Exam: **9855, DX PELVIS 3 VIEWS OR**

Completed **4/26/05 1:00 pm**

Clinical Information: **1 APPLE TRAUMA;**

Requesting Provider: **BOSSE, MICHAEL**

**CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232**

FINAL REPORT

EXAM: **PELVIS, THREE VIEWS**

DATE OF SERVICE: **04/26/2005**

Fluoroscopic spot views of the left acetabulum demonstrate status post operative reduction and internal fixation with spring marginal plates and parallel contoured reconstruction plates over the posterior column. Multiple views demonstrate no definite intra-articular hardware. Construct appears stable with reduction of posterior column posterior wall fracture fragments with secondary containment by high and low semi-tubular spring plates.

D: **04/27/2005 0851 SC: 151**

Dictated By: **Brian Howard, M.D.**

Transcribed By: **KAREN COSTEA**

Signed By: **BRIAN HOWARD M.D.**

Wednesday, April 27, 2005 10:02:30AM

Wednesday, April 27, 2005 2:15:02 PM

**CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES**

Carolinas HealthCare System

Patient Name: STROUD, JOHN

Patient Location: 5202-01, 5202-01 SBC

Exam: 7202, US PERIPHERAL VENOUS LEGS P

Clinical Information: 1 APPLE TRAUMA; ;R/O DVT

MRN: 0004859016

Patient Type IP

Accession #: 10566669

Visit #: 8100014567

Completed 5/3/05 9:00 am

Requesting Provider: MANSOUR, PAUL G

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: BILATERAL LOWER EXTREMITIES VENOUS DOPPLER EXAM

DATE OF SERVICE: 05/03/2005

CLINICAL HISTORY: Trauma patient, rule out DVT.

There is a bandage overlying the right lower leg and the right lower leg below the level of the knee cannot be examined. There is compressibility, spontaneous and phasic flow noted bilaterally in the femoral, superficial femoral and popliteal veins. There is augmentation with demonstrated valvular competency throughout both lower extremities.

CONCLUSION: Negative bilateral lower extremity venous Doppler exam. The right lower leg cannot be examined because of overlying bandage.

D: 05/03/2005 0943 SC: 131

Dictated by: Dale Shaw, M.D.

Transcribed By: CAROL MILLER

Signed By: DALE SHAW M.D.

Tuesday, May 03, 2005 10:45:22AM

Tuesday, May 03, 2005 11:54:28AM

CAROLINAS MEDICAL CENTER
RADIOLOGICAL SERVICES
Carolinas HealthCare System

Patient Name: STROUD, JOHN**MRN:** 0004859016**Accession #:** 10602606**Patient Location:** E119-01, E119-01 EAC**Patient Type** IP**Visit #:** 8100014567**Exam:** 7078, CT HEAD SCAN W/O CONTRAST**Completed** 5/16/05 3:18 pm**Clinical Information:** 1 APPLE TRAUMA; ;CRASHED PLANE**Requesting Provider:** MCLANAHAN, C. SCOTTCHAR.NEUR.ASSOC., 1010 EDGEHILL RD,
CHARLOTTE, NC 28207**FINAL REPORT****EXAM:** CT SCAN OF THE BRAIN WITHOUT CONTRAST**DATE OF SERVICE:** 05/16/2005; 1517 HOURS**CLINICAL HISTORY:** Trauma.**FINDINGS:** Comparison is made with a prior CT scan of the brain from 04/23/2005.

The study demonstrates a small right frontal, extraaxial hygroma measuring approximately 5 mm and exerting minimal mass effect on adjacent brain. This appears to have evolved since the prior study. There is no intraparenchymal hemorrhage. There is no hydrocephalous. No shift or herniation is noted. The remainder of the study is stable.

IMPRESSION: Small, right frontal, subdural, chronic hygroma. Minimal mass effect on the adjacent brain. This appears to have evolved since the prior study.

D: 05/16/2005 1534 SC: 141**Dictated By:** Jonathan Clemente, M.D.**Transcribed By:** TAMMY RICHBERG

Monday, May 16, 2005 9:58:52 PM

Signed By: JONATHAN CLEMENTE M.D.

Monday, May 16, 2005 10:03:17 PM



Carolina's HealthCare System

CMC-MERCY

RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: 7028-01, 7028-01 7SM

Exam: 70214, SP PICC INSERTION US>2 YRS P

Clinical: -ULTRA LIGHT PLANE CRASH

Information: -PIC LINE INSERTION

MRN: 0003000820

Accession #: 10609671

Patient Type OBL

Visit #: 0513800183

Completed 5/19/05 2:16 pm

Requesting Provider: GARUBA, ABDUL K

3030 SENNA DR,

MATTHEWS, NC 28105

FINAL REPORT

EXAM: PICC LINE INSERTION USING ULTRASOUND AND FLUOROSCOPIC GUIDANCE

DATE OF SERVICE: 05/19/2005

HISTORY: Need for long-term IV access.

PROCEDURE: Informed consent was obtained. The left upper arm was prepped and draped sterilely. Local analgesia was administered. Using a 21-gauge needle, ultrasound and fluoroscopic guidance were used to gain entry into the basilic vein, after which a 0.018 guidewire was passed into the central veins. The needle was removed and a peel-away sheath was advanced over the wire, after which the double lumen PICC line was passed through the sheath and situated with its tip at the cavoatrial junction. The length of the PICC line was 48 cm. The PICC aspirated and flushed readily. Heparinized saline was used to block the catheter. The PICC line was sutured to the skin and a sterile dressing applied. The patient and caregivers were given instructions on proper use and care of the PICC line, including routine flushing and dressing changes.

This procedure was performed by the attending radiologist.

FINDINGS: Post-procedure film revealed good position of the catheter with its tip in the cavoatrial junction.

IMPRESSION: Successful sonographic- and fluoroscopic-guided PICC line placement.

D: 05/19/2005 1411 SC: 121

Dictated by: Jeffrey Stein, M.D.

Transcribed By: CAROL MILLER

Signed By: JEFFREY STEIN MD

Thursday, May 19, 2005 5:06:13 PM

Friday, May 20, 2005 11:07:15AM

CMC-MERCY 2001 VAIL AVENUE, CHARLOTTE, NC 28207 (704) 379-5868
Patient Name: STROUD, JOHN DOB: 03/28/1943 Age: 62 Y Sex: M



Carolinus HealthCare System

CMC-MEDICAL CENTER ASSOCIATES
RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN
Patient Location: CACT, MEDICAL CENTER ASSOC
Exam: 7328, DX ANKLE MINIMUM 3 VIEWS R
Clinical | -ROUTINE MEDICAL EXAM
Information: | -

MRN: 0003000820 Accession #: 10641706
Patient Type PRO Visit #: 0515000621
Completed 6/1/05 3:35 pm.

Requesting Provider: BOSSE, MICHAEL
CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT ANKLE, TWO VIEWS
DATE OF SERVICE: 06/01/2005

The forefoot appears intact. The AP and lateral views of the forefoot demonstrate periarticular bony fragment associated with percutaneous quadruple K-wire transfixion stabilization of the subtalar tibiotalar articulation. Alignment appears near anatomic on the lateral examination. The ankle mortise view is not supplied. AP view of the forefoot shows normal tarsal mid tarsal articulations with normal alignment of the talonavicular calcaneocuboid articulation.

D: 06/02/2005 0838 SC: 151
Dictated By: Brian Howard, M.D.

Transcribed By: KAREN COSTEA
Signed By: BRIAN HOWARD M.D.

Thursday, June 02, 2005 10:12:52AM
Thursday, June 02, 2005 10:31:46AM



Carolinan HealthCare System

CMC-MEDICAL CENTER ASSOCIATES
RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: CACT, MEDICAL CENTER ASSOC

Exam: 7304, DX FEMUR 2 VIEWS R

Clinical: -ROUTINE MEDICAL EXAM

Information: -

MRN: 0003000820

Patient Type PRO

Accession #: 10641703

Visit #: 0515000621

Completed 6/1/05 3:35 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT FEMUR, TWO VIEWS
DATE OF SERVICE: 06/01/2005

FINDINGS: The hip joint is unremarkable. Retrograde interlocked intramedullary nail fixation of spiral mid third distal third right femoral shaft fracture with early bridging remodeling callus across the fracture site with anatomic alignment. Patellofemoral joint is unremarkable. The hip joint appears normal.

IMPRESSION: Retrograde interlocked intramedullary nail fixation of the femur with single interfragmental screw stabilization of secondary fracture propagation line questioned. Anatomic alignment. Normal healing changes identified.

D: 06/02/2005 0849 SC: 151
Dictated By: Brian Howard, M.D.

Transcribed By: KAREN COSTEA
Signed By: BRIAN HOWARD M.D.

Thursday, June 02, 2005 10:14:38AM
Thursday, June 02, 2005 10:31:43AM



Carolinus HealthCare System

**CMC-MEDICAL CENTER ASSOCIATES
RADIOLOGICAL SERVICES**

Patient Name: **STROUD, JOHN**
 Patient Location: **CACT, MEDICAL CENTER ASSOC**
 Exam: **9855, DX PELVIS 3 VIEWS**
 Clinical | -ROUTINE MEDICAL EXAM
 Information: | -

MRN: **0003000820** Accession #: **10641696**
 Patient Type **PRO** Visit #: **0515000621**
 Completed **6/1/05 3:35 pm**

Requesting Provider: **BOSSE, MICHAEL**
CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT**EXAM: PELVIS, THREE VIEWS****DATE OF SERVICE: 06/01/2005**

Moderate fecal loading of the colon identified. Patient status post dual parallel contoured reconstruction plates of the posterior column posterior wall left acetabulum supplementing spring plate superiorly inferiorly with interfragmental screws transfixing the lower left ischial region.

Joint spaces well maintained. Normal healing changes identified. No joint incongruence of hardware is demonstrated. Femoral head appears normal. Incidental finding retrograde interlocking nail fixation of the right femur is present.

D: 06/02/2005 0839 SC: 151**Dictated by: Brian Howard, M.D.**

Transcribed By: **CAROL MILLER**
 Signed By: **BRIAN HOWARD M.D.**

Thursday, June 02, 2005 10:13:47AM
 Thursday, June 02, 2005 10:31:38AM

RECEIVED
 HDI/CONNECTICUT
 05 JUN 28 PM 3:07

Cl. 6/2/05
 UR 70913 1570
 Charlotte
 P.C.



Carolinus HealthCare System

CAROLINAS MEDICAL CENTER

RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: E113-01, E113-01 EAC

Exam: 7304, DX FEMUR R

Clinical Information: -ATTEN-SURG DRESSNG/SUTUR

-HARDWARE REMOVAL/BKA

MRN: 0004859016

Accession #: 10671282

Patient Type IP

Visit #: 0515301007

Completed 6/14/05 2:48 pm

Requesting Provider: MORGAN, ROBERT J

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: RIGHT FEMUR, TWO VIEWS

DATE OF SERVICE: 06/14/2005

The patient is status post retrograde interlocked intramedullary nail fixation of the mid third distal third junctional spiral multifragmented fracture with bulky irritation bridging early callus. Moderate cutaneous staple suture line noted laterally, extending from greater trochanteric region to the lateral supracondylar region suggesting cutaneous myofascial staple suture line. Hip and knee joint appear neutrally aligned. Early bridging irritation callus is noted.

D: 06/14/2005 1538 SC: 151

Dictated By: Brian Howard, M.D.

Transcribed By: KAREN COSTEA

Signed By: BRIAN HOWARD M.D.

Wednesday, June 15, 2005 6:51:07AM

Wednesday, June 15, 2005 12:43:03 PM



Carolinus HealthCare System

CAROLINAS MEDICAL CENTER

RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: E113-01, E113-01 EAC

Exam: 9855, DX PELVIS 3 VIEWS

Clinical: -ATTEN-SURG DRESSNG/SUTUR

Information: -HARDWARE REMOVAL/BKA

MRN: 0004859016

Patient Type IP

Accession #: 10671284

Visit #: 0515301007

Completed 6/14/05 2:49 pm

Requesting Provider: MORGAN, ROBERT J

PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: PELVIS, THREE VIEWS

DATE OF SERVICE: 06/14/2005

Marked fecal loading of the colon is associated with retrograde intramedullary interlocked nail fixation of the right femur with marked progressive heterotopic ossification noted around the left hip with evidence for superior and inferior angled spring plates supplementing the mediolateral contoured reconstruction plates, posterior column. Grade II/III immature heterotopic ossification noted. Compared to the intraoperative views of 04/26/2005, interval exuberant periacetabular heterotopic ossification is noted without loss of reduction. Construct appears relatively stable, however, the degree of heterotopic ossification raises the question of CNS injury.

D: 06/14/2005 1536 SC: 151

Dictated By: Brian Howard, M.D.

Transcribed By: KAREN COSTEA

Signed By: BRIAN HOWARD M.D.

Wednesday, June 15, 2005 6:49:34AM

Wednesday, June 15, 2005 12:42:58 PM

CAROLINAS MEDICAL CENTER 1000 BLYTHE BLVD, CHARLOTTE, NC 28203 (704) 355-2270
Patient Name: STROUD, JOHN DOB: 03/28/1943 Age: 62 Y Sex: M



Carolina's HealthCare System

CMC-MEDICAL CENTER ASSOCIATES

RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: CACT, MEDICAL CENTER ASSOC

Exam: 9855, DX PELVIS 3 VIEWS

Clinical: -ROUTINE MEDICAL EXAM

Information: -

MRN: 0003000820

Patient Type PRO

Accession #: 10820707

Visit #: 0522401404

Completed 8/17/05 2:00 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAMINATION: PELVIS, THREE VIEWS

DATE OF SERVICE: 08/17/2005

There is internal fixation of the left acetabulum. There is substantial heterotopic ossification around the hip. I do not see any articular bridging. The hip is congruent grossly.

D: 08/17/2005 1630 SC: 151

Dictated by: William B. Guilford, M.D.

Transcribed By: SUZANNE UPTON

Signed By: WILLIAM GUILFORD M.D.

Wednesday, August 17, 2005 7:51:23 PM

Thursday, August 18, 2005 12:51:14 PM

Cl. 6/2/05
UR 709151570
Charlotte
P.C.

RECEIVED
HDI/CONNECTICUT
05 AUG 29 AM 10:13



Carolina's HealthCare System

CMC-MEDICAL CENTER ASSOCIATES
RADIOLOGICAL SERVICES

Patient Name: STROUD, JOHN

Patient Location: CACT, MEDICAL CENTER ASSOC

Exam: 7304, DX FEMUR 2 VIEWS R

Clinical: -ROUTINE MEDICAL EXAM

Information:

MRN: 0003000820

Patient Type PRO

Accession #: 10820716

Visit #: 0522401404

Completed 8/17/05 2:00 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

FINAL REPORT

EXAM: TWO VIEWS RIGHT FEMUR

DATE OF SERVICE: 08/17/2005

Internal fixation distal third femoral fracture. Fixation is intact. There is callus at the fracture site and probable early bony bridging.

D: 08/17/2005 1629 SC: 151

Dictated By: W. Guilford, M.D.

Transcribed By: TAMMY RICHBERG

Signed By: WILLIAM GUILFORD M.D.

Wednesday, August 17, 2005 7:48:02 PM

Thursday, August 18, 2005 12:51:10 PM



Carolinus HealthCare System

CMC-MEDICAL CENTER ASSOCIATES

RADIOLOGICAL SERVICES (704) 355-5501

Patient Name: STROUD, JOHN

Patient Location: CACT, MEDICAL CENTER ASSOC

Exam: 9855, DX PELVIS 3 VIEWS

Clinical | -ROUTINE MEDICAL EXAM

Information: | -

MRN: 0003000820

Patient Type PRO

Accession #: 11386585

Visit #: 0609502353

Completed 4/5/06 4:56 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,
CHARLOTTE, NC 28232

Cl. 12/19/05

FINAL REPORT

NR 70913570

p.c. Charlotte
SC

EXAM: PELVIS THREE VIEWS

DATE OF SERVICE: 04/05/2006

Compared to 11/18/2005.

Stable retrograde intramedullary nail fixation on the right hip joint relatively well maintained. Density joint space with minimal marginal sclerosis suggesting minimal early degenerative arthrosis. Asymmetry of the symphyseal region with minor degenerative changes in both right and left sacroiliac joints appear stable.

Stable heterotopic ossification associated with the posterior column dual vertical reconstruction plate fixation augmented by two horizontal laterally spring plates. Joint space is relatively well maintained. However, there is at least Grade III heterotopic mature ossification posterior laterally unchanged in appearance.

IMPRESSION: Stable heterotopic ossification Grade III with evidence of post ORIF fixation of left acetabular posterior column, posterior wall fracture.

D: 04/05/2006, 1659 SC: 151

DICTATED BY: BRIAN ADRIAN HOWARD, M.D.

Transcribed By: GINGER OSBORNE

GINGER OSBORNE

Signed By:

BRIAN HOWARD M.D.

Wednesday, April 05, 2006 9:07:22 PM

Wednesday, April 05, 2006 9:07:22 PM

Thursday, April 06, 2006 8:14:17 AM

RECEIVED
HDI/CONNECTICUT
06 MAY -2 AM 11:27

CMC-MEDICAL CENTER ASSOCIATES 1001 BLYTHE BLVD, CHARLOTTE, NC 28208 (704) 355-5501

Patient Name: STROUD, JOHN

DOB: 03/28/1943

Age: 63 Y

Sex: M



Carolina's HealthCare System

CMC-MEDICAL CENTER ASSOCIATES

RADIOLOGICAL SERVICES (704) 355-5501

Patient Name: STROUD, JOHN

Patient Location: CACT, MEDICAL CENTER ASSOC

Exam: 7304, DX FEMUR 2 VIEWS R

Clinical | -ROUTINE MEDICAL EXAM

Information: | -

MRN: 0003000820

Patient Type PRO

Accession #: 11386584

Visit #: 0609502353

Completed 4/5/06 4:56 pm

Requesting Provider: BOSSE, MICHAEL

CMC, DEPT. OF ORTHO., PO BOX 32861,

CHARLOTTE, NC 28232

FINAL REPORT

EXAM: TWO VIEWS RIGHT FEMUR

DATE OF SERVICE: 04/05/2006

Below knee amputation. Internal fixation and femoral fracture which appears to be healed.

D: 04/06/2006, 0854 SC: 151

Dictated By: W. Guilford, M.D.

Transcribed By: PHYLLIS MCDONALD

Signed By: WILLIAM GUILFORD M.D.

Thursday, April 06, 2006 10:52:32AM

Thursday, April 06, 2006 4:12:28 PM

CMC-MEDICAL CENTER ASSOCIATES 1001 BLYTHE BLVD, CHARLOTTE, NC 28208 (704) 355-5501
Patient Name: STROUD, JOHN DOB: 03/28/1943 Age: 63 Y Sex: M

**CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC**

NAME: STROUD, JOHN
MR#: 0000561
ATTENDING: ABDUL GARUBA, MD
DOB: 03/28/1943

ADMISSION DATE: 05/18/2005
DISCHARGE DATE:
PATIENT TYPE:

ADMISSION HISTORY AND PHYSICAL

STROUD, JOHN

0000561

ATTENDING: Abdul Garuba, M.D.

CHIEF COMPLAINT: The patient is status post ultra light plane crash of 04/10/2005, admitted from Carolinas Health Care System with vertebral fractures, right sacral fracture, left acetabulum fracture, multiple rib fractures, right femur fracture, right ankle fracture, left wrist fracture, subarachnoid and right subdural ~~hemorrhage~~ ^{hemorrhage} as the discharge summary does not say what the involvement of the subarachnoid and right subdural is, complex mid face fractures, left pleural effusion, and bilateral hygromas of the brain.

HISTORY OF PRESENT ILLNESS: This is a 62-year-old Caucasian male who crashed his ultra light plane on April 10, 2005. He was brought into Carolinas Health Care System by helicopter with a Glasgow coma scale reported of 14. His hospital course included chest tube insertions for pneumothorax, right subclavian central line, Intensive Care Unit for coagulopathy, vasopressins and anemia as well as several transfusions, bronchoscopies and vent associated pneumonia, Acinetobacter sepsis as well as C-difficile. He was on an oscillator and then changed to conventional vent. Dopplers done bilateral showed no DVTs. He had several surgeries including open reduction internal fixations for several of his fractures as well as plastics for his multiple facial fractures. He is currently on a trach collar and for the transport from Carolinas Health Care System to Carolinas Speciality Hospital, wound VACs from his abdomen and thigh have been removed and only had saline dressings. Please see discharge summary for detailed identified operations and procedures.

PAST MEDICAL HISTORY: Positive for non-insulin dependent diabetes and glaucoma.

PAST SURGICAL HISTORY: Positive only for a fatty tumor removed just distal to the right scapula.

FAMILY HISTORY: Noncontributory.

PSYCHOSOCIAL HISTORY: The patient drank social alcohol up until six years ago. Following that he had a rare beer. The patient's family

**CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC**

NAME: STROUD, JOHN
MR#: 0000561
ATTENDING: ABDUL GARUBA, MD
DOB: 03/28/1943

ADMISSION DATE: 05/18/2005
DISCHARGE DATE:
PATIENT TYPE:

ADMISSION HISTORY AND PHYSICAL

denies any history of patient smoking or IV drug use.

ALLERGIES: Rash and swelling from CODEINE and PENICILLIN.

REVIEW OF SYSTEMS: The patient is not capable of communicating such.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 98.1 degrees, heart rate 108, respiratory rate is 24, blood pressure is 135/90.

GENERAL: The patient is laying in bed. Currently wounds are being dressed by wound care. He shows clear evidence of hearing and comprehending my questions but admits he cannot identify what year, what month, what day or where he is. He does not respond when I ask him if he remembers the plane crash.

FACE: The patient is status post multiple facial fracture corrections. **EYES:** His left eyelid shows absolutely no nerve intervention. Lifting the left eyelid, the globe is permanently fixated medially and showing no pupillary reaction. Apparently there is no vision in that eye. The right pupil shows extraocular motion intact. Pupil is somewhat dilated and shows very minimal reaction.

EARS: TMs: Left TM is within normal limits. Right TM is 100% occluded by cerumen.
NECK: Trachea is midline. He is trached. There are no bruits, adenopathy or masses noted.

CHEST: Symmetrical, minimal breath sounds but clear to auscultation bilaterally.

HEART: Regular rate and rhythm with no murmurs, gallops or rubs.

ABDOMEN: Good bowel sounds, a little bit firm, questionable tenderness. No guarding or rebound.

SKIN: Shows large secondary burns to the right abdomen, the right thigh, and a third degree burn with tendon visible to the right distal tibia and ankle. All of these wounds are quite impressively large, some showing puss secretion.

GENITALIA: Normal male.

RECTAL: Deferred at this time.

DIAGNOSTIC DATA: Prealbumin is 13, sodium is 136, potassium is 4.7, chloride is 102, carbon-dioxide is 29, glucose is 198, Anion gap is 5, BUN is 15, creatinine is 0.6, albumin is 1.9, total protein 6.4, bilirubin 0.5, alkaline phosphatase is 126, AST is 15, ALT is 15, calcium is 8.3. WBCs are 10.0, RBCs are 3.97, hemoglobin 11.1, hematocrit 11.7, platelets 525,000, MCV 84.9. Blood gas shows a pH of 7.46, PCO2 of 42, PO2 of 108, HCO3 30, BE of 5, FIO2 28%, saturation is 97.4%. Blood cultures are pending.

**CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC**

NAME: STROUD, JOHN
MR#: 0000561
ATTENDING: ABDUL GARUBA, MD
DOB: 03/28/1943

ADMISSION DATE: 05/18/2005
DISCHARGE DATE:
PATIENT TYPE:

ADMISSION HISTORY AND PHYSICAL

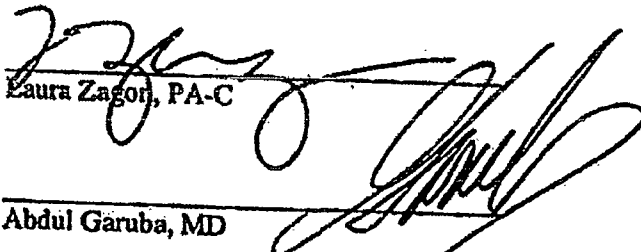
IMPRESSION:

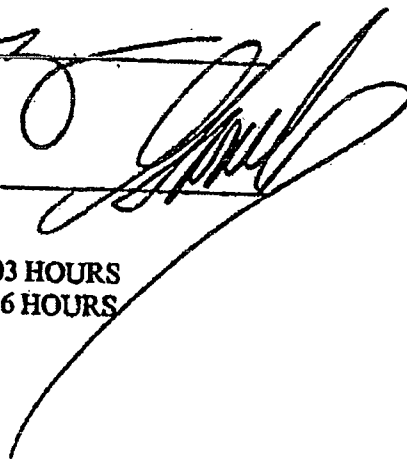
1. Status post ultra light plane crash with multiple facial fractures, left wrist fracture, right lower extremity fractures, brain hygromas, loss of vision in left eye, brain trauma.

PLAN:

1. Brain trauma - possible consult further into his stay here with Charlotte Institute of Rehab Brain Trauma Unit.
2. Multiple second and third degree burns. He is to follow up with Dr. Stanley B. Getz Jr. in two weeks. He is also to follow up with Dr. Michael J. Bosse in two weeks. Wound Care is assigned and applying wound VACs. PT and OT and nutrition consult will be obtained.

DISCUSSION: This is a 62-year-old white male at six weeks status post ultra light plane crash with multiple facial fractures, left wrist fracture, multiple right lower extremity fractures, loss of left eyesight, brain trauma, and second and third degree burns. The patient is to be followed up with plastic surgery, brain trauma, Dr. Hartman, Dr. Bosse, Dr. Getz. Wound Care will be greatly involved. Eventual PT and OT will be important.


Laura Zagor, PA-C


Abdul Garuba, MD

DD: 05/19/2005 1103 HOURS
DT: 05/19/2005 1436 HOURS
LZ: 973:2913162

ADMISSION HISTORY AND PHYSICAL
Page 3 of 3

CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC

claim #
✓ 109-131570

NAME: STROUD, JOHN

MR#: 0000561

ACCT#:

ATTENDING: LAURA ZAGON, PA-C

DOB: 03/28/1943

ADMISSION DATE: 05/18/2005

DISCHARGE DATE: 06/02/2005

LOCATION:

PATIENT TYPE:

ALP DP33 OCT 07 2005

RECEIVED

DISCHARGE SUMMARY

OCT - 6 2005

STROUD, JOHN

0000561

ALP DP33 OCT 07 2005

CHIEF COMPLAINT: The patient was admitted status post an ultra-lite plane crash of 04/10/2005, for which he was admitted to Carolinas Healthcare System for multiple fractures, brain trauma and burns.

HISTORY OF PRESENT ILLNESS: This is a 62-year-old Caucasian male who crashed his ultra-lite plane on April 10, 2005. He was brought in to Carolinas Healthcare System with a Glasgow Coma Scale reported of 14. The hospital course was complicated by pneumothorax, coagulopathies, anemias, bronchoscopies and vent-associated pneumonia as well as Acinetobacter sepsis and C. difficile. He had several surgeries including open reduction internal fixations for several of his fractures as well as plastics for multiple facial fractures. He came into Carolina Speciality Hospital on a trach collar with wound vacs removed from his abdomen and thigh for transport.

HOSPITAL COURSE: The patient was consulted here by Wound Care. Hospital course here at Carolinas Specialty Hospital was not very remarkable. It turned out he had a respiratory culture positive for pseudomonas. His gentamicin and Levaquin started empirically was changed on 05/29 to amikacin. It is important to note this as patient has a history of severe hearing loss. The patient's wife reported today that she thought his hearing was getting worse. Please make note of this along his course of amikacin due to its propensity to affect hearing after a longer period of time than the three days the patient has been on it. The patient had wound vacs put on his abdominal and right lower extremity wounds. The patient was on a 28% T-collar and stayed at that level for the short duration that he was here. Today the patient was sent over to Carolinas Medical Center to see Dr. Michael J. Bosse, the orthopedic surgeon who was supposed to remove the pins in his right lower extremity as well as debride the wound, however, it was noted that the right lower extremity was infected and the patient was admitted back into CMC for care of that infected extremity.

FINAL DIAGNOSES:

1. Pseudomonas pneumonia, amikacin to be continued as noted in the summary above. Please note the patient's preexisting severe hearing loss but wife noting that the hearing has gotten worse. Again, note that amikacin was started only three days ago, on May 29.

DISCHARGE SUMMARY

CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC

NAME: STROUD, JOHN
MR#: 0000561
ACCT#:
ATTENDING: LAURA ZAGON, PA-C
DOB: 03/28/1943

ADMISSION DATE: 05/18/2005
DISCHARGE DATE: 06/02/2005
LOCATION:
PATIENT TYPE:

DISCHARGE SUMMARY

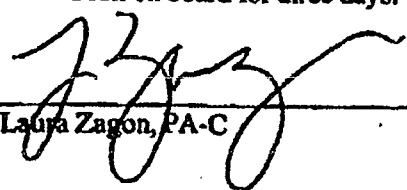
2. Multiple fractures. The patient is currently being attended by Dr. Michael J. Bosse.
3. Apparent infected right lower extremity wound, again Dr. Michael J. Bosse has admitted the patient to CMC for care of this infection.

MEDICATIONS: The patient is on Mucomyst. Mucomyst was to be added to his nebulizer treatments of albuterol and ipratropium q.6h. p.r.n. wheezing or dyspnea. Novolin-R insulin sliding scale, Novolin-N insulin 25 units subcutaneously q.12h., Lantus 5 units subcutaneously at h.s., Protonix 40 mg via tube q.d., diltiazem 30 mg via tube q.8h. hold for heart rate less than 50 or systolic blood pressure less than 100, clonidine 0.1 mg via tube q.12h. hold for systolic blood pressure less than 100, Lovenox 40 mg subcutaneously q.d., Cosopt eyedrops, one drop in each eye b.i.d., Accuzyme topically q.d. to right thigh, right abdomen, right ankle, bacitracin topically b.i.d. to left leg scabbed areas, Levaquin 500 mg IV q.d. times 14 doses, to stop June 8, 2005, amikacin 1100 mg IV given q.d. at 10 p.m. rate 254 cc an hour, started 05/29, Vicodin 5/500 one to two tabs p.o. q.4h. p.r.n. pain, hydromorphone 1 to 3 mg IV q.4h. p.r.n. breakthrough pain.

LABORATORY DATA: As of today, June 2, prealbumin is 14. WBC 8.4, a hemoglobin 9.6, hematocrit 27.4, platelets 533,000, MCV is 85.4. Sodium 138, potassium 3.9, chloride 100, CO2 31, glucose 191, BUN 14, creatinine 0.6, calcium 8.7. Anion gap is 7. Albumin is 2.1, magnesium 1.8, phosphorus 3.4,

IMPRESSION/PLAN:

1. Multiple fractures, second to third-degree burns, current infected right lower extremity wound. The patient being admitted to CMC for wound care, as mentioned above in the summary.
2. Patient was to follow up with Dr. Stanley B. Getz Jr. from Plastics two weeks from his date of admission here, which again was May 18, 2005. I believe Dr. Stanley B. Getz Jr. had been here one time to see the patient. He should be followed up for any further visits necessary and wound care is going to need to be continued as per the wound vacs.
3. As noted above, pseudomonas pneumonia, now on amikacin, please be aware of the patient's severe loss of hearing initially and supposed reporting of decreased hearing, although amikacin has only been on board for three days.


Laura Zagon, PA-C

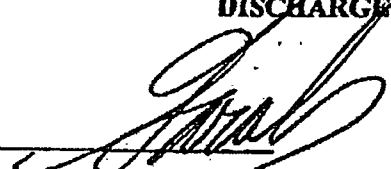
DISCHARGE SUMMARY

**CAROLINAS SPECIALTY HOSPITAL
CHARLOTTE, NC**

NAME: STROUD, JOHN
MR#: 0000561
ACCT#:
ATTENDING: LAURA ZAGON, PA-C
DOB: 03/28/1943

ADMISSION DATE: 05/18/2005
DISCHARGE DATE: 06/02/2005
LOCATION:
PATIENT TYPE:

DISCHARGE SUMMARY


Abdul Garuba, MD

DD: 06/02/2005 1800 HOURS
DT: 06/02/2005 1920 HOURS
LZ: 930:2925342

DISCHARGE SUMMARY
Page 3 of 3



CMC ORTHOPAEDICS
OFFICE NOTES

STROUD, JOHN

H: 3000820

Michael J. Bosse, M.D.

06/03/2005

HISTORY: The patient presents for follow-up. He was involved in a ultra-light air plane crash and sustained multiple lower extremity injuries. He was seen and treated in the emergency room and had surgeries done at CMC. This is his 1st post-op visit to the office. He presents today via stretcher with trach. in place.

PHYSICAL EXAMINATION: The patient is arousable to verbal stimuli. Vital signs are stable. Examination of the right lower extremity at the ankle reveals necrotic skin to the medial aspect at the site of the fracture with ulceration. The patient is seen and examined by Dr. Bosse.

IMPRESSION:

1. Open tibiotalar ankle dislocation right.
2. Left acetabular fracture with ORIF.
3. Right femur fracture with IM nailing.

PLAN:

1. The patient will be scheduled for debridement of this ankle wound as well as hardware removal tomorrow. H&P is completed. The patient will follow-up after his surgery.


Michael J. Bosse, M.D./SIM/hj/F678931.MCA

dd: 06/03/2005 id: 06/04/2005

Dictated by Joanne Holzinger, F.N.P.

CAROLINAS
MEDICAL CENTER

CMC ORTHOPAEDICS
OFFICE NOTES

STROUD, JOHN

H: 3000820

Michael J. Bosse, M.D.

07/06/2005

HISTORY: Mr. Stroud is a 62-year-old male who was involved in an ultralight airplane crash sustaining bilateral lower extremity injuries including left femoral nail treated with intramedullary nail fixation and a below-knee-amputation on June 8, 2005. He's had multiple injuries including closed head injury and left distal radius fracture treated by Dr. Boatright. He's been at a long term care facility currently enrolled in physical therapy to work on range-of-motion and conditioning. He had a right hip fracture/dislocation status post ORIF of the acetabular fracture.

PHYSICAL EXAMINATION: Well developed, well nourished male in no apparent distress. Focused evaluation of bilateral lower extremities demonstrates all incisions are well healed. His skin-graft on the right lower extremity has taken well without problems. His stump on the right lower extremity is shrinking and healing well. Hip range-of-motion is full without restriction, however, his residual limb knee motion is from 10 degrees to 90 degrees. The left lower extremity has brisk capillary refill to the digits. Sensation is intact. He has restricted ankle motion to neutral dorsiflexion and approximately 20 degrees plantar flexion. Knee motion is 10 degrees to 100 degrees. Hip range-of-motion is limited with a 10 degree flexion contracture and flexion to approximately 100 degrees. He has the ability to actively dorsiflex the left lower extremity.

RADIOGRAPHS: Radiographs were reviewed demonstrating the retrograde femoral nail in the left lower extremity with interval fracture healing and the left acetabulum with no change in hardware positioning, concentric hip reduction and presence of a Booker type 2-3 heterotopic ossification.

IMPRESSION: Status post ORIF left acetabulum, retrograde intramedullary nail left femur and right below-knee-amputation.

PLAN: Lengthy discussion was held with the patient and family regarding the above findings and management options. We will continue with physical therapy with aggressive range-of-motion and strengthening exercises for conditioning and eventual transition from a wheelchair to parallel bar standing. In addition, referral to the Amputation Clinic for counseling and future fitting of a

STROUD, JOHN
07/06/2005

OFFICE NOTES - Page 2

H: 3000820

prosthesis in approximately 4 weeks at which time we anticipate his stump will be accepting of a prosthesis. We will see him back in approximately 6 weeks for a repeat clinical and radiographic evaluation.

Michael J. Bosse, MD/SIM/jv/G993483.MCA

dd: 07/06/2005 id: 07/08/2005

CMC Orthopaedics • 1001 Rhyne Boulevard • MCP - Suite 402 • Charlotte, NC 28203
(704)355-5982 • Fax (704)355-2467

P.5

7043559777

CMC ORTHOPAEDICS 12:27PM

CAROLINAS
MEDICAL CENTER

CMC ORTHOPAEDICS
OFFICE NOTES

STROUD, JOHN

H: 3000820

Michael J. Bosse, M.D.

08/19/2005

The patient comes back today in follow up for his amputation of his right leg, his right femur fracture and right thigh burns and his left acetabular fracture. He is doing well. He is progressing to ambulation with a walker. He is being fitted for his prosthesis. He is complaining of some bony prominence in his left hip.

PAST MEDICAL HISTORY: Past medical history and review of systems are unchanged. The patient is doing well and is adjusting to his disabilities.

Evaluation: The vital signs are stable. The patient is alert and oriented times three. His skin is intact. Skin grafts are well healed. His enucleation of his left thigh and non-icteric sclerae on the right. Respirations are symmetrical and unlabored. Pulse are symmetrical. Neurologic is normal. Range of motion of the right knee is from 0 to 90 degrees. Skin grafts of the right thigh are healed. Range of motion of the left hip is restricted to 95 degrees of flexion and 0 degrees external rotation but he has the same external rotation on the opposite side.

X-rays: The patient's femur is healed. The patient has Grade 3, ectopic bone formation on the left.

IMPRESSION:

RECOMMENDATION:

1. Observe HO and range of motion of the left hip.
2. Advance to full weight bearing with a prosthesis.
3. See me back in about 3 months.

Michael J. Bosse, M.D./SIM/h/D751508.MCA

dd: 08/19/2005 id: 08/21/2005

Patient: Stroud, John F	History No: 000-300-08-20
ATT. MD: MICHAEL J. BOSSE, M.D.	Date: 11/18/2005
ACC. No: 0532202032	DOB: 03/28/1943

CMC MEDICAL CENTER PLAZA ORTHOPEDIC CLINIC

Stroud, John F

000-300-08-20

HISTORY OF PRESENT ILLNESS: Mr. Stroud returns for follow-up of his amputation to the right leg, his right femur fracture and left acetabular fracture. He is doing well. He is in the process of seeing another Ophthalmologist regarding his blindness and he has continued to have some improvement in the sight that is remaining in his right eye.

PAST MEDICAL HISTORY, MEDICATIONS and SOCIAL HISTORY: Otherwise, unchanged; please see past notes.

PHYSICAL EXAMINATION:

VITAL SIGNS: Are stable. He is afebrile. He is alert and oriented x3.

SKIN: Is intact. His grafts remain well-healed.

EYES: He has enucleation of the left eye and nonicteric sclera on the right.

RESPIRATIONS: Are symmetric and unlabored.

NEUROLOGIC EXAM: He has a normal neurologic.

EXTREMITIES: He has motion on the right at the knee from 0 to about 100 degrees. Range of motion on the left hip is approximately the same. He has a decrease in external rotation.

RADIOGRAPHS: Are obtained today. He continues to have grade 3 heterotopic ossification formation on the left hip. The femur is healed.

IMPRESSION: The patient will follow-up at his one year date. He needs to continue working on his motion. He is congratulated on his recovery.

D: 11/18/2005 3:04 P J HOLZINGER, NP
T: 11/21/2005 1:45 P smg

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-300-08-20

Page 1 of 1

704355977

CMC ORTHOPAEDICS

Patient: Stroud, John F
ATT. MD: MICHAEL J. BOSSE, M.D.
ACC. No: 0609502353

History No: 000-300-08-20
Date: 04/05/2006
DOB: 03/28/1943

CMC MEDICAL CENTER PLAZA ORTHOPEDIC CLINIC

Stroud, John F

000-300-08-20

Mr. Stroud comes back to the clinic today in followup for an amputation on his right lower extremity and a complex acetabular fracture on his left. The patient is legally blind secondary to major optic nerve damage and has some vision only in his right eye. He walks full time with a walker.

His complaints today are of pain in his amputation area. Further, he relates that his general body pain is decreasing and that his hip pain has improved over the last six months.

The patient states that he has been seen by multi centered at Duke University. His vision is expected himself around his farm and relaxes and watches 12 hours a day.

0609502353

in a low vision program time. He states he occupies his prosthesis approximately 8-

Past medical history and review of systems are u

AIG
clinet 709131570

5/15

PHYSICAL EXAMINATION:

Vital signs stable. The patient is alert and oriented times three. The patient has difficulty with vision, is blind in his left eye. His respirations are normal and unlabored. Pulses are symmetrical and without arrhythmia. His skin is intact. His prosthesis is well-fitting, and there is no breakdown of his stump. Distal neurovascular examination is intact.

X-RAYS: X-rays of his right femur shows a healed fracture. His right amputation stump shows no ectopic bone formation. The patient's left hip shows an acetabular fracture with grade 3 HO and some joint space narrowing.

The patient has no pain in his hip.

IMPRESSION: The patient is doing well.

RECOMMENDATIONS: The patient is released to p.r.n. followup. I advised him regarding the issues of the arthritis of his hip, and should he develop problems in the future, he will come see me.

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-300-08-20

| Patient: Stroud, John F
| ATT. MD: MICHAEL J. BOSSE, M.D.
| ACC. No: 0609502353

| History No: 000-300-08-20
| Date: 04/05/2006
| DOB: 03/28/1943

D: 04/05/2006 5:23 P MICHAEL J. BOSSE, M.D.
T: 04/06/2006 3:20 P mle
000003111
cc:

PT: Stroud, John F
ATD: MICHAEL J. BOSSE, M.D.

HIST #: 000-300-08-20

CHARLOTTE INSTITUTE OF REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.M.D.: SONYA GORSKI RISSMILLER, M.D.	DATE: 09/08/2005
	DOB: 03/28/1943

OUTPATIENT CLINIC NOTE

The patient comes in for a followup following his Charlotte Institute of Rehabilitation stay from 07/11 to 07/26/05 following multitrauma and right below knee amputation. He comes here for prosthetic evaluation.

The patient has been doing fairly well. He continues physical therapy. He is now walking over 100 feet. He has some difficulty using his left arm given his fractures and nerve injury. He feels like overall he is getting stronger. He denies phantom pain. He has occasional phantom sensation. He denies stump pain. He is wearing his shrinker about 10 to 12 hours a day.

PAST MEDICAL HISTORY: Is significant for-

1. Plane crash, which resulted in multiple fractures and blindness.
2. Right below knee amputation 06/08/05.
3. Left wrist fracture.
4. Full thickness burns to right abdomen and right thigh, status post split thickness skin graft.
5. Left arm fracture.
6. Left hip fracture.
7. Right leg fracture.
8. Loss of vision left eye with permanent fixed pupil and ptosis.
9. Decreased vision right eye.

SOCIAL HISTORY: The patient lives with his wife. He was working full-time as a contractor. He does have a supportive family. He does not smoke or drink alcohol.

FAMILY HISTORY: Noncontributory.

FUNCTIONAL HISTORY: The patient is currently minimal assist to contact guard assist ambulating over 100 feet. He did tell me that he walked over 200 feet. Per wife he has difficulty getting out of a chair. He has been sitting in a recliner which is low to the ground, thus he is unable to get up. She actually did purchase him a lift chair.

REVIEW OF SYSTEMS: As above. He denies chest pain, shortness of breath.

PHYSICAL EXAMINATION:

VITAL SIGNS: Temperature 97.8. Blood pressure 132/83. Pulse 77. Weight 138.8.

GENERAL: The patient is awake, alert, very pleasant male in no acute distress.

PT: Stroud, John F

HIST #: 000-300-08-20

ATD: SONYA GORSKI RISSMILLER, M.D.

CHARLOTTE INSTITUTE OF REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.M.D.: SONYA GORSKI RISSMILLER, M.D.	DATE: 09/08/2005
	DOB: 03/28/1943

HEAD, EYES, EARS, NOSE, AND THROAT: Left eye has ptosis, and he cannot open it. He has decreased vision in the right. Otherwise, face is symmetric.

CARDIOVASCULAR: Regular rate and rhythm.

LUNGS: Clear to auscultation.

ABDOMEN: Soft.

EXTREMITIES: Right below knee amputation is well-healed. He has 50% length. Stump is bulbous. It is nontender. He has a well-healed skin graft on the right thigh. Left lower extremity does have atrophy. He has trace edema of both feet. He does have some flexion contractures of the left PIPs. Motor exam reveals good strength in the right upper extremity and right below knee amputation. He does have about 4/5 dorsiflexion and extensor hallucis longus on the left, otherwise, strength is fair. Left upper extremity has 3+ deltoids, 4/5 biceps and triceps, minimal grip and interosscous movement.

ASSESSMENT AND PLAN:

1. Multi fractures. All now healed, though they are limiting his overall function, especially with the left upper extremity fracture.
2. Right below knee amputation. The patient is ready to be fitted with a prosthesis. I am going to set him up with Dr. Kanclos in the Monroe prosthetic clinic, as he lives on the other side of Monroe. His appointment is next Tuesday for prosthetic fitting, and then in a month with Dr. Kanelos. I believe he will be a level 3 ambulator once he gets up and mobile. He was extremely active prior to his accident.
3. Near blindness. This will limit his ambulation as well, and hopefully he will make significant gains with therapy.
4. Left footdrop. I am unsure if he had a peroneal portion of sciatic nerve injury versus peroneal injury at the fibular head. He did have significant hip fracture with repair. This is likely to have caused injury. He may benefit from an electromyogram nerve conduction study in the near future. In the meantime, I am going to order a toe-up orthosis. I think he will be okay ambulating around the house, but for longer distances I think he is going to fatigue. He can get this through Metrolina as well.

PT: Stroud, John F

HIST #: 000-300-08-20

ATT: SONYA GORSKI RISSMILLER, M.D.

CHARLOTTE INSTITUTE OF REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.MD.: SONYA GORSKI RISSMILLER, M.D.	DATE: 09/08/2005
	DOB: 03/28/1943

5. Followup with Dr. Kanclos in 4 weeks.

Over half of 30 minutes was spent discussing patient care and coordination.

D: 09/08/2005 11:46 A SONYA GORSKI RISSMILLER, M.D.

T: 09/08/2005 12:11 P sah

000004387

cc: MICHAEL J. BOSSE, M.D.
SHARON K. KANELOS, MD
SONYA GORSKI RISSMILLER, M.D.

**Dr. John McLeod

PT: Stroud, John F

ATD: SONYA GORSKI RISSMILLER, M.D.

HIST #: 000-300-08-20

AHN: Jeff Haskett

Charlotte Institute of Rehabilitation
1100 BLYTHE BLVD. • CHARLOTTE, NC 28203
704-333-4300

PATIENT'S FULL NAME <u>John Stroud</u>		MEDICAL RECORD #		DOB	WT.
ADDRESS		DATE <u>9/8/05</u>			
MEDICATION	STRENGTH	QUANTITY	Sig (Directions)	REFILLS	
② toe up afo					
dx ② for amp					

DEA #:

VALID FOR ONE CONTROLLED SUBSTANCE RX PER BLANK

PROVIDER'S SIGNATURE

PRINT PROVIDER'S NAME

DOCTOR'S

Charlotte Institute of Rehabilitation
1100 BLYTHE BLVD. • CHARLOTTE, NC 28203
704-333-4300

PATIENT'S FULL NAME <u>John Stroud</u>		MEDICAL RECORD #		DOB	WT.
ADDRESS		DATE <u>9/8/05</u>			
MEDICATION	STRENGTH	QUANTITY	Sig (Directions)	REFILLS	
② BKA prostheses					
Sliver socket PTB			total contact		
level 3 foot					

DEA #:

VALID FOR ONE CONTROLLED SUBSTANCE RX PER BLANK

PROVIDER'S SIGNATURE

PRINT PROVIDER'S NAME

DOCTOR'S

CHARLOTTE INSTITUTE OF REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.M.D.: SHARON K. KANELOS, MD	DATE: 10/10/2005
	DOB: 03/28/1943

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Mr. Stroud presents for reevaluation today. He was last seen by Dr. Rissmiller in the Charlotte clinic on 09/08/05. At that time, she was going to go ahead and begin prosthetic fabrication for him. Since his last visit he received his right below knee prosthesis with a pin suspension and a Venture foot. He continues receiving physical therapy 3x per week. He is not having any phantom pain, some rare phantom sensation. He is having some stump pain after having difficulty donning the prosthesis in the last 2 or 3 days. He had been using a thin liner with a 3 ply socks, but the last 2 to 3 days he had difficulty donning this, even with just the thin liner and a sheath. He complains of some pain along the medial joint line now. The only other complaint is persistent left hip and leg pain, which limits some of his activities. Occasionally some left wrist pain.

PAST MEDICAL HISTORY: Pertinent for-

1. Plane crash which resulted in multiple fractures and blindness in the left eye, and some loss of vision in the right eye.
2. Right below knee amputation on 06/08/05.
3. Left wrist fracture.
4. Full thickness burns to right abdomen and right thigh status post split thickness skin grafting.
5. Left arm fracture.
6. Left hip fracture.
7. Right femur fracture.
8. Nerve injuries that affect hearing.

SOCIAL HISTORY: He lives with his wife. He is working full-time as a contractor. No tobacco. No alcohol.

FAMILY HISTORY: Noncontributory.

CURRENT MEDICATIONS: Include-

1. Timolol drops 0.5% 1 drop daily.
2. Diltiazem 30 mg q.8 hours.
3. Glucotrol 5 mg daily.
4. Clonidine 0.1 mg q.12 hours.
5. Percocet 10/650 q.4 hours as needed for pain. He usually takes 1 to sleep at night, and may take it during the day if he is having significant pain, otherwise does not take it.
6. Calcium 500 mg twice daily.

REVIEW OF SYMPTOMS: Pertinent for what is mentioned in the history of present illness, otherwise unremarkable.

PT: Stroud, John F
ATD: SHARON K. KANELOS, MD

HIST #: 000-300-08-20

Copy

CAROLINAS REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.M.D.: SHARON K. KANELOS, MD	DATE: 03/13/2006
	DOB: 03/28/1943

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Mr. Stroud presents for reevaluation today. He was last seen on 12/12/2005. In the interim he has been doing very well. His major complaint today is that he feels that his right prosthetic leg is longer than the left, and it is causing him some difficulty as he begins to ambulate more. He is very rarely having phantom pain. No significant stump pain, other than a little friction across the kneecap, and some mild distal tibia pain if he does a lot of ambulation. He is donning his prosthesis independently. He is wearing a sheath underneath the liner, and then a single sheath over. No other complaints or problems.

PAST MEDICAL, FAMILY, SOCIAL HISTORY: Unchanged from the visit on 10/10/2005.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS INCLUDE:

1. Timolol 0.5% 1 drop daily.
2. Diltiazem 30 mg q. 8 hours.
3. Glucotrol 5 mg daily.
4. Clonidine 0.1 mg every 12 hours.
5. Percocet 10/650 every 4 hours as needed for pain.
6. Lunesta 2 mg at night.

REVIEW OF SYMPTOMS: Is pertinent for what is mentioned in the HPI. All other review of systems are negative.

PHYSICAL EXAMINATION:

GENERAL: Awake, alert, well-developed, well-nourished male in no apparent distress.

EXTREMITIES: Left hand has increasing strength. Not quite full normal strength and range of motion. Right residual limb skin intact. Full range of motion at the knee. No areas of breakdown. Some mild erythema over the suprapatellar region. He is able to don his prosthesis independently when he stands. He is about 3/8 of an inch long on the prosthetic side compared to his own leg. Adjustments were made to shorten the pilon. After doing that he ambulated much better. The patient felt that his height was even. No other adjustments were made.

PT: Stroud, John F
ATD: SHARON K. KANELOS, MD

HIST #: 000-300-08-20

Copy



Carolina's Rehabilitation
1100 BLYTHE BLVD. • CHARLOTTE, NC 28203
704-355-4300

PATIENT'S FULL NAME <u>John Shaud</u>	MEDICAL RECORD #	DOB	WT
ADDRESS	DATE <u>1/23/07</u>		

MEDICATION	STRENGTH	QUANTITY	Sig (Directions)	REFILLS
(R) BKA liners		(silicone)		
x2				

DEA #: _____

VALID FOR ONE CONTROLLED SUBSTANCE RX PER BLANK

FORM # 324807 (4/06)

Substance (Proprietary/Brand) is trademark unless the provider writes the words "NO SUBSTITUTES" on this Rx.

S. Kanelson
PROVIDER'S SIGNATURE
Sharon Kanelson
PRINT PROVIDER'S NAME
DOCTOR #

CAROLINAS REHABILITATION

PATIENT: Stroud, John F	HISTORY NO: 000-300-08-20
ATT.MD.: SHARON K. KANELOS, MD	DATE: 11/12/2007
ACC. NO:	DOB: 03/28/1943

ASSESSMENT:

1. Right below knee amputation doing very well.
2. Multitrauma with left wrist, left hip and right leg fractures are stable and continue to improve.
3. Decreased vision as a result of his accident. It is unchanged.

PLAN:

1. Continue with his prosthetic ambulation. He may add up to a 3-ply in addition to the 6-ply that he has on now, but will probably not be able to get another 6-ply on due to the pretibial pads.
2. Will have him follow up in six months. But if he is experiencing any pain or problems, will have him follow up sooner.

Electronically Signed by
SHARON K. KANELOS, MD 11/15/2007 16:18

D: 11/12/2007 SHARON K. KANELOS, MD

T: 11/13/2007 5:13 P CXS

000005724

cc: SHARON K. KANELOS, MD

***Dr. John McLeod in Cheraw, South Carolina.

PT: Stroud, John F
ATD: SHARON K. KANELOS, MD

HIST #: 000-300-08-20

Page 2 of 2
Copy

Anson-Union Prosthetic-Orthotic Services
PATIENT PROGRESS REPORT

Prosthetic Management: ARM() AK() BK(☒) SYMES() HIP DIS.()
OTHER()

RIGHT(☒) LEFT() BILATERAL()

Patient's Name: John Stroud

Referring Phys. Rosmiller, MD

Diagnosis: BKA

Practitioner: Jeff Haslett

Initial Date of Service: 9-13-05

Complications: ① Behavioral Amputation 2° to traumatic injury; Left foot A/A & assist with foot drop

Type of Appliance: ② 13K Endolite, complete plug gel liner, energy return foot with mechanical function

Findings & Recommendations:

13-05 Cast and/or Measure: Impression & measurements taken & patient was scheduled for foot fit.

-22-05 Initial Test Socket Procedure: Test fit went very well. I will reduce mold by 1/4" & make definitive pressure from now.

Second Test Socket Procedure:

Alignment:

Practitioner's Signature: Jeff Haslett, MS, CPO, FASOP

Additional Comments:

Anson-Union Prosthetic-Orthotic Services
PATIENT PROGRESS REPORT

Patient's Name: John Stoad Practitioner: Jeff Haskell
DATE OF DELIVERY: 9-29-05

Fit of Appliance is Good: yes; However today I used
3mm liner because leg was swollen. The fit was
6 ply over this liner however once swelling subsides
Alignment is Good: patient will go into thicker liner.

Dynamic Alignment performed & looked good
No Evident of Undue Pressure: none
only typical 1st day pressures present.

Patient Advised as to Proper Care & Maintenance: yes; Donning
slipping & wear/care procedures were thoroughly
reviewed.

Patient Advised to Return in case of Problems & Questions: I will follow
up with patient with Dr. Kowalew at clinic in
2 weeks.

Practitioner's Signature: Jeff Haskell, M.S.C.P.

Additional Comments: _____

Anson-Union Prosthetic-Orthotic Services
PATIENT PROGRESS REPORT

Patient's Name: John Stroud

Referring Phys.: Rasmiller, MD

Diagnosis: ODA

Practitioner: Kanelos, MD

Jeff Haslett

Additional Notes for Adjustments: 10-10-05

Mr. Stroud in for prosthetic clinic with Dr. Kanelos. He had been having problems donning prostheses stating it was too tight. I formed prostheses easily with clear liner of 6 ply sock. We reviewed donning & doffing of wear procedure. I will check up on Mr. Stroud again in 2 weeks.

Jeff Haslett, M.S.C.P.

10-21-05=

Mr. Stroud in for follow up. He is now able to wear ankle foot device with sock on it. However he can only do this for wearing thinner socks with 6 ply sock for half a day. After questioning I found out that he had discontinued wearing sock checker. I told him to begin wearing this again to avoid swelling problems in the morning. Patient already has follow up with Dr. Kanelos @ prosthetic clinic but they will call me if they need to see me for an adjustment before that date arrives.

Jeff Haslett, M.S.C.P.

12-12-05

Mr. Stroud in for clinic visit. All is going well. He trimmed his spare leg. I gave him a pair of provided him with extra socks. He will call as needed & he is scheduled for Dr. Kanelos again in 3 months.

ANSON-UNION REGIONAL PROSTHETIC-ORTHOTIC CENTER

PATIENT PROGRESS REPORT

Patient Name: John Stroud Attending Physician: Kanelos MD

Diagnosis: @ BKA

Practitioner: Jeff Haslett Type of Appliance: @ BKA Prox.

3/30/06

Mr. Stroud in for Dr. Kanelos clinic follow up visit. He's doing very well. Only adjustment needed at this time was shortening 3/8". Mr. Stroud scheduled for 4 month follow up.

Jeff Haslett, MS, PO

7/25/06

Mr. Stroud in for follow up with Dr. Kanelos. He's doing very well with ambulating with walker. Walking easy with prosthesis. He just arrived with physician about his present. He was scheduled for 6 month follow up.

Jeff Haslett, MS, PO

1-23-06=

Mr. Stroud in for follow up with Dr. Kanelos at prosthetic clinic. He's doing fine ambulating however his cast has atrophied to the point where he needs a new cast. Comfort plus 25 E. pin is appropriate size. I provided him with one liner and we will hold to obtain authorization from workman's comp for 2 liners. Once we have this done we will call & schedule him for fitting & check prosthesis fit again.

Jeff Haslett, MS, PO

ANSON-UNION REGIONAL PROSTHETIC-ORTHOTIC CENTER

PATIENT PROGRESS REPORT

Patient Name: John Stroud Attending Physician: S. Kaneko

Diagnosis: ② BKA

Practitioner: Jeff Haskett Type of Appliance: ② BKA ProS

1-29-07 Mr. Stroud is for follow up. His hip fracture is no longer bothering him now that limb is not slipping. I provided him with 25cm cane that we were holding for him. All set for good & no adjustments are needed. He will call as needed.

Jeff Haskett, M.S., CPO

ANSON-UNION REGIONAL PROSTHETIC-ORTHOTIC CENTER

PATIENT PROGRESS REPORT

RECEIVED
FEB 01 2008

2099-07303

Patient Name: John Stroud Attending Physician: S. Karelko, MD

Diagnosis: 897.0 Rt.

Practitioner: Bob Wto, CPO Type of Appliance: BIL PMS

5-28-07 pt for appt, everything checks out
OK. Pt to follow up in 6 months.

W. B. Boush, CPO

11-12-07 Pt is seen for a 6 month fin appt in
prosthetic clinic. Pt is constantly wearing a
12 ply fin. Pt's primary complaint is
bumping on the Portland shelf and noise coming
from the foot. I added 1/2 inch titanic pads to
heel of shoe. So the ply fit as well as
cleared / lubricated the foot. Pt stated the
sock fit fine and the noise from the foot
is diminished. Pt is scheduled to be seen
again in 6 months.

W. B. Boush, CPO

cc: Dr. John McLeod, Cheraw, South Carolina

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: This patient presents for re-evaluation today. He was last seen on 1-23-2007. At that time, we decreased his liner size so that his line would stop sliding, and he has noticed that he has had much improvement. He currently wears his prosthesis all day and is wearing 8 ply socks. No significant problems with pain. He still requires the use of his walker because of balance issues related to his vision, his hearing, and his prosthesis. No significant phantom pain or phantom sensation. He continues to get some improvement in the strength of his hands, as well, especially of the left hand.

PAST MEDICAL HISTORY:

1. Is pertinent for a plane crash with multiple fractures and blindness in the left eye.
2. Right, below knee amputation on 6-8-2005.
3. Left wrist fracture.
4. Full thickness burn to the right abdomen.
5. Right thigh is status post a split thickness skin graft.
6. Left hip fracture.
7. Right leg fracture.
8. Loss of vision in the left eye with significant decrease in vision in the right eye.

SOCIAL HISTORY: He is retired. No tobacco or alcohol. He is married. He is functionally independent with his activities of daily living, although does require a little assistance with donning his prosthesis, due to vision difficulties.

ALLERGIES: No known drug allergies.

MEDICATIONS:

1. Include Timolol.
2. Diltiazem.
3. Glucotrol.
4. Clonidine.
5. Percocet.
6. Lunesta.

REVIEW OF SYSTEMS: Pertinent for those mentioned in the HPI. All other review of systems are negative.

PHYSICAL EXAMINATION:

GENERAL: Awake, alert, well-developed, well-nourished male in no apparent distress.

The right, residual limb has skin intact. Full range of motion. Normal strength. Normal sensation. No tenderness to palpation. He is able to don his prosthesis independently. No significant abnormalities with his gait. He was getting a little patellar pressure on the patellar tendon. Some alignment and adjustments were made which relieved the pressure, including dorsiflexing his foot. This patient ambulates with an excellent gait pattern when using his rolling walker for balance.

ASSESSMENT:

1. Right, below knee amputation, doing well.
2. Multi-trauma with left wrist, left hip, and right leg fractures, stable.
3. Decreased vision, stable.

PLAN:

1. Continue with current prosthetic ambulation.
2. He is to contact us if he continues to have some patellar tendon pain. Otherwise, will just have him follow up in 6 months for re-evaluation.

MD 05/29/2007 18:15

Electronically Signed by SHARON K. KANELOS,

D: 05/23/2007 9:35 A SHARON K. KANELOS, MD
T: 05/24/2007 3:09 P sim

cc: SHARON K. KANELOS, MD

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: The patient presents for reevaluation today. Was last seen on 05/22/2007. In the interim he has been doing fairly well. He is wearing his prosthesis about 7-10 hours per day. Is getting some intermittent phantom pain but it is not significantly limiting his activities. Does complain of a squeaking in the foot as well as some tightness in the popliteal region as well as some tenderness over the patella. He continues to ambulate with a walker because of his vision issues but otherwise no significant complaints.

PAST MEDICAL, SOCIAL HISTORY: Unchanged from the visit on 05/22/2007.

ALLERGIES: No known drug allergies.

MEDICATIONS: Include,

1. Timolol.
2. Diltiazem.
3. Glucotrol.
4. Clonidine.
5. Percocet.
6. Lunesta.
7. Benadryl p.r.n.

Patient did not bring medications today but states that they were unchanged from his previous visit.

REVIEW OF SYMPTOMS: Pertinent for what is mentioned in HPI. All other review of symptoms are negative.

ON PHYSICAL EXAMINATION:

Awake, alert, well-developed, well-nourished male in no apparent distress. Right residual limb has skin intact. There is some mild erythema over the patella as well as anterior medial distal tibia. He also has some erythema in the popliteal fossa. He had been donning a thin ply sheath under his liner and then had been wearing 12-ply over that. Leg felt too tight with a 12-ply on. We did remove 6-ply of the socks. Patient felt as if he was sliding too far into the prosthesis. An adjustment was made, including placing pretibial pads which resolved the problem and still have him a little bit more room in the popliteal fossa. Also adjusted the foot to prevent the squeaking. When he ambulates, when he is using his walker, he has an excellent gait pattern. When he is ambulating without an assistive device, he tends to take shorter stride length on the right and spend a little bit less time weightbearing on that side.

ASSESSMENT:

1. Right below knee amputation doing very well.

2. Multitrauma with left wrist, left hip and right leg fractures are stable and continue to improve.
3. Decreased vision as a result of his accident. It is unchanged.

PLAN:

1. Continue with his prosthetic ambulation. He may add up to a 3-ply in addition to the 6-ply that he has on now, but will probably not be able to get another 6-ply on due to the pretibial pads.
2. Will have him follow up in six months. But if he is experiencing any pain or problems, will have him follow up sooner.

Electronically Signed by SHARON K. KANELOS, MD
MD 11/15/2007 16:18

D: 11/12/2007 SHARON K. KANELOS, MD

T: 11/13/2007 5:13 P CXS

000005724

cc: SHARON K. KANELOS, MD

***Dr. John McLeod in Cheraw, South Carolina.

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Mr. Stroud presents for reevaluation today. Was last seen in the office on 11/12/2007. In the interim, he had been doing fairly well until several weeks ago when he notes he is getting some rubbing and pain behind the knee. Currently, wears his prosthesis all day. He is wearing a six ply socks. No problems with his ambulation. Continues to use the walker because of vision issues. He is using Alps ointment over his patella, which has significantly helped. No other complaints or problems are reported. No changes and no other changes.

PAST MEDICAL HISTORY:

1. Is pertinent for plane crash with multiple fractures.
2. Left eye blindness secondary to his plane crash.
3. Right below-knee amputation on 06/06/2005.
4. Previous left wrist fracture.
5. Full-thickness burn to right abdomen.
6. Right thigh status post a split thickness skin graft.
7. Left hip fracture.
8. Right leg fracture.
9. Decreased vision in the right eye.

SOCIAL HISTORY: He is retired, married. No tobacco or alcohol.

ALLERGIES: No known drug allergies.

CURRENT MEDICATIONS:

1. Timolol.
2. Diltiazem.
3. Glucotrol.
4. Clonidine.
5. Percocet.
6. Lunesta.
7. Benadryl p.r.n.

REVIEW OF SYMPTOMS: Pertinent for what is mentioned in the HPI. All other review of symptoms are negative.

PHYSICAL EXAMINATION:

In general, age-appropriate-appearing, well-developed, well-nourished male in no apparent distress. Right residual limb has skin intact. Skin with some mild erythema over the patella. He has significantly erythematous line in the popliteal region where he is getting pressure from the posterior wall of the socket. When he stands with a six ply socks on, he is sinking a little too far into the prosthesis. Adjustments were made including adding a spacer along the pin to help hold him up out of the socket a little bit as well as adding an extra sock. The seven ply fit did help hold him up out of the socket a little bit better. Additionally, we externally rotated his toe a little bit.

ASSESSMENT:

1. Right below-knee amputation, doing well.
2. Previous history of multi trauma, stable.
3. Decreased vision as a result of his plane crash, unchanged.

PLAN:

1. Will go ahead and get him some new prosthetic socks as well as some sheets for under his liner.
2. He was given Alps lotion to help, so he is not getting rubbing across the patella.
3. For the area in the popliteal fossa, did increase sock ply to seven ply and added a spacer.
4. For gait, externally rotated his toe.
5. Will have him follow up in six months for reevaluation.

Electronically Signed by SHARON K. KANE
MD 05/29/2008 08:14

D: 05/27/2008 9:03 P SHARON K. KANELOS, MD

T: 05/27/2008 10:10 P FCH

000402811..

cc: SHARON K. KANELOS, MD

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Mr. Stroud presents for reevaluation today. Was last seen on 05/27/2008. In the interim he has been doing very well until he about a week ago began experiencing pain in the posterior portion of his calf and on his patella. No areas of breakdown. He and his wife tried adding socks, as well as spacers, which seemed to help, but he continued to have some pain. Wife was concerned about the possibility of breakdown occurring again, and so they came for a visit today. No other complaints or problems are reported. He is wearing between 6-10 ply socks. Is getting some pain over the patella, as well as in the popliteal region. No other complaints or problems are reported.

PAST MEDICAL, SOCIAL, FAMILY HISTORY: Unchanged from the visit on 05/27/2008.

ALLERGIES: No known drug allergies.

MEDICATIONS:

1. Atenolol.
2. Diltiazem.
3. Glucotrol.
4. Clonidine.
5. Percocet.
6. Lunesta.
7. Benadryl p.r.n.

REVIEW OF SYMPTOMS: Pertinent for what is mentioned in the HPI. All other review of symptoms are negative.

PHYSICAL EXAMINATION:

Awake, alert, well-developed, well-nourished male, no apparent distress. Right residual limb has some erythema over the patella, as well as erythema in the popliteal region. No breakdown. His liner appears to be bunching when he is bending the knee and is creating pressure on the popliteal region. The posterior brim of his socket is creating the rest of the pressure. Able to ambulate with an excellent gait pattern when he wears his prosthesis.

ASSESSMENT:

1. Right below-knee amputation.
2. Residual limb pain, even with multiple modifications to the socket.

PLAN:

1. Will go ahead and refabricate his socket as his current socket is at least three years old. Recommend trying a flexible liner which will enhance the bending at the knee without

bunching up.

2. Will have him follow up with me once his socket has been completed.

Electronically Signed by SHARON K. KANE—
MD 08/18/2008 08:16

D: 08/11/2008 5:35 P SHARON K. KANELOS, MD

T: 08/13/2008 10:08 A SAH

000561279

cc: SHARON K. KANELOS, MD

MONROE PROSTHETIC CLINIC NOTE

HISTORY OF PRESENT ILLNESS: Mr. Stroud presents for reevaluation today. He was last seen in the office on 08/11/2008. In the interim he did receive a new prosthesis, and an adjustment was made around the knee which completely resolved his knee pain, and patient has had none since that time. He reports he is wearing the prosthesis all day, ambulating with his rolling walker, mainly due to his vision. No significant problems with phantom pain.

PAST MEDICAL, SOCIAL, FAMILY HISTORY: Unchanged from the visit on 05/27/2008.

ALLERGIES: No known drug allergies.

MEDICATIONS:

1. Atenolol.
2. Diltiazem.
3. Glucotrol.
4. Clonidine.
5. Percocet.
6. Lunesta.
7. Benadryl p.r.n.

REVIEW OF SYMPTOMS: Pertinent for what is mentioned in the HPI. All other review of symptoms are negative.

PHYSICAL EXAMINATION:

In general, age-appropriate appearing, well-developed, well-nourished male in no apparent distress. Right residual limb has skin intact. No erythema. No areas of breakdown. He is able don his prosthesis independently. Ambulates with an excellent gait pattern.

ASSESSMENT:

1. Right below-knee amputation.
2. Right residual limb pain has resolved with socket refabrication.

PLAN:

1. Continue with prosthetic wear as he is doing.
2. Will have him follow up in six months for reevaluation.

MD 12/01/2008 08:16

Electronically Signed by SHARON K. KANELOS,

D: 11/25/2008 3:35 P SHARON K. KANELOS, MD

T: 11/26/2008 8:37 A SAH

000866850

cc: SHARON K. KANELOS, MD

North Carolina Neuropsychiatry
5208 Park Road
Charlotte, NC 28209

Independent Medical Evaluation

PATIENT: John Stroud
DOB: 03/28/43
DOI: 04/10/05
DOE: 05/07/08

RECEIVED
MAY 30 2008
2094.07303

REFERRAL: Workmen's Compensation AIG Claims Services.

MEDICAL RECORD REVIEW: Initial emergency intake reports a Glasgow Coma Scale (GCS) of 14. He is responsive to voice and is reported to have taken 20 minutes to be extracted from the wreckage of his "nose-dived" plane. They suspect there was no loss of consciousness on the scene. Exam shows right pupil 4 mm and reactive, left pupil 7 mm nonreactive, fixed medially. A head CT initially reported as negative, however, (later scanned that day?) reports "traumatic" subarachnoid hemorrhage near the right Sylvian fissure, left and right frontal subdural hematoma without mass effect and small intracranial air associated with the left orbital frontal sinus fracture. Posttrauma Day #1 note describes him as being placed on a ventilator, paralyzed, and sedated. On 04/15/05 GCS is 3. He is on fentanyl, Ativan, Norcuron for muscle cramps. He is described as doing "remarkably well". Repeat head CT on 04/22/05 shows left anterior temporal lobe edema/ischemia, a small left anterior frontal subdural hematoma, and a small right parietal hygroma. The left temporal lobe lesion is compatible with a subacute contusion. Repeat scan on 04/23/05 shows no change and does comment on a "tiny" subarachnoid hemorrhage. On that day his GCS is 4. On 04/25 GCS increases to 9 and remains in that range until 05/10/08. On 05/03/08 mental status is described as improving but still depressed. On 05/05/08 he is responsive but does not follow commands and cannot sustain arousal. There is occasional agitation. Anisocoria is noted. Fevers are returning but Neurosurgery cancelled out meningitis. Rehabilitation note from 05/18/05 reports comprehension but no orientation. 05/18/08 speech therapy note reports impaired attention, recall, initiation or algorithm comprehension. 06/20/08 pastoral notes described the patient as upbeat and optimistic. States he has the best wife in the world. He feels "blessed" for his right foot amputation because "it hurt and got in the way".

Additional injuries at the time of accident includes L3-L4 end plate fracture, left acetabular fracture right ankle and femur fracture. Pelvic bleed right pneumothorax with rib fracture, multiple facial fractures requiring initial cricothyroidectomy in the emergency room and later tracheotomy in the critical care. Jaws needed to be wired shut. Blood in both tympanic membranes is noted. Complications of the right ankle injury including infection later demanded a right below-knee amputation. There are severe burns at the right thigh and abdomen regions. Ophthalmology note describes left eye closed with ptosis. O.U. shows glaucoma, O.S. shows cataract, esotropia and optic nerve damage.

PATIENT: John Stroud
Page 2

Pre-injury physician notes are then reviewed. In 2003 an orthopedic note describes him as fully oriented with a normal affect. Primary care notes from 1993 up to 2007 expressed no concerns of mental status functioning. He is placed on testosterone therapy for hypogonadism and Lunesta for insomnia.

HPI: Today patient is a 65 yowm interviewed alone but brought to the appointment by his secretary. He states he is here "because my lawyer told me to come". He thinks of the accident daily upon awakening in the morning. No intrusive re-experiencing or avoidance behaviors throughout the day. Lunesta has been partially helpful for sleep. He feels he has accepted the accident but at one point in his recovery there was suicidal ideation. He will not elaborate on this further. He notes his memory is better for the past than recent events. His wife and secretary manage his appointments and medications. His children apparently are managing his business.

PAST PSYCHIATRIC HISTORY: None.

PAST MEDICAL HISTORY:

1. Concussion. This was on 07/15/04, a backhoe rolled over him. There was loss of consciousness. GCS was 15. No pupillary signs were noted.
2. Diabetes.
3. Renal stones.
4. Hypogonadism.
5. Insomnia.
6. Congenital hearing loss.

ALLERGIES: Codeine and penicillin.

MEDICATIONS: Lunesta 2 mg q.h.s., timolol eye drops, lisinopril 10 mg daily, metformin 500 mg b.i.d., Glucotrol 5 mg q.d., diltiazem 120 mg q.d., clonidine 0.1 mg b.i.d., and Percocet 10/650 1/2 to 1 q. 6h p.r.n. pain.

SOCIAL HISTORY: There was some level of heavy drinking until his 50s when he stopped cold turkey after he was diagnosed with diabetes. No current alcohol, tobacco or substance misuse. He drinks a cup of coffee daily. He is a high school graduate. He was apparently a successful general contractor in the construction business. He still has some involvement with the company but more out of courtesy and in an advisory position. He denies early traumatic stress.

FAMILY HISTORY: Negative for psychiatric illness.

REVIEW OF SYSTEMS: Notable for daily physical limitations, pain related to his received injuries.

PHYSICAL EXAM: Pulse 80 beats per minute, blood pressure 176/106 mmHg that remained at this level after a repeat. Height is 5'9-1/2", weight is 176 pounds.

PATIENT: John Strickland

Page 3

General: He is wearing hearing aids and right lower leg prosthesis. He has a walker with him. There is an old healed vertical scar in the mid forehead. There is stiffness in the left arm and hip. Dexterity in the right hand is good. Left eye is closed. Right eye perception is limited but ocular motility is full. He is able to read large words accurately.

Mental Status Exam: The patient is casually dressed and somewhat disheveled. He is alert and oriented. Recall of recent events is vague at times. He relates his history independently. He tracks conversation well. He is quite talkative, opinionated and boisterous. Every two to three sentences include a curse word. At one point he invites me to go visit topless dancers with him. There is one episode of labile tearfulness when describing his physical disabilities. He seems embarrassed and regroups fairly quickly. No morbid ruminations are elicited. He is not preoccupied with regrets or anger of events surrounding the accident. He is somewhat arrogant but not grandiose. No delusionality. He can be rambling but there is no flight of ideas. He is not interacting with hallucinations. No suicidality. Insight seems partial. He is cooperative with the examination. He is oriented to the year but not to month. He does know the current presidential candidates.

DATA: Computer Cognitive Testing: CNS Vital Signs Battery standard scores are:
summary index 60 (very low) memory 54 (very low)
verbal memory 48 (very low) visual memory 77 (low)
psychomotor speed 49 (very low) reaction time 50 (low)
complex attention 73 (low) cognitive flexibility 72 (low)
processing speed 53 (very low)

Patient reports adequate effort and comprehension.

Symbol-digit coding was extremely slow and possibly invalidating his processing speed and psychomotor speed scores. His right hand is also grossly impaired relative to the left on finger-tapping test though it is more dexterous on physical exam. Complex reaction time is slowed relative to simple reaction time. On Stroop test there is no evidence of disinhibition. Shifting attention test is mildly slowed. Excessive errors noted. Unresponsive to randomly changing rules. Continuous performance test was mildly slowed and there were excessive errors of omission.

Bedside Cognitive Testing:

Rey 15-item screen was 6/15 suggesting less than full effort. He confabulated an extra symbol which follows an overlearned sequence pattern.

RAVLT shows immediate recall of 2/15 (very impaired). There was a depressed learning curve peaking at 5/15 by trial 4 but declining at 3/15 on trial 5 suggestive of fatigue. There is a sustained self-generated intrusion word. There is some loss of primacy effect. Immediate recall on List B is better at 4/15. Brief delayed recall is 2/15 (nonsignificant decline). Long delayed recall remained at 2.

FAS scored 18 (impaired at 1-3%).

Design fluency produced only two configurations with four lines in 60 seconds with a repeat and they were all mild variances of the initial configuration (very impaired).

PATIENT: John Str...

Page 4

Attempt to copy a 3D drawing reverted to a related image from procedural memory. Clock drawing test showed correct number sequence and spacing. Time was correct though hands were sloppily placed.

Rating Scales:

Neuropsych Questionnaire. Severe = learning, mood stability and sleep. Moderate = impulsivity, memory, anxiety and fatigue.

General symptom Checklist rates the following as severe:

1. Not being able to remember things.
2. Easily annoyed.
3. Lack of energy.
4. Doing things slowly to be sure they are correct.
5. Difficulty falling asleep.
6. Mind going blank.
7. Hopeless about the future.
8. Arguing with others often.
9. Feeling worthless.
10. Worrying something is wrong with your mind.

Beck Anxiety Inventory is 10 (mild).

Beck Depression Inventory is 27 (moderate).

Personality Assessment Inventory showed a consistent response style. There is no evidence of an intentional effort to portray himself as being free of common shortcomings. Additionally there is no evidence that he was motivated to create a more negative or pathological clinical picture. Significant clinical elevations were with distress over his physical functioning and a significant depressive experience. He also notes mood swings as being rapid and extreme. Self-concept is generally negative with variation from periods of relative self-confidence to harsh self-criticism and self-doubt based on current circumstances. Interpersonal style is described as pragmatic and independent. His perceived level of environmental stress and social support are both average. There is no endorsement of suicidal ideation.

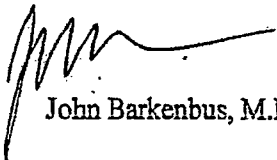
SUMMARY: Medical records show evidence of anatomical injury to the brain on CT scans that are consistent with his mechanism of traumatic injury. The initial lucidity with which he presented is somewhat atypical but was quickly lost suggestive of an expanding intracranial volume (hematoma or general cerebral edema). There is evidence of posttraumatic amnesia lasting at least one month. Though mention is made of a prior concussion, there are no documented concerns of pre injury cognitive decline or aberrant mood states. It is unclear at what level he was functioning in his occupation prior to the accident (presumably intact as he was solo flying planes) but he seems definitely unable to return to this now even beyond his physical limitations. Rating scales and psychiatric examination do show some mood lability and depression though his somewhat overbearing manner is the more immediate finding noted. His mood instability could be

PATIENT: John Stro...
Page 5

a product of damage to frontotemporal regions of the brain or a reactive mood state but we would need collaborative history to premorbid personality before declaring this a new change for him. Cognitive testing today showed an impulsive style with some fluctuating effort at times. Computer testing likely overestimates his impairment but deficits in new learning, processing speed, and strategic mental searches are demonstrated in this and on bedside cognitive testing. These difficulties are common sequelae of closed head injuries such as the one the patient sustained.

RECOMMENDATIONS:

1. There are no follow-ups for treatment scheduled. Lunesta has been partially helpful. I would clarify premorbid and current level of interpersonal, cognitive and community functioning. I would consider a trial of an antidepressant as well.



John Barkenbus, M.D.

CNS Vital Signs Clinical Report	Test Date: May 07 2008 13:47:52
Subject ID: JohnStroud	Administrator: administrator
Language: English (United States)	Age: 65

Above average domain scores indicate a standard score in that domain of greater than 109. Average is 90-109. Low Average is 80-89. Below Average is 70-79. Very Low is less than 70. Reaction times are in milliseconds. An * denotes that "lower is better", otherwise higher scores are better.

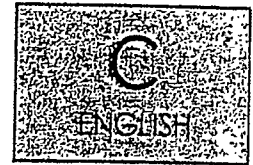
Patient Profile:	Percentile Range			> 74	25 - 74	9 - 24	2 - 8	< 2
	Standard Score Range			> 109	90 - 109	80 - 89	70 - 79	< 70
Domain Scores	Subject Score	Standard Score	Percentile	Above	Average	Low Average	Low	Very Low
Neurocognition Index (NCI)		60	1					x
Memory	70	54	1					x
Verbal Memory	34	48	1					x
Visual Memory	36	77	6				x	
Psychomotor Speed	46	49	1					x
Reaction Time*	1137	50	1					x
Complex Attention*	30	73	4				x	
Cognitive Flexibility	-5	72	3				x	
Processing Speed	4	53	1					x
Social Acuity	-6							
Reasoning	-5							
Executive Functioning	-2	73	4				x	
Working Memory	2							
Sustained Attention	17							
Total Test Time (min:secs)	59:03			Total time taken to complete the tests shown.				

Verbal Memory Test (VBM)	Score	Mean±1SD	
Correct Hits - Immediate	5	9 - 15	A Memory test: Subjects have to remember 15 words and recognize them in a field of 15 distractors. The test is repeated at the end of the battery. "Correct Hits" refers to the number of target words recognized. Low scores indicate verbal memory impairment. Deficits in delayed recognition occur in patients with early dementia.
Correct Passes - Immediate	13	13 - 15	
Correct Hits - Delay	2	7 - 13	
Correct Passes - Delay	14	13 - 15	
Visual Memory test (VIM)	Score	Mean±1SD	
Correct Hits - Immediate	7	11 - 14	A Memory test: Subjects have to remember 15 geometric figures, and recognize them in a field of 15 distractors. The test is repeated at the end of the battery. "Correct Hits" refers to the number of target figures recognized. Low scores indicate visual memory impairment. Deficits in delayed recognition occur in patients with early dementia.
Correct Passes - Immediate	12	7 - 13	
Correct Hits - Delay	7	10 - 14	
Correct Passes - Delay	10	6 - 13	
Finger Tapping Test (FTT)	Score	Mean±1SD	
Right Taps Average	9	40 - 63	Motor speed and fine motor control test: There are three rounds of tapping with each hand. Low scores indicate motor slowing. Most people are faster with their preferred hand but not always.
Left Taps Average	32	38 - 60	
Symbol Digit Coding (SDC)	Score	Mean±1SD	
Correct Responses	5	29 - 53	Psychomotor speed and visual-motor coordination test: Errors may be due to impulsive responding, misperception or confusion. SDC is very sensitive to aging and also keyboarding skills. SDC is a two minute test.
Errors*	1	0 - 3	
Stroop Test (ST)	Score	Mean±1SD	
Simple Reaction Time*	399	198 - 427	Processing speed, cognitive flexibility, and inhibition/disinhibition test: Prolonged reaction times indicate cognitive slowing/impairment. Errors may be due to impulsive responding, misperception or confusion. Reading disabilities may be apparent in this test. The ST generates simple and complex reaction times.
Complex Reaction Time Correct*	943	542 - 781	
Stroop Reaction Time Correct*	1331	619 - 924	
Stroop Commission Errors*	3	0 - 4	

CNS Vital Signs Clinical Report			Test Date: May 07 2008 13:47:52
Subject ID: JohnStroud		Administrator: administrator	
Language: English (United States)		Age: 65	
Shifting Attention Test (SAT)	Score	Mean±1SD	
Correct Responses	20	32 - 52	Executive control and set shifting test: Subjects have to adjust their responses to randomly changing rules. The best scores are high correct responses, few errors and a short RT. Normal subjects may be slow but accurate, or fast but not so accurate. ADD disabilities may be apparent.
Errors*	22	1 - 19	
Correct Reaction Time*	1652	999 - 1399	
Continuous Performance Test (CPT)	Score	Mean±1SD	
Correct Responses	37	40 - 40	Sustained attention, or vigilance, and choice reaction time test: Most normal subjects obtain near-perfect scores on this test. A long response time may suggest cognitive slowing and/or impairment. More than 2 errors (total) may be clinically significant. More than 4 errors (total) indicate attentional dysfunction.
Omission Errors*	3	0 - 0	
Commission Errors*	2	0 - 2	
Choice Reaction Time Correct*	571	367 - 456	
Perception Of Emotions Test (POET)	Score	Mean±1SD	
Correct Responses	9		"Social cognition" or "emotional acuity" test: The positive emotions are "happy" and "calm" and the negative emotions are "angry" and "sad". Social cognition has been defined as "the way in which people make sense of other people and themselves". It is the ability to perceive and understand social information. In conditions like autism and schizophrenia, individuals are compromised in their capacity to relate to other individuals appropriately because they lack the "theory" that others have, in fact, a "mind". To a greater or a lesser degree, they are blind to the motivations, intentions or emotions of other people. The reaction times in POET are much longer than in the other tests, indicating the complexity of central processes governing emotional acuity.
Average Correct Reaction Time*	1530		
Omission Errors*	3		
Commission Errors*	15		
Correct Hits - Positive Emotions	6		
Reaction Time - Positive Emotions*	1479		
Correct Hits - Negative Emotions	3		
Reaction Time - Negative Emotions*	1632		
Nonverbal Reasoning Test (NVRT)	Score	Mean±1SD	
Correct Responses	5		Abstract problem-solving test: It is comprised of 15 matrices, or visual analogies. The matrices are progressively more difficult. Each is presented for 14.5 seconds. "Concrete thinking" and "mental inflexibility" are signs of impaired conceptual functions. Both signs are present in the examination of patients who have had severe brain injuries, or who have dementia or schizophrenia.
Average Correct Reaction Time*	5984		
Commission Errors*	10		
Omission Errors*	0		
Working Memory Test (WMT)	Score	Mean±1SD	
Part 1 - Average Correct Response Time*	594		Part one is a simple Reaction Time task; the subject must press the space bar as soon as he/she see any figure at all. Parts 2, 3 and 4 are tests of sustained attention, variants of the Continuous Performance Test. In Part 2, the subject is asked to respond to one particular target, but not to any others. Discrimination is required, so the reaction times that are generated are "choice RT's". Part 3 is a "one back" CPT. The subject has to respond to a figure only if the figure immediately preceding was the same. Part 3 also measures working memory. Working memory is one's span of attention. It is very sensitive to medication effects. Part 4 is a "two-back" CPT. It is a difficult task. It measures working memory as well as sustained attention. It is similar in concept to the PASAT, although in this test one has to keep track of an ongoing array of abstract forms, in different colors. The Working Memory Test generates domain scores for sustained attention and working memory. It is sensitive to mild cognitive dysfunction, of any cause.
Part 2 - Correct Responses	6		
Part 2 - Average Correct Response Time*	515		
Part 2 - Incorrect Responses*	1		
Part 2 - Average Incorrect Response Time*	552		
Part 2 - Omission Errors*	0		
Part 3 - Correct Responses	10		
Part 3 - Average Correct Response Time*	672		
Part 3 - Incorrect Responses*	0		
Part 3 - Average Incorrect Response Time*	0		
Part 3 - Omission Errors*	6		
Part 4 - Correct Responses	6		
Part 4 - Average Correct Response Time*	742		
Part 4 - Incorrect Responses*	4		
Part 4 - Average Incorrect Response Time*	1377		
Part 4 - Omission Errors*	10		
Short Form Health Survey (SFHS)	Score	Mean±1SD	
Physical Functioning			Test Incomplete As part of the Medical Outcomes Study (MOS) — a multi-year,
Role Functioning - Physical			
Role Functioning - Emotional			
Energy/Fatigue			
Emotional Well Being			
Social Functioning			

NORTH CAROLINA NEUROPSYCHIATRY, PA

REY AUDITORY VERBAL LEARNING TEST



NAME John Stroud DATE 5/7/08

INSTRUCTIONS: I am going to read a long list of words. When I finish, try to remember as many words as you can. You can repeat the words in any order. Then I shall repeat the list a few more times, to see how many words you can learn. Ready? (Read the words at the rate of one per second.)

After each trial: That was a good start. Now I shall repeat the list again. How many words can you remember, including the words you remembered on the previous trials.

After the fifth trial: Good. Try to remember as many of these words as you can, because I am going to ask you to repeat them later. (Only psychologists: Now I am going to read a different list of words. Try to remember as many as you can. Ready?)

Then: How many words can you remember from the first list - the one I gave you 5 times. Ready?

LIST C	1	2	3	4	5	6	7
book					/	drum	/
flower						curtain	/
train						bell	/
rug	/					coffee	
meadow						school	
harp						parent	
salt						moon	
finger			/	/		garden	
apple	/	/	/	/		hat	/
chimney						farmer	/
button						nose	
log		/		/		turkey	
key						color	
rattle			/	/	/	house	
gold		/	/	/	/	river	/
	2	3	4	5	3	4	2

apple
gold

laborers	7 ± 2.1	10.5 ± 1.9	12.9 ± 1.6	13.4 ± 2	13.9 ± 1.2
professionals	8.6 ± 1.5	11.8 ± 2	13.4 ± 1.4	13.8 ± 1.1	14 ± 1
students	8.9 ± 1.9	12.7 ± 1.8	12.8 ± 1.5	13.5 ± 1.3	14.5 ± 0.7
eld labor	3.7 ± 1.4	6.6 ± 1.4	8.4 ± 2.4	8.7 ± 2.3	9.5 ± 2.3
eld prof	4 ± 2.9	7.2 ± 2.9	8.5 ± 2.5	10 ± 3.3	10.9 ± 2.9

SUM 1-5	17
TRIAL 6	
TRIAL 7	

VFT

NAME John Strand DATE 5/7/08
 SEX M AGE 65 YRS. OF EDUCATION 12

Instructions to be read to patient: I will say a letter of the alphabet. Then I want you to give me as many words that begin with that letter as quickly as you can. For instance, if I say "B", you might give me "bad, battle, bed..." I do NOT want you to use words which are proper names, such as 'Boston, Bob, or Buick.' Also, do NOT use the same word again with a different ending such as 'eat' and 'eating'. Any questions? Begin when I say the letter.

The first letter is F. Go ahead. Begin timing immediately.
 Allow 1 minute for each letter (F, A, and S).

F

1. fair
2. farmer
3. fun
4. food
5. faith
6. frank
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

TOTAL: 6

A

1. apple
2. an
3. ate
4. at
5. and
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

TOTAL: 5

S

1. state
2. steal
3. South
4. shoe
5. sheet
6. sin
7. see
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

TOTAL: 7

RAW SCORE: 18

%TILE: 1-31
(impaired)

Neuropsych Questionnaire	Test Date: 2008-05-07 14:39:53
Subject ID: JohnStroud	Administrator: Patty Morford
Language: English (United States)	Age: 65
Respondent: patient	Time Frame: over the past month

The NP Questionnaire is a list of the symptoms that occur in different neuropsychiatric disorders. The patient is asked if he or she has had any of the symptoms, or "problems," over a period of time specified by the examiner. The default span is "the past couple of weeks." Each symptom is rated on a scale of zero to three. Zero is "not a problem". One is a "mild problem," that is, present, but not particularly troubling. Two is a "moderate problem," that is, troubling, but not disabling. Three is a "severe problem," that is, disabling, because it significantly interferes with the patient's day-to-day life.

The symptoms associated with each different condition are added up and averaged. The patient's scores are presented in the table below. Scores are reported on a scale of 0 (not a problem) to 300 (severe). As a rule, scores above 225 indicate a severe problem; scores from 150-224 indicate a moderate problem; and scores from 75-149, a mild problem.

		SYMPTOM SCALE				
CATEGORY	SCORE	50	100	150	200	250
ATTENTION	127					
IMPULSIVE	167					
LEARNING	254					
MEMORY	209					
ANXIETY	200					
PANIC	33					
AGORAPHOBIA	100					
OBSSESSIONS & COMPULSIONS	142					
SOCIAL ANXIETY	75					
DEPRESSION	147					
MOOD STABILITY	238					
MANIA	75					
AGGRESSION	120					
PSYCHOTIC	43					
SOMATIC	67					
FATIGUE	183					
SLEEP	300					
SUICIDE	83					
PAIN	125					
SUBSTANCE ABUSE	0					

		CONDITIONAL SCALE				
CATEGORY	SCORE	50	100	150	200	250
AVERAGE SYMPTOM SCORE	134					
PTSD scale	161					
BIPOLAR scale	159					
AUTISM scale	158					
ASPERGERS scale	140					
ADHD short test	147					
MCI short test	171					
CONCUSSION short test	189					
TY_DEPRESSION short test	177					

The "symptom scale" indicates patient scores in specific symptom clusters. The "conditional scale" reflects patient scores relative to specific conditions, and to the VS Short Tests. The "average symptom score" is the mean of all symptoms; it is a calculation that reflects the patient's overall symptom load.

SYMPTOM LIST

The following symptoms were reported as "severe": LEARNING, MOOD STABILITY, SLEEP

The following symptoms were reported as "moderate": IMPULSIVE, MEMORY, ANXIETY, FATIGUE

ABOUT THE NEUROPSYCH QUESTIONNAIRE

NAME JOHN E. STROUDDATE 05/14/08

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	NOT AT ALL	MILDLY It bothered me a little	MODERATELY It was very unpleasant, but I could stand it	SEVERELY I could barely stand it
1. Numbness or tingling.		X		
2. Feeling hot.			X	
3. Wobbliness in legs.		X		
4. Unable to relax.		X		
5. Fear of the worst happening.	X			
6. Dizzy or lightheaded.		X		
7. Heart pounding or racing.	X			
8. Unsteady.		X		
9. Terrified.	X			
10. Nervous.		X		
11. Feelings of choking.	X			
12. Hands trembling.	X			
13. Shaky.	X			
14. Fear of losing control.		X		
15. Difficulty breathing.	X			
16. Fear of dying.	X			
17. Scared.	X			
18. Indigestion or discomfort in abdomen.		X		
19. Faint.	X			
20. Face flushed.	X			
21. Sweating (not due to heat).	X			

10 = MILD



Symptom Checklist

North Carolina Neuropsychiatry, PA

NAME: JOHN F. STROUD

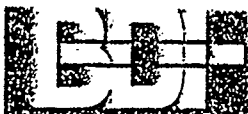
DATE: 05/06/08

INSTRUCTIONS: Below is a list of problems that people sometimes experience. Read each one carefully and mark the appropriate box that best describes how much that particular problem has bothered you within the last week.

HOW MUCH WERE YOU BOTHERED BY:	Not at all	Minimal	Moderate	Severe	Item#
1. Headaches	0	1	2	3	1
2. Nervousness or shakiness	0	1	2	3	2
3. Unpleasant thoughts that you can't get out of your mind	0	1	2	3	3
4. Feeling faint or dizzy	0	1	2	3	4
5. Loss of sexual interest or pleasure	0	1	2	3	5
6. Feeling critical of others	0	1	2	3	6
7. Feeling that someone else can control your mind	0	1	2	3	7
8. Believing others are to blame for your problems	0	1	2	3	8
9. Not being able to remember things	0	1	2	3	9
10. Feeling concerned about being sloppy or careless	0	1	2	3	10
11. Getting annoyed or irritated easily	0	1	2	3	11
12. Pains in your heart or chest	0	1	2	3	12
13. Feeling scared in open spaces or out in public	0	1	2	3	13
14. Feeling a lack of energy or feeling slower than usual	0	1	2	3	14
15. Ideas of ending your life	0	1	2	3	15
16. Hearing voices that others don't	0	1	2	3	16
17. Trembling	0	1	2	3	17
18. Feeling that you can't trust most people	0	1	2	3	18
19. Lack of appetite	0	1	2	3	19
20. Crying easily	0	1	2	3	20
21. Being shy or nervous around the opposite sex	0	1	2	3	21
22. Feelings of being trapped	0	1	2	3	22
23. Suddenly feeling frightened for no reason	0	1	2	3	23
24. Temper outbursts that were out of your control	0	1	2	3	24
25. Feeling scared to leave your house alone	0	1	2	3	25
26. Blaming yourself for things	0	1	2	3	26
27. Lower back pain	0	1	2	3	27
28. Feeling blocked from completing tasks	0	1	2	3	28
29. Feeling lonely	0	1	2	3	29
30. Feeling sad	0	1	2	3	30
31. Worrying too much	0	1	2	3	31
32. Feeling a lack of interest in things	0	1	2	3	32
33. Feeling afraid	0	1	2	3	33
34. Having your feelings hurt easily	0	1	2	3	34
35. Others knowing your private thoughts	0	1	2	3	35
36. Feeling others are unsympathetic or don't understand you	0	1	2	3	36
37. Thinking that people are not friendly or don't like you	0	1	2	3	37
38. Having to do things slowly to make sure they are correct	0	1	2	3	38
39. Heart pounding or racing	0	1	2	3	39
40. Nausea or stomach upset	0	1	2	3	40
41. Feeling inferior to others or not as important	0	1	2	3	41
42. Muscle soreness	0	1	2	3	42

43. Feeling that others are watching or talking about you	0	1	2	3	43
44. Difficulty falling asleep	0	1	2	3	44
45. Having to check and re-check what you did	0	1	2	3	45
46. Feeling indecisive	0	1	2	3	46
47. Feeling scared to use buses, subways, or trains	0	1	2	3	47
48. Trouble catching your breath	0	1	2	3	48
49. Hot or cold flashes	0	1	2	3	49
50. Avoiding certain things or places because they scare you	0	1	2	3	50
51. Your mind going blank	0	1	2	3	51
52. Numbness or tingling in your body	0	1	2	3	52
53. A lump in your throat	0	1	2	3	53
54. Feeling hopeless about the future	0	1	2	3	54
55. Poor concentration	0	1	2	3	55
56. Feeling weak	0	1	2	3	56
57. Feeling tense or worked up	0	1	2	3	57
58. Your arms or legs feeling heavy	0	1	2	3	58
59. Ideas of death or dying	0	1	2	3	59
60. Eating too much	0	1	2	3	60
61. Nervousness when people watch or talk about you	0	1	2	3	61
62. Sensing that you are not your own	0	1	2	3	62
63. The urge to injure or hurt someone	0	1	2	3	63
64. Waking up earlier than normal	0	1	2	3	64
65. Repetitive gestures like touching, counting, or washing	0	1	2	3	65
66. Restless or disturbed sleep	0	1	2	3	66
67. The urge to break or destroy things	0	1	2	3	67
68. Having ideas or opinions that disagree with others	0	1	2	3	68
69. Feeling self-conscious	0	1	2	3	69
70. Feeling uncomfortable in crowds	0	1	2	3	70
71. Feeling that everything involves effort	0	1	2	3	71
72. Terror or panic attacks	0	1	2	3	72
73. Feeling uneasy over eating or drinking in public	0	1	2	3	73
74. Arguing with others often	0	1	2	3	74
75. Feeling uneasy when left alone	0	1	2	3	75
76. Not receiving enough credit for your achievements	0	1	2	3	76
77. Feeling lonely even when you are around others	0	1	2	3	77
78. Feeling restless and fidgety, like you can't sit still	0	1	2	3	78
79. Feeling worthless	0	1	2	3	79
80. Sensing that something bad will happen to you	0	1	2	3	80
81. Yelling or throwing things	0	1	2	3	81
82. Worrying about fainting in public	0	1	2	3	82
83. Feeling that you will be taken advantage of	0	1	2	3	83
84. Thoughts about sex that bother you a lot	0	1	2	3	84
85. Believing that you should be punished for your sins	0	1	2	3	85
86. Terrifying thoughts and images	0	1	2	3	86
87. Worrying that something bad is wrong with your body	0	1	2	3	87
88. Never being able to feel close to another person	0	1	2	3	88
89. Feeling guilty	0	1	2	3	89
90. Worrying that something is wrong with your mind	0	1	2	3	90

NUMBER OF "MODERATE"	?	TOTAL SCORE	
NUMBER OF "SEVERE"			



Date: _____

Name: JOHN F. STROUD Marital Status: M Age: 65 Sex: M
Occupation: SELF- CONSTRUCTION Education: 12 YRS

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one** statement in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

- 0 I do not feel sad.
- ☒ 1 I feel sad much of the time.
- 2 I am sad all the time.
- 3 I am so sad or unhappy that I can't stand it.

2. Pessimism

- 0 I am not discouraged about my future.
- ☒ 1 I feel more discouraged about my future than I used to be.
- 2 I do not expect things to work out for me.
- 3 I feel my future is hopeless and will only get worse.

3. Past Failure

- 0 I do not feel like a failure.
- 1 I have failed more than I should have.
- ☒ 2 As I look back, I see a lot of failures.
- 3 I feel I am a total failure as a person.

4. Loss of Pleasure

- 0 I get as much pleasure as I ever did from the things I enjoy.
- 1 I don't enjoy things as much as I used to.
- 2 I get very little pleasure from the things I used to enjoy.
- ☒ 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

- 0 I don't feel particularly guilty.
- ☒ 1 I feel guilty over many things I have done or should have done.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6. Punishment Feelings

- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- ☒ 3 I feel I am being punished.

7. Self-Dislike

- 0 I feel the same about myself as ever.
- ☒ 1 I have lost confidence in myself.
- 2 I am disappointed in myself.
- 3 I dislike myself.

8. Self-Criticalness

- 0 I don't criticize or blame myself more than usual.
- ☒ 1 I am more critical of myself than I used to be.
- 2 I criticize myself for all of my faults.
- 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- ☒ 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10. Crying

- 0 I don't cry anymore than I used to.
- ☒ 1 I cry more than I used to.
- 2 I cry over every little thing.
- 3 I feel like crying, but I can't.

8 + 6 = 14

Subtotal Page 1

11. Agitation

- 0 I am no more restless or wound up than usual.
- ☒ 1 I feel more restless or wound up than usual.
- 2 I am so restless or agitated that it's hard to stay still.
- 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- 0 I have not lost interest in other people or activities.
- ☒ 1 I am less interested in other people or things than before.
- 2 I have lost most of my interest in other people or things.
- 3 It's hard to get interested in anything.

13. Indecisiveness

- 0 I make decisions about as well as ever.
- ☒ 1 I find it more difficult to make decisions than usual.
- 2 I have much greater difficulty in making decisions than I used to.
- 3 I have trouble making any decisions.

14. Worthlessness

- 0 I do not feel I am worthless.
- ☒ 1 I don't consider myself as worthwhile and useful as I used to.
- 2 I feel more worthless as compared to other people.
- 3 I feel utterly worthless.

15. Loss of Energy

- 0 I have as much energy as ever.
- 1 I have less energy than I used to have.
- ☒ 2 I don't have enough energy to do very much.
- 3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- 0 I have not experienced any change in my sleeping pattern.
-
- ☒ 1a I sleep somewhat more than usual.
- ☒ 1b I sleep somewhat less than usual.
-
- 2a I sleep a lot more than usual.
- 2b I sleep a lot less than usual.
-
- 3a I sleep most of the day.
- 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- 0 I am no more irritable than usual.
- 1 I am more irritable than usual.
- ☒ 2 I am much more irritable than usual.
- 3 I am irritable all the time.

18. Changes in Appetite

- 0 I have not experienced any change in my appetite.
-
- ☒ 1a My appetite is somewhat less than usual.
-
- 1b My appetite is somewhat greater than usual.
-
- 2a My appetite is much less than before.
- 2b My appetite is much greater than usual.
-
- 3a I have no appetite at all.
- 3b I crave food all the time.

19. Concentration Difficulty

- 0 I can concentrate as well as ever.
- ☒ 1 I can't concentrate as well as usual.
- 2 It's hard to keep my mind on anything for very long.
- 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

- 0 I am no more tired or fatigued than usual.
- ☒ 1 I get more tired or fatigued more easily than usual.
- 2 I am too tired or fatigued to do a lot of the things I used to do.
- 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- 0 I have not noticed any recent change in my interest in sex.
- ☒ 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

22 23 24 25 26 27 28 29 30 A B C D E

= 27 M.d

PERSONALITY ASSESSMENT INVENTORY™

Clinical Interpretive Report

by

Leslie C. Morey, PhD
and PAR Staff

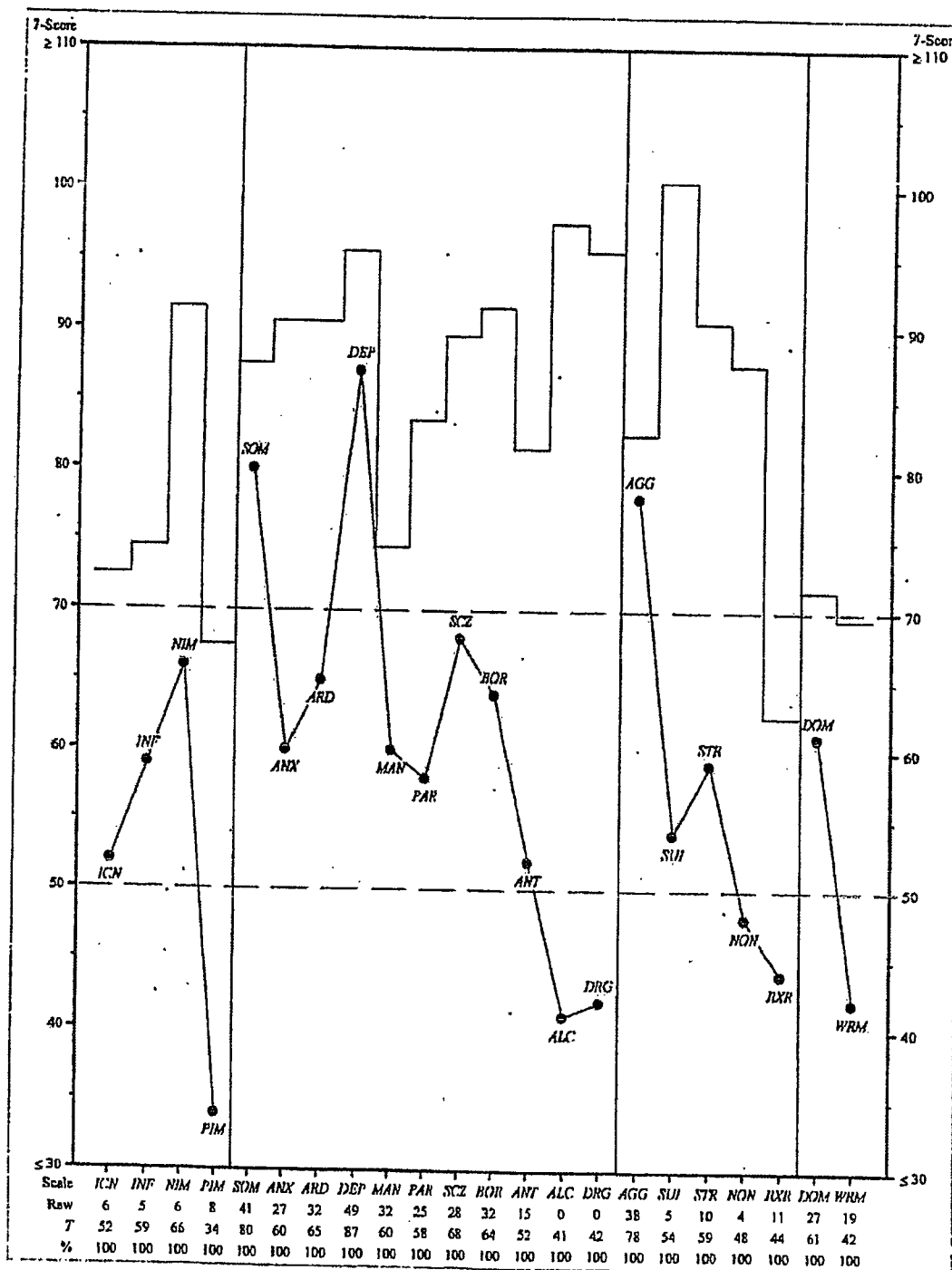
Client Information

Client Name	: John F. Stroud
Client ID	: -Not Specified-
Age	: 65
Gender	: Male
Education	: 12
Marital Status	: Married
Test Date	: 05/07/2008
Prepared For	: -Not Specified-

The interpretive information contained in this report should be viewed as only one source of hypotheses about the individual being evaluated. No decisions should be based solely on the information contained in this report. This material should be integrated with all other sources of information in reaching professional decisions about this individual.

This report is confidential and intended for use by qualified professionals only. It should not be released to the individual being evaluated.

Full Scale Profile

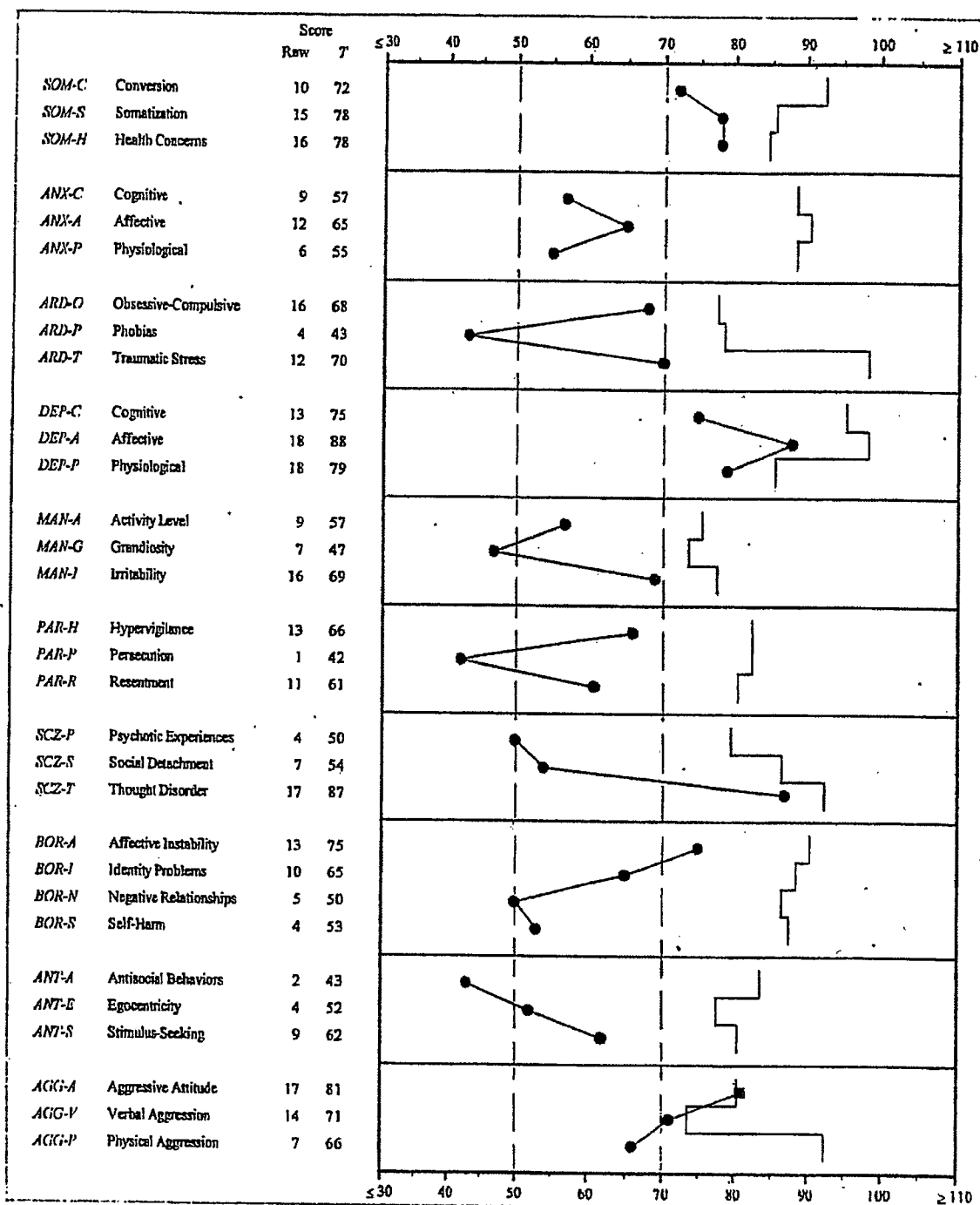


Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.

■ indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.

◆ indicates that the scale has more than 20% missing items.

Subscale Profile



Missing Items = 0

Plotted T scores are based upon a census matched standardization sample of 1,000 normal adults.

■ indicates that the score is more than two standard deviations above the mean for a sample of 1,246 clinical patients.

◆ indicates that the scale has more than 20% missing items.

Additional Profile Information

Supplemental PAI Indexes

Index	Value	T Score
Defensiveness Index	1	38
Cashel Discriminant Function	148.02	57
Malingering Index	1	57
Rogers Discriminant Function	-2.27	38
Suicide Potential Index	10	71
Violence Potential Index	5	66
Treatment Process Index	3	60
ALC Estimated Score	---	59 (18T higher than ALC)
DRG Estimated Score	---	58 (16T higher than DRG)
Mean Clinical Elevation	---	62

Coefficients of Fit with Profiles of Known Clinical Groups

Database Profile	Coefficient of Fit
Cluster 8	0.758
Somatoform Disorder	0.711
Posttraumatic Stress Disorder	0.693
Cluster 7	0.642
Anxiety Disorder	0.632
PIM Predicted	0.623
Antipsychotic medications	0.598
Auditory hallucinations	0.597
Schizophrenia	0.596
Dysthymic Disorder	0.593
Adjustment reaction	0.576
Cluster 2	0.562
Schizoaffective Disorder	0.562
NIM Predicted	0.557
Major Depressive Disorder	0.557
Paranoid delusions	0.528

Database Profile	Coefficient of Fit
Current suicide	0.517
Borderline Personality Disorder	0.512
Fake Bad	0.489
Cluster 5	0.480
All "Very True"	0.470
Current aggression	0.453
All "Mainly True"	0.440
Cluster 6	0.437
Random responding	0.416
Self-Mutilation	0.401
Assault history	0.399
Mania	0.395
Suicide history	0.393
Cluster 10	0.375
Rapists	0.310
Cluster 3	0.297
Cluster 4	0.267
All "Slightly True"	0.255
Antisocial Personality Disorder	0.226
Alcoholic	0.135
Drug abuse	0.102
Spouse abusers	0.086
Prisoners	0.030
All "False"	-0.157
Cluster 9	-0.260
Cluster 1	-0.302
Fake Good	-0.500

Validity of Test Results

The PAI provides a number of validity indices that are designed to provide an assessment of factors that could distort the results of testing. Such factors could include failure to complete test items properly, carelessness, reading difficulties, confusion, exaggeration, malingering, or defensiveness. For this protocol, the number of uncompleted items is within acceptable limits.

Also evaluated is the extent to which the respondent attended appropriately and responded consistently to the content of test items. The respondent's scores suggest that he did attend appropriately to item content and responded in a consistent fashion to similar items.

The degree to which response styles may have affected or distorted the report of symptomatology on the inventory is also assessed. Certain of these indicators fall outside of the normal range, suggesting that the respondent may not have answered in a completely forthright manner; the nature of his responses might lead the evaluator to form a somewhat inaccurate impression of the client based upon the style of responding described below. With respect to positive impression management, there is no evidence to suggest that the respondent was generally motivated to portray himself as being relatively free of common shortcomings or minor faults. However, certain aspects of the profile raise the possibility of denial of problems with drinking or drug use, as individuals with similar personality characteristics typically report greater involvement with alcohol or drugs than was described by this client. Interpretive hypotheses in this report regarding the abuse of these substances should be reviewed with caution.

With respect to negative impression management, there is no evidence to suggest that the respondent was motivated to portray himself in a more negative or pathological light than the clinical picture would warrant.

Clinical Features

The PAI clinical profile is marked by significant elevations, indicating the presence of clinical features that are likely to be sources of difficulty for the respondent. The configuration of the clinical scales suggests a person who is reporting significant distress, with particular concerns about his physical functioning. The respondent sees his life as severely disrupted by a variety of physical problems. These problems have left him unhappy, with little energy or enthusiasm for concentrating on important life tasks and little hope for improvement in the future. His performance in important social roles has probably suffered as a result, and his lack of success in these roles serves as an additional source of stress.

The respondent reports a number of difficulties consistent with a significant depressive experience. He is likely to be plagued by thoughts of worthlessness, hopelessness, and personal failure. He admits openly to feelings of sadness, a loss of interest in normal activities, and a loss of sense of pleasure in things that were previously enjoyed. He is likely to show a disturbance in sleep pattern, a decrease in level of energy and sexual interest, and a loss of appetite and/or weight. Psychomotor slowing might also be expected.

The respondent demonstrates an unusual degree of concern about physical functioning and health matters and probable impairment arising from somatic symptoms. He is likely to report that his daily functioning has been compromised by numerous and varied physical problems. He feels that his health is not as good as that of his age peers and likely believes that his health problems are complex and difficult to treat successfully. Physical complaints are likely to include symptoms of distress in several biological systems, including the neurological, gastrointestinal, and musculoskeletal systems. The item endorsement pattern indicates that he reports symptoms consistent with both conversion and somatization disorders. He is likely to be continuously concerned with his health status and physical problems. His social interactions and conversations tend to focus on his health problems, and his self-image may be largely influenced by a belief that he is handicapped by his poor health.

The respondent describes his thought processes as marked by confusion, distractibility, and difficulty concentrating. He may also have problems communicating clearly with other people because of speech that may tend to be tangential or circumstantial.

The respondent indicates that he occasionally experiences, or may experience to a mild degree, maladaptive behavior patterns aimed at controlling anxiety. The respondent has likely experienced a disturbing traumatic event in the past—an event that continues to distress him and produce recurrent episodes of anxiety. Whereas the item content of the PAI does not address specific causes of traumatic stress, possible traumatic events involve victimization (e.g., rape, abuse), combat experiences, life-threatening accidents, and natural disasters.

The respondent indicates that he is quite moody and emotionally labile, with the mood swings being fairly rapid and rather extreme. In particular, he may experience episodes of poorly controlled anger, although other affects are also likely to be poorly controlled.

The respondent describes certain problems potentially associated with elevated and variable mood. Although he may view himself as active, outgoing, ambitious, and self-confident, others may perceive him as impatient and somewhat demanding.

The respondent mentions that he is experiencing some degree of anxiety and stress; this degree of worry and sensitivity is still within what would be considered the normal range.

According to the respondent's self-report, he describes NO significant problems in the following areas: antisocial behavior; problems with empathy; undue suspiciousness or hostility. Also, he reports NO significant problems with alcohol or drug abuse or dependence. However, attention should be paid to the possibility of denial of problems with drinking or drug use, as the respondent described certain personality characteristics that are often associated with involvement with alcohol or drugs.

Self-Concept

The self-concept of the respondent appears to involve a generally negative self-evaluation that may vary from states of harsh self-criticism and self-doubt to periods of relative self-confidence and intact self-esteem. This fluctuation is likely to vary as a function of his current circumstances. During stressful times, he is prone to be self-critical and p

dwelling on past failures and lost opportunities with considerable uncertainty and indecision about his plans and goals for the future. Given this self-doubt, he tends to blame himself for setbacks and sees any prospects for future success as dependent upon the actions of others.

Interpersonal and Social Environment

The respondent's interpersonal style seems best characterized as pragmatic and independent. He may tend to view relationships as a means to an end, rather than as a source of satisfaction. He is not likely to be perceived by others as a warm and friendly person, although he is not necessarily lacking in social skills and he can be reasonably effective in social interactions. Those who know him well are likely to see him as being shrewd, competitive, and self-confident.

In considering the social environment of the respondent with respect to perceived stressors and the availability of social supports with which to deal with these stressors, his responses indicate that both his recent level of stress and his perceived level of social support are about average in comparison to normal adults. The reasonably low stress environment and the intact social support system are both favorable prognostic signs for future adjustment.

Treatment Considerations

Treatment considerations involve issues that can be important elements in case management and treatment planning. Interpretation is provided for three general areas relevant to treatment: behaviors that may serve as potential treatment complications, motivation for treatment, and aspects of the respondent's clinical picture that may complicate treatment efforts.

With respect to anger management, the pattern of responses suggests that aggressive behaviors play a prominent role in the clinical picture and that such behaviors may represent a potential treatment complication. His responses suggest that he is an individual who is easily angered, has difficulty controlling the expression of his anger, and is perceived by others as having a hostile, angry temperament. He is not intimidated by confrontation and he will tend to display his anger readily when it is experienced; he may be verbally aggressive at relatively low levels of provocation. More extreme displays of anger, including damage to property and threats to assault others, would not be unexpected. It is likely that those around him are intimidated by his temper and the potential for verbal abuse or displays of physical violence. He does appear to have some degree of control over more extreme displays of anger, such as damage to property and threats to assault others. However, it is likely that those around him are intimidated by his temper and the potential for verbal abuse.

With respect to suicidal ideation, the respondent is not reporting distress from thoughts of self-harm.

The respondent's interest in and motivation for treatment is comparable to that of adults who are not being seen in a therapeutic setting. However, his level of treatment motivation is somewhat lower than is typical of individuals being seen in treatment settings. His responses suggest that he is satisfied with himself as he is, that he is not experiencing marked distress.

and that, as a result, he sees little need for changes in his behavior. However, the respondent does report a number of strengths that are positive indications for a relatively smooth treatment process, if he were willing to make a commitment to treatment.

If treatment were to be considered for this individual, particular areas of attention or concern in the early stages of treatment could include:

- He may currently be too disorganized or feel too overwhelmed to be able to participate meaningfully in some forms of treatment.

***DSM-IV* Diagnostic Possibilities**

Listed below are *DSM-IV* diagnostic possibilities suggested by the configuration of PAI scale scores. The following are advanced as hypotheses; all available sources of information should be considered prior to establishing final diagnoses.

Axis I Diagnostic Considerations:

- 296.20 Major Depressive Disorder, Single Episode, Unspecified
- 296.89 Bipolar II Disorder
- 300.81 Undifferentiated Somatoform Disorder

Axis I Rule Out:

- 301.13 Cyclothymic Disorder
- 294.9 Cognitive Disorder NOS
- 300.81 Somatization Disorder

Axis II: 799.9 Diagnosis Deferred on Axis II

Axis II Rule Out:

- 301.9 Personality Disorder NOS (Mixed Personality Disorder With Borderline, Paranoid, and Obsessive-Compulsive Features)

Critical Item Endorsement

A total of 27 PAI items reflecting serious pathology have very low endorsement rates in normal samples. These items have been termed critical items. Endorsement of these critical items is not in itself diagnostic, but review of the content of these items with the respondent may help to clarify the presenting clinical picture. Significant items with item scores of 1, 2, or 3 are listed below.

Delusions and Hallucinations

170. I've heard voices that no one else could hear. (MT, 2)

Potential for Self-Harm

206. I have no interest in life. (ST, 1)

Potential for Aggression

21. People are afraid of my temper. (ST, 1)
61. Sometimes my temper explodes and I completely lose control. (MT, 2)
181. I've threatened to hurt people. (ST, 1)

Potential Malingering

249. Sometimes my vision is only in black and white. (VT, 3)

Unreliability / Resistance

71. I'll take advantage of others if they leave themselves open to it. (ST, 1)

Traumatic Stressors

34. I keep reliving something horrible that happened to me. (VT, 3)
114. I've been troubled by memories of a bad experience for a long time. (MT, 2)
274. Since I had a very bad experience, I am no longer interested in some things that I used to enjoy. (MT, 2)

PAI Item Responses

1. MT	44. ST	87. F	130. F	173. ST	216. F	259. F	302. F
2. MT	45. ST	88. MT	131. F	174. MT	217. ST	260. F	303. ST
3. VT	46. MT	89. F	132. ST	175. F	218. F	261. F	304. MT
4. VT	47. F	90. F	133. MT	176. MT	219. MT	262. F	305. F
5. VT	48. F	91. F	134. MT	177. F	220. F	263. F	306. MT
6. ST	49. F	92. VT	135. F	178. F	221. F	264. ST	307. ST
7. ST	50. F	93. ST	136. F	179. ST	222. F	265. ST	308. ST
8. MT	51. F	94. F	137. ST	180. F	223. ST	266. F	309. F
9. F	52. VT	95. F	138. MT	181. ST	224. ST	267. MT	310. ST
10. ST	53. MT	96. ST	139. MT	182. F	225. F	268. F	311. F
11. MT	54. MT	97. MT	140. F	183. F	226. ST	269. F	312. F
12. VT	55. F	98. ST	141. F	184. VT	227. ST	270. MT	313. MT
13. MT	56. MT	99. ST	142. VT	185. MT	228. F	271. ST	314. MT
14. VT	57. VT	100. F	143. ST	186. MT	229. MT	272. F	315. ST
15. F	58. MT	101. F	144. VT	187. ST	230. MT	273. F	316. MT
16. MT	59. ST	102. F	145. ST	188. ST	231. F	274. MT	317. ST
17. MT	60. F	103. VT	146. VT	189. F	232. VT	275. MT	318. F
18. F	61. MT	104. VT	147. VT	190. MT	233. ST	276. MT	319. ST
19. F	62. F	105. F	148. VT	191. F	234. MT	277. F	320. ST
20. F	63. VT	106. F	149. F	192. F	235. MT	278. VT	321. F
21. ST	64. F	107. VT	150. F	193. F	236. MT	279. ST	322. MT
22. F	65. ST	108. F	151. F	194. F	237. MT	280. F	323. VT
23. F	66. F	109. VT	152. F	195. MT	238. ST	281. F	324. F
24. VT	67. F	110. F	153. F	196. MT	239. F	282. F	325. F
25. MT	68. ST	111. MT	154. ST	197. MT	240. MT	283. F	326. ST
26. F	69. F	112. F	155. VT	198. ST	241. F	284. F	327. MT
27. ST	70. ST	113. F	156. MT	199. MT	242. F	285. F	328. ST
28. F	71. ST	114. MT	157. MT	200. F	243. MT	286. F	329. F
29. F	72. VT	115. F	158. ST	201. VT	244. ST	287. F	330. ST
30. ST	73. F	116. MT	159. F	202. ST	245. MT	288. VT	331. MT
31. F	74. F	117. F	160. MT	203. ST	246. F	289. F	332. VT
32. VT	75. F	118. MT	161. MT	204. ST	247. F	290. MT	333. F
33. ST	76. ST	119. ST	162. ST	205. VT	248. ST	291. VT	334. VT
34. VT	77. MT	120. F	163. MT	206. ST	249. VT	292. F	335. F
35. VT	78. VT	121. F	164. F	207. VT	250. F	293. MT	336. F
36. VT	79. ST	122. ST	165. MT	208. MT	251. VT	294. VT	337. VT
37. MT	80. MT	123. MT	166. MT	209. F	252. F	295. VT	338. VT
38. VT	81. MT	124. MT	167. F	210. F	253. MT	296. ST	339. VT
39. MT	82. MT	125. ST	168. MT	211. VT	254. F	297. ST	340. F
40. F	83. F	126. VT	169. VT	212. F	255. F	298. F	341. F
41. MT	84. ST	127. MT	170. MT	213. F	256. VT	299. F	342. VT
42. MT	85. VT	128. F	171. ST	214. MT	257. F	300. F	343. MT
43. F	86. VT	129. F	172. F	215. F	258. MT	301. ST	344. F

*** End of Report ***

**NOTICE OF POSSIBLE
SECOND INJURY FUND CLAIM**

W.C.C. No.	504228
Carrier Code	170
NCCI Ins. Code	13781
Carrier File No.	709-131570
Carrier's Policy No.	007760665
Policy Eff. Date	11/15/04 to 11/15/05
SIF No.	116667

Employee:	John Stroud	Social Security No.:	238-68-3216
Address:	971 NC Zoar Road, Cheraw, SC 29520	Date of Accident:	April 10, 2005
Employer:	John F. Stroud & Sons, Inc.	Carrier:	American Home Assurance Company
Location:	927 East Boulevard, Chesterfield, SC 29709-1835	Address:	P. O. Box 1821, Alpharetta, GA 30023
Employee's Attorney	Vincent A. Sheheen	Carrier's Attorney:	Ashleigh L. Ciulla (<i>SIF Case Only</i>)
Address:	Post Office Drawer 10 Camden, SC 29020	Address:	P.O. Box 10589, Greenville, SC 29603

SUBSEQUENT INJURY: Nature of Second Injury:
Multiple injuries to the head, brain, right lower extremity, eyes and left upper extremity.

Current Status:
Appellate Panel Decision & Order dated, 5/1/09, attached.

Treating Physicians:
Dr. Bosse; Carolinas Medical Center, Monroe Prosthetic Clinic; Palmetto Health Richland; Dr. John McLeod (family doctor)

Average Weekly Wage:	\$1,208.00	Comp Rate:	\$592.56
Date of First Temporary Total:	4/11/05	Date Returned to Work:	N/A
Weeks of All Benefits Paid:	321	Medical Cost to Date:	\$651,679.97

NATURE OF IMPAIRMENT: Refer to Section 42-9-400, Paragraph (d)

- ☒ Listed Impairment (1-33; #4 arthritis D/A prior to 7/1/07): Diabetes
- ☐ Other (34a or b; D/A prior to 7/1/07):
- ☐ Paragraph (a):

KNOWLEDGE REQUIREMENT:

- ☒ Employer knew about the pre-existing condition. (Please attach affidavit, application, etc.)
* *Claimant was the company owner. Knowledge of pre-existing condition evidenced by medical records pre-DOI.*
- ☐ Employee withheld existence of pre-existing condition from employer. (Please attach application, post-employment physical, etc.)
- ☐ Employee was unaware of existence of pre-existing condition. (Please attach affidavit) (D/A prior to 06/25/03)

THESE FORMS MUST BE PROVIDED

BEFORE CLAIMS CAN BE PROCESSED:

(1)	All narrative medical reports
(2)	Form 12-A
(3)	Form 15
(4)	Current Form 18
(5)	Any W.C.C. Order

Signature: Ashleigh L. Ciulla
Mailing address: P.O. Box 10589, Greenville, SC

Date of Claim: June 8, 2011

Effective July 1, 2007, notice requirements were changed per Section 42-9-400 (f). Failure to comply with the provisions of this subsection shall bar an employer or his carrier from recovery from the Fund.

Revised November 2007

SIF - John Stroud/Chartis Insurance Company v. SC Injury Fund

W.C.C. File No.: 504228

SIF File No.: 116667

SS#: 238-68-3216 DOB: 3/28/1943

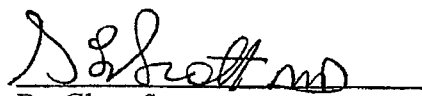
It is my opinion to a reasonable degree of medical certainty that:

Mr. Stroud suffered multiple traumatic injuries in an Ultra-light plane crash on April 10, 2005. Among his many injuries, he had a right femur fracture, a right talar fracture with burns as well as degloving and full-thickness skin loss from his right thigh.

Prior to April 10, 2005, Mr. Stroud suffered from diabetes and took Glucophage to control his diabetes. Prior to April 10, 2005, he was non-insulin dependent. One day after the accident, a doctor at Carolinas Medical Center, Dr. Jacobs, noted that Mr. Stroud was "quite hyperglycemic," which means that his blood sugar was high. The hospital attempted to control his blood sugar with an insulin infusion at that time. As late as June 3, 2005, Mr. Stroud was undergoing sliding scale insulin therapy, which means that he still required insulin to control his diabetes.

Mr. Stroud initially underwent surgery with Dr. Bosse on April 18, 2005, for pinning of the subtalar joint and pinning of the ankle joint. Postoperatively he was diagnosed with necrosis of the posterior tibial tendon, flexor digitorum hallucis tendon, and infection of the ankle joint and subtalar joint with necrosis of all ligaments in the region. On June 2, 2005, he underwent debridement of the right ankle wound with removal of necrotic skin, subcutaneous tissues, multiple tendons and debridement of talar and subtalar joints. Dr. Bosse also removed the hardware at that time. Following the debridement, Dr. Bosse recommended a free tissue transfer, at a minimum. By June 3, 2005, Mr. Stroud had developed a known methicillin-resistant *Staphylococcus aureus* colonization of his right leg and ankle wounds. As a result, Dr. Bosse performed a debridement of skin and subcutaneous tissue with talectomy of the ankle on June 7, 2005. This surgery essentially resulted in removal of all tendons and soft tissues of the medial side. Mr. Stroud had a completely devascularized and loose talus that extruded from the wound with a deep infection below that. At that time, Dr. Bosse noted, "The patient is diabetic. There was no salvage option other than the below-knee amputation." On June 8, 2005, Dr. Bosse performed a below-knee amputation with primary closure.

I have reviewed the medical records from Mr. Stroud's family physician, Dr. McLeod and records from Carolinas Medical Center, including the records of Dr. Bosse. Based on my review of the records, it is my opinion to a reasonable degree of medical certainty that because of the severity of the right knee injury, the subsequent deep infection and the patient's diabetes, there was no salvage option other than the below-knee amputation of the right leg.


Dr. Glenn Scott

Date: May 11, 2011

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist

The Oaks Business Center
1459 Stuart Engals Blvd.
Suite 204-A
Mt. Pleasant, S.C. 29464

Telephone
(843) 881-2778
Fax
(843) 881-6878

June 1st, 2011

Ashleigh L. Ciulla, Esquire
Post Office Box 10589
Greenville, SC 29603

RE.: John Stroud v. John F. Stroud and Sons, Inc.

Dear Ms. Ciulla:

Per your request, I had the opportunity to review records regarding Mr. John Stroud who suffered traumatic injuries in an ultra-light plane crash on April 10th, 2005. Records reviewed included medical records from Palmetto Health-Richland; medical/treatment records from John F. McLeod, III, MD; medical records from Carolinas Medical Center; and report of an evaluation conducted by John Barkenbus, MD, North Carolina Neuropsychiatry.

As you well know, Mr. Stroud experienced multiple traumas as a result of the plane crash including a traumatic brain injury. Mr. Stroud's history has been noteworthy for Diabetes, Type II, that necessitated use of Glucophage at 1000 mg bid. prior to the accident. Medical records reveal that the day after the accident the diabetes was quite volatile as Mr. Stroud was assessed by Dr. Jacobs as being "quite hyperglycemic". There was need to place Mr. Stroud on insulin infusion. Subsequently, he underwent sliding scale insulin therapy. More recently, he returned to medication control.

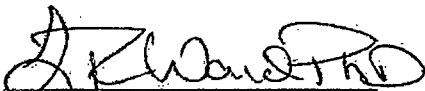
It was also noted in the medical records that in July, 2004, Mr. Stroud was involved in an accident where a backhoe rolled over him. This involved a loss of consciousness. He was noted to have a right temporal hematoma though a CT scan of the head was negative. Mr. Stroud was assessed as having suffered a concussion. Neuropsychiatric evaluation conducted by John Barkenbus, MD, in May, 2008, revealed Mr. Stroud to be experiencing considerable neurocognitive, emotional, and somatic difficulties. Dr. Barkenbus noted that Mr. Stroud had a previous concussion would serve as a risk factor for greater impairments due to the traumatic brain injury sustained in April, 2005. Yet, Dr. Barkenbus stated that he was unable to clarify premorbid level of interpersonal, cognitive, and community functioning as it related to John Stroud.

It was noted that the traumatic accident occurred when Mr. Stroud was 62 years of age. Review revealed that he had diabetes and need for use of medications well before the date of the accident

(4/10/2005). It is my opinion that Mr. Stroud's preexisting diabetes was permanent and serious enough to constitute a hindrance to employment or re-employment. I also believe that Mr. Stroud's concussive head injury sustained in July, 2004, served as a risk factor for him to experience greater level of impairments associated with the traumatic brain injury sustained on April 10th, 2005. Indeed, research literature has documented how a previous concussion, particularly within a relatively short period of time, renders an individual more at risk for persistent and permanent impairments due to a second head injury.

Thus, it is my opinion that Mr. Stroud's preexisting diabetes as well as the manner in which he had sustained a concussion within a year prior to the accident of April 10th, 2005, served to render him with a greater disability; greater medical costs; as well as more significant disability with loss of time from employment capacities.

Please feel free to contact me if you have any questions regarding the review of records that was conducted on Mr. John Stroud.

A handwritten signature in black ink, appearing to read "L. Randolph Waid". The signature is stylized with a large initial "L" and a cursive "Waid".

L. Randolph Waid, Ph.D.
Licensed Clinical Psychologist (SC # 333)
Clinical Associate Professor in Psychiatry and Neurology at MUSC

LRW/plr

Re: SIF – John Stroud v. John F. Stroud & Sons, Inc.

W.C.C. No.: 504228

SIF File No.: 116667

Soc. Sec. No.: 238-68-3216

Date of Injury: 4/10/2005

To the best of my knowledge and within a reasonable degree of medical certainty:

A. The patient had diabetes prior to April 10, 2005.

Yes ☒ No ☐

B. The pre-existing diabetes is permanent and serious enough to constitute a hindrance or obstacle to employment or re-employment.

Yes ☒ No ☐

C. The injuries from the April 10, 2005, accident combined with or aggravated the pre-existing diabetes (i.e., had the patient been previously healthy, it is likely this accident would have resulted in a less severe overall condition?)

Yes ☒ No ☐

D. The aggravation or combination of the pre-existing diabetes with the injuries of April 10, 2005, resulted in:

1. Substantially greater lost time from work (i.e., had the patient not had pre-existing diabetes, is it likely he would have lost less time from work?)

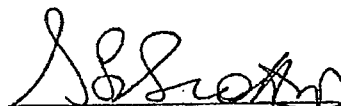
Yes ☒ No ☐

2. Substantially greater permanent disability (i.e., had the patient not had pre-existing diabetes, is it likely he would have suffered less permanent disability?)

Yes ☒ No ☐

3. Substantially greater medical costs (i.e., had the patient not had pre-existing diabetes is it likely his overall medical costs would have been reduced?)

Yes ☒ No ☐


Glenn Scott, M.D.

5/11/11
Date

Re: SIF - John Stroud v. John F. Stroud & Sons, Inc.

W.C.C. No.: 504228

SIF File No.: 116667

Soc. Sec. No.: 238-68-3216

Date of Injury: 4/10/2005

To the best of my knowledge and within a reasonable degree of medical certainty:

A. The patient had diabetes prior to April 10, 2005.

Yes X No _____

B. The pre-existing diabetes is permanent and serious enough to constitute a hindrance or obstacle to employment or re-employment.

Yes X No _____

C. The head injury from the April 10, 2005, accident combined with or aggravated the pre-existing diabetes (i.e., had the patient not had pre-existing diabetes, it is likely this accident would have resulted in a less severe overall condition?)

Yes X No _____

D. The aggravation or combination of the pre-existing diabetes with the head injury of April 10, 2005, resulted in:

1. Substantially greater lost time from work (i.e., had the patient not had pre-existing diabetes, is it likely he would have lost less time from work?)

Yes X No _____

2. Substantially greater permanent disability (i.e., had the patient not had pre-existing diabetes, is it likely he would have suffered less permanent disability?)

Yes X No _____

3. Substantially greater medical costs (i.e., had the patient not had pre-existing diabetes is it likely his overall medical costs would have been reduced?)

Yes X No _____


L. Randolph Waid, M.D.

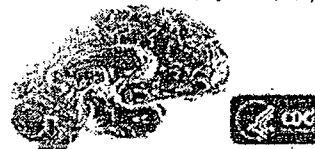
5/31/2011
Date



Centers for Disease Control and Prevention
 CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

CDC's Heads Up on Brain Injury

Follow us at [Facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup)



Share your stories with other brain injury survivors, family members and caregivers.

[facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup) 
<http://www.facebook.com/cdcheadsup/>

Learn about our partnership with Lifetime Television and Army Wives.
[/TraumaticBrainInjury/tb/index.html](http://www.cdc.gov/TraumaticBrainInjury/tb/index.html)

Traumatic Brain Injury

Traumatic brain injury (TBI) is a serious public health problem in the United States. Each year, traumatic brain injuries contribute to a substantial number of deaths and cases of permanent disability. Recent data shows that, on average, approximately 1.7 million people sustain a traumatic brain injury annually.

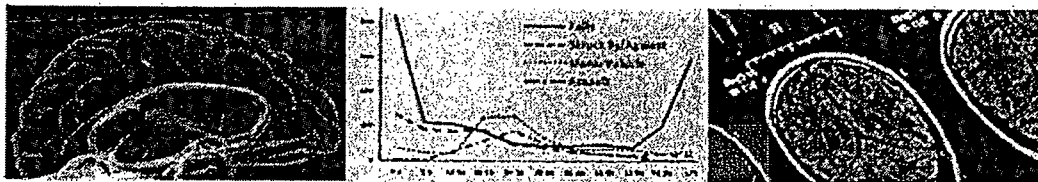
A TBI is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. The severity of a TBI may range from "mild," i.e., a brief change in mental status or consciousness to "severe," i.e., an extended period of unconsciousness or amnesia after the injury. The majority of TBIs that occur each year are concussions or other forms of mild TBI.

CDC's research and programs work to prevent TBI and help people better recognize, respond, and recover if a TBI occurs.

Traumatic Brain Injury Topics

- [Concussion and Mild TBI \(/concussion/index.html\)](/concussion/index.html)
- [Concussion in Sports \(/concussion/sports/index.html\)](/concussion/sports/index.html)
- [Clinical Diagnosis and Management \(/concussion/clinician.html\)](/concussion/clinician.html)
- [Statistics \(/traumaticbraininjury/statistics.html\)](/traumaticbraininjury/statistics.html)
- [Long-term Outcomes \(/traumaticbraininjury/outcomes.html\)](/traumaticbraininjury/outcomes.html)
- [Causes and Risk Groups \(/traumaticbraininjury/causes.html\)](/traumaticbraininjury/causes.html)
- [Prevention \(/traumaticbraininjury/prevention.html\)](/traumaticbraininjury/prevention.html)
- *Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations, and Deaths, 2002-2006.* Available as [\[PDF 2MB !\[\]\(54a282d3ed55c9b1ac66d6fb81d5de2b_img.jpg\)](/traumaticbraininjury/pdf/blue_book.pdf)] or [\[Word 482K !\[\]\(990a6ed8a8b9db20056986ea871bc6c5_img.jpg\)](/traumaticbraininjury/pdf/blue_book.docx)]
- *New Report – Surveillance for Traumatic Brain Injury–Related Deaths – United States, 1997–2007, MMWR Surveillance Summaries*
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6005a1.htm?s_cid=ss6005a1_w

Research Activities



- [TBI Reports and Fact Sheets \(/traumaticbraininjury/factsheets_reports.html\)](/traumaticbraininjury/factsheets_reports.html)
- [Research Findings on Treatment Guidelines for Severe TBI \(/TraumaticBrainInjury/brain_trauma_guidelines.html\)](/TraumaticBrainInjury/brain_trauma_guidelines.html)
- [CDC Study Finds Traumatic Brain Injuries Can Result from Seniors Falls \(/TraumaticBrainInjury/tbi_falls_results.html\)](/TraumaticBrainInjury/tbi_falls_results.html)

Educational Initiatives and Campaigns



- [Heads Up: Brain Injury in Your Practice \(/concussion/HeadsUp/physicians_tool_kit.html\)](/concussion/HeadsUp/physicians_tool_kit.html)
- [Heads Up: Concussion in High School Sports \(/concussion/HeadsUp/high_school.html\)](/concussion/HeadsUp/high_school.html)
- [Heads Up: Concussion in Youth Sports \(/concussion/HeadsUp/youth.html\)](/concussion/HeadsUp/youth.html)
- [Heads Up: Prevent Shaken Baby Syndrome \(/concussion/HeadsUp/sbs.html\)](/concussion/HeadsUp/sbs.html)
- [Heads Up to Schools: Know Your Concussion ABCs \(/concussion/HeadsUp/schools.html\)](/concussion/HeadsUp/schools.html)
- [Help Seniors Live Better, Longer: Prevent Brain Injury \(/traumaticbraininjury/seniors.html\)](/traumaticbraininjury/seniors.html)

Page last reviewed: March 8, 2010

Page last updated: May 5, 2011

Content source: [Centers for Disease Control and Prevention, National Center for Injury Prevention and Control](#)

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov





Centers for Disease Control and Prevention

CDC 24/7: Saving Lives, Protecting People, Saving Money Through Prevention.

Quick Links

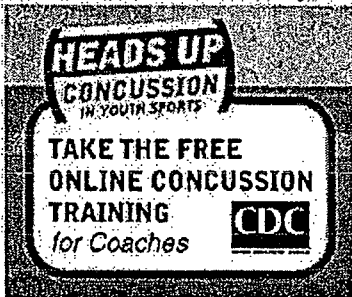
- [Concussion in Sports \(/concussion/sports/index.html\)](/concussion/sports/index.html)
- [Clinical Diagnosis and Management \(/concussion/clinician.html\)](/concussion/clinician.html)
- [Order \(http://www.cdc.gov/pubs/ncipc.aspx#tbi1\)](http://www.cdc.gov/pubs/ncipc.aspx#tbi1) or [Download \(http://www.cdc.gov/injury/publications/index.html#tbi\)](http://www.cdc.gov/injury/publications/index.html#tbi) Tools and Resources

Concussion and Mild TBI

What is a Concussion?

A concussion is a type of [traumatic brain injury \(/TraumaticBrainInjury/index.html\)](/TraumaticBrainInjury/index.html), or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a fall or a blow to the body that causes the head and brain to move quickly back and forth.

Health care professionals may describe a concussion as a “mild” brain injury because concussions are usually not life-threatening. Even so, their effects can be serious.



[\(/concussion/HeadsUp/online_training.html\)](/concussion/HeadsUp/online_training.html)

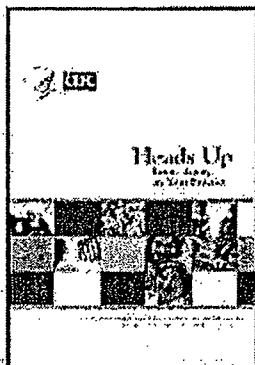
- [What are the Signs and Symptoms of Concussion? \(/concussion/signs_symptoms.html\)](/concussion/signs_symptoms.html)
- [What Should I do If a Concussion Occurs? \(/concussion/what_to_do.html\)](/concussion/what_to_do.html)
- [What Can I do to Help Feel Better After a Concussion? \(/concussion/feel_better.html\)](/concussion/feel_better.html)
- [What Can I do to Help Prevent Concussion and other forms of TBI? \(/traumaticbraininjury/prevention.html\)](/traumaticbraininjury/prevention.html)
- [Where Can I Find Videos, Podcasts, and Other Media \(/concussion/sports/resources.html\)?](/concussion/sports/resources.html)
- [Where Can I Find Support and Additional Resources? \(/concussion/support.html\)](/concussion/support.html)

“Heads Up” on Concussion

CDC has created free tools for youth and high school sports coaches, parents, athletes, and health care professionals that provide important information on preventing, recognizing, and responding to a concussion.

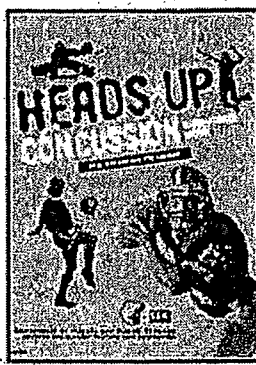
Download the “Heads Up” Toolkits:

Follow us on Facebook [Ⓢ \(http://www.facebook.com/cdcheadsup\)](http://www.facebook.com/cdcheadsup)



Heads Up: Brain Injury in Your Practice

[\(/concussion/HeadsUp/practice.html\)](http://concussion/HeadsUp/practice.html)

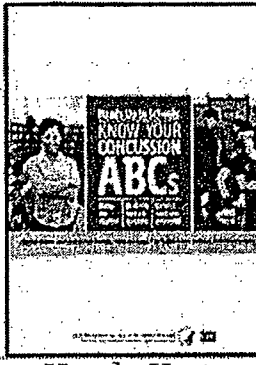


Heads Up: Concussion in High School

[\(/concussion/HeadsUp/high_school.html\)](http://concussion/HeadsUp/high_school.html)



Heads Up: Concussion in Youth Sports



Heads Up to Schools: Know Your Concussion

[\(/concussion/HeadsUp/schools.html\)](http://concussion/HeadsUp/schools.html)

Page last reviewed: August 25, 2010
Page last updated: August 25, 2010
Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention

1600 Clifton Rd. Atlanta, GA 30333, USA

800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov





Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

Concussion

What are the Signs and Symptoms of Concussion?

Most people with a concussion recover quickly and fully. But for some people, symptoms can last for days, weeks, or longer. In general, recovery may be slower among older adults, young children, and teens. Those who have had a concussion in the past are also at risk of having another one and may find that it takes longer to recover if they have another concussion.

Symptoms of concussion usually fall into four categories:

 Thinking/ Remembering	 Physical	 Emotional/ Mood	 Sleep
Difficulty thinking clearly	Headache Fuzzy or blurry vision	Irritability	Sleeping more than usual
Feeling slowed down	Nausea or vomiting (early on) Dizziness	Sadness	Sleep less than usual
Difficulty concentrating	Sensitivity to noise or light Balance problems	More emotional	Trouble falling asleep
Difficulty remembering new information	Feeling tired, having no energy	Nervousness or anxiety	

Some of these symptoms may appear right away, while others may not be noticed for days or months after the injury, or until the person starts resuming their everyday life and more demands are placed upon them. Sometimes, people do not recognize or admit that they are having problems. Others may not understand why they are having problems and what their problems really are, which can make them nervous and upset.

The signs and symptoms of a concussion can be difficult to sort out. Early on, problems may be missed by the person with the concussion, family members, or doctors. People may look fine even though they are acting or feeling differently.

See [Getting Better \(/concussion/feel_better.html\)](/concussion/feel_better.html), for tips to help aid your recovery after a concussion.

When to Seek Immediate Medical Attention:

Danger Signs in Adults

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. Contact your health care professional or emergency department right away if you have any of the following danger signs after a bump, blow, or jolt to the head or body:

- Headache that gets worse and does not go away.
- Weakness, numbness or decreased coordination.
- Repeated vomiting or nausea.
- Slurred speech.

The people checking on you should take you to an emergency department right away if you:

- Look very drowsy or cannot be awakened.
- Have one pupil (the black part in the middle of the eye) larger than the other.
- Have convulsions or seizures.
- Cannot recognize people or places.
- Are getting more and more confused, restless, or agitated.
- Have unusual behavior.
- Lose consciousness (*a brief loss of consciousness should be taken seriously and the person should be carefully monitored*).

Danger Signs in Children

Take your child to the emergency department right away if they received a bump, blow, or jolt to the head or body, and:

- Have any of the danger signs for adults listed above.
- Will not stop crying and cannot be consoled.
- Will not nurse or eat.

Related Links

- [Facts about Concussion and Brain Injury: Where to Get Help \(/concussion/get_help.html\)](/concussion/get_help.html)
- [Heads Up: Brain Injury in Your Practice \(/concussion/HeadsUp/physicians_tool_kit.html\)](/concussion/HeadsUp/physicians_tool_kit.html)

Page last reviewed: March 8, 2010

Page last updated: March 8, 2010

Content source: [Centers for Disease Control and Prevention, National Center for Injury Prevention and Control](#)

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA

800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day - cdcinfo@cdc.gov





Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

Concussion

What Should I do If a Concussion Occurs?

People with a concussion need to be seen by a health care professional. If you think you or someone you know has a concussion, contact your health care professional. Your health care professional can refer you to a neurologist, neuropsychologist, neurosurgeon, or specialist in rehabilitation (such as a speech pathologist). Getting help soon after the injury by trained specialists may speed recovery.

See [Signs and Symptoms \(/concussion/signs_symptoms.html\)](/concussion/signs_symptoms.html), to learn about common signs and symptoms that you may experience, as well as about [danger signs \(/concussion/signs_symptoms.html#3\)](/concussion/signs_symptoms.html#3) and when to seek immediate medical attention.

Concussion in Sports and Recreation:

If a concussion occurs during sports- and recreation-related activities, implement the 4-step [action plan \(/concussion/sports/response.html\)](/concussion/sports/response.html).

Athletes with a concussion should never return to sports or recreation activities the day of the injury and until a health care professional, experienced in evaluating for concussion, says they are symptom-free and it's OK to return to play.

What to Expect When You See a Health Care Professional

While most are seen in an emergency department or medical office, some people must stay in the hospital overnight. Your health care professional may do a scan of your brain (such as a CT scan) or other tests. Other tests, known as "neuropsychological" or "neurocognitive" tests, assess your learning and memory skills, your ability to pay attention or concentrate, and how quickly you can think and solve problems. These tests can help your health care professional identify the effects of a concussion. Even if the concussion doesn't show up on these tests, you may still have a concussion.

Your health care professional will send you home with important instructions to follow. Be sure to follow all of your health care professional's instructions carefully.

If you are taking medications—prescription, over-the-counter medicines, or "natural remedies"—or if you drink alcohol or take illicit drugs, tell your health care professional. Also, tell your health care professional if you are taking blood thinners (anticoagulant drugs), such as Coumadin and aspirin, because they can increase the chance of complications.

See [Getting Better \(/concussion/feel_better.html#1\)](/concussion/feel_better.html#1), for tips to help aid your recovery after a concussion.

Related Links

- [Facts about Concussion and Brain Injury: Where to Get Help \(/concussion/get_help.html\)](/concussion/get_help.html)
- [Concussion in Sports \(/concussion/sports\)](/concussion/sports)

Page last reviewed: March 8, 2010

Page last updated: March 8, 2010

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA

30333, USA

800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -

cdcinfo@cdc.gov





Centers for Disease Control and Prevention
 CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

Heads Up to Clinicians

Clinical Diagnosis and Management

Clinicians play a key role in helping to identify, diagnose and manage traumatic brain injuries (TBIs) (</TraumaticBrainInjury/index.html>). They can also help improve patient outcomes when a TBI is suspected or diagnosed by implementing early management and appropriate referral.

Each year, an estimated 1.7 million TBI-related deaths, hospitalizations, and emergency department visits occur in the U.S.

(</TraumaticBrainInjury/statistics.html>). This data translates to 52,000 deaths and 275,000 hospitalizations. In addition, nearly 80%, 1.365 million people are treated and released from an emergency department. The majority of TBIs that occur each year are diagnosed as mild TBIs (MTBI). In fact, a study found that about 75% of TBIs that occur each year are concussions or other forms of MTBI. While a MTBI is usually not life-threatening, this injury can have serious and long-term impact on a person's cognitive, physical and psychological function.

Appropriate diagnosis, referral, and patient and family/caregiver education are critical for helping patients with MTBI achieve optimal recovery and to reduce or avoid significant adverse health outcomes. However, diagnosing MTBIs can be challenging as symptoms of MTBI are common to those of other medical conditions and the onset and/or recognition of symptoms may occur days or weeks after the initial injury.

Therefore, CDC has collaborated with multiple organizations and leading experts to develop clinical guidelines and tools for diagnosis and management of patients with MTBI. This critical information is packaged into tool kits, fact sheets and pocket cards, making it easy for clinicians to get what they need to know, when they need to know it. CDC has also developed patient discharge fact sheets, podcasts and other resources for both patients and caregivers about concussion, including tips to help with recovery.

CDC/Medscape Expert Commentary: Four Critical Questions to Ask in the Evaluation of Adult Traumatic Brain Injury

Vikas Kapil, DO, MPH

[View the video](http://www.medscape.com/viewarticle/729612)  (<http://www.medscape.com/viewarticle/729612>)

(Free login required through Medscape to view the video)

For Clinicians

Primary Care Setting:

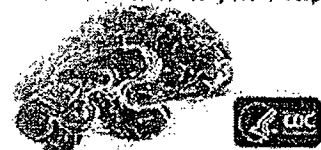


Heads Up: Brain Injury In Your Practice ([/concussion/HeadsUp/physicians_tool_kit.html](/concussion/HeadsUp/physicians_tool_kit.html))

This tool kit for clinicians includes a patient assessment tool, fact sheets for patients, and pocket card for on-field sports concussion management.

CDC's Heads Up on Brain Injury

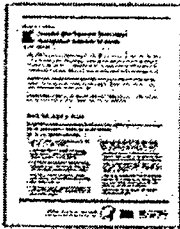
Follow us at [Facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup)



Share your stories with other brain injury survivors, their family members and caregivers. Become a Partner for better Prevention, Recognition and Response to TBI.

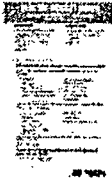
[facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup) 
 (<http://www.facebook.com/cdcheadsup/>)

Acute Care Setting:

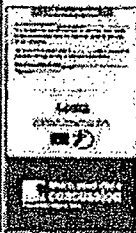
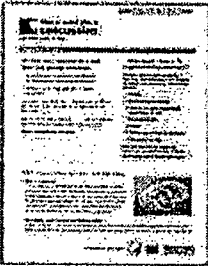


Updated Mild Traumatic Brain Injury Guideline for Adults **(/concussion/HeadsUp/clinicians_guide.html)**

Developed by CDC and the American College of Emergency Physicians (ACEP) & (<http://www.acep.org/>), these tools include a fact sheet and pocket card of the updated clinical diagnosis and management guideline for the acute care setting, based on the 2008 Clinical Policy for adult patients with MTBI & (<http://www.acep.org/>). Also included are a patient discharge fact sheet and a wallet card.



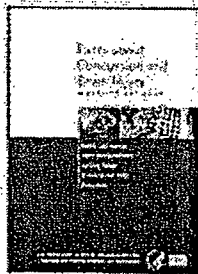
For Patients



Heads Up: What to Expect After a Concussion

(/concussion/HeadsUp/clinicians_guide.html#downloads)

Patients and caregivers can use the discharge instruction sheet and wallet card to learn about post-concussive symptoms, when to return to the emergency department, and to keep track of follow-up appointments.



Facts About Concussion and Brain Injury: Where to Get Help **(/concussion/get_help.html)**

This brochure and fact sheet provide information for people with concussion and their family members or caregivers on concussion symptoms and danger signs, tips for healing, and information on where to get help after a concussion.

Listen and download podcasts and radio PSAs about concussion **(/concussion/sports/resources.html).**

Page last reviewed: March 18, 2010

Page last updated: August 25, 2011

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov





Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People, Saving Money Through Prevention.

Quick Links

- [NEW NFL/CDC Poster for Young Athletes \(/concussion/sports/nfl_poster.html\)](/concussion/sports/nfl_poster.html)
- [NCAA/CDC Concussion Resources \(/concussion/sports/cdc_ncaa.html\)](/concussion/sports/cdc_ncaa.html)

Concussion in Sports

Fast Facts

- A concussion is a brain injury and all are serious.
- Most concussions occur without loss of consciousness.
- Recognition and proper response to concussions when they first occur can help prevent further injury or even death.

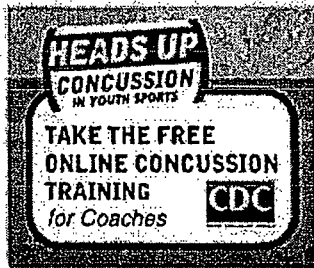


What is a Concussion?

[\(/concussion/HeadsUp/online_training.html\)](/concussion/HeadsUp/online_training.html)



A concussion is a type of traumatic brain injury (</TraumaticBrainInjury/index.html>), or TBI, caused by a bump, blow, or jolt to the head that can change the way your brain normally works. Concussions can also occur from a blow to the body that causes the head to move rapidly back and forth. Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious.



[\(/concussion/HeadsUp/online_training.html\)](/concussion/HeadsUp/online_training.html) Concussions can occur in *any* sport or recreation activity. So, all coaches, parents, and athletes need to learn concussion signs and symptoms and what to do if a concussion occurs.

- [How can I recognize a possible concussion \(/concussion/sports/recognize.html\)?](/concussion/sports/recognize.html)
- [What should I do if a concussion occurs \(/concussion/sports/response.html\)?](/concussion/sports/response.html)
- [What can I do to prevent concussions in sports \(/concussion/sports/prevention.html\)?](/concussion/sports/prevention.html)
- [Where can I find videos, podcasts, and other media \(/concussion/sports/resources.html\)?](/concussion/sports/resources.html)
- [Where can I find information about my sport? \(/concussion/HeadsUp/sports_specific.html\)](/concussion/HeadsUp/sports_specific.html)

How can I learn more?

CDC has created free tools for youth and high school sports coaches, parents, athletes, and health care professionals that provide important information on preventing, recognizing, and responding to a concussion.

- [Heads Up to Schools: Know Your Concussion ABCs \(/concussion/HeadsUp/schools.html\)](/concussion/HeadsUp/schools.html)
- [Heads Up: Concussion in Youth Sports \(/concussion/HeadsUp/youth.html\)](/concussion/HeadsUp/youth.html)
- [Heads Up: Concussion in High School Sports \(/concussion/HeadsUp/high_school.html\)](/concussion/HeadsUp/high_school.html)
- [Heads Up: Brain Injury in Your Practice \(/concussion/HeadsUp/physicians_tool_kit.html\)](/concussion/HeadsUp/physicians_tool_kit.html)

Did you know?

- Each year, U.S. emergency departments treat an estimated 135,000 sports- and recreation-related TBIs, including concussions, among children ages 5 to 18. (*MMWR* July 2007) (<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5629a2.htm>)
- Athletes who have ever had a concussion are at increased risk for another concussion.
- Children and teens are more likely to get a concussion and take longer to recover than adults.

Follow us on Facebook  (<http://www.facebook.com/cdcheadsup>)

Page last reviewed: August 30, 2010

Page last updated: August 30, 2010

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov





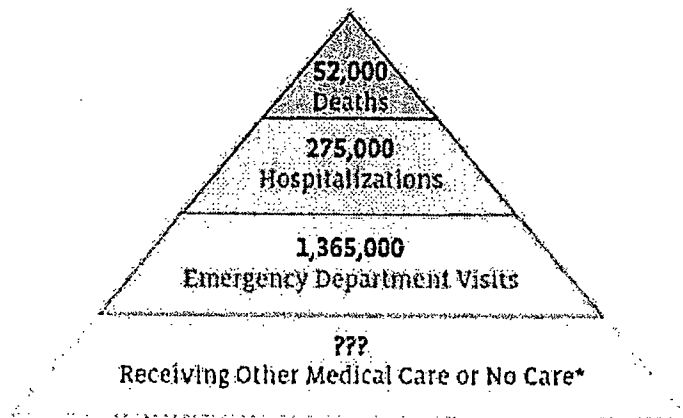
Centers for Disease Control and Prevention
 CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

How Many People Have TBI?

Data are critical to understand traumatic brain injury (TBI) (</TraumaticBrainInjury/index.html>) as an important public health problem. This data ([/traumaticbraininjury/factsheets_reports.html](/traumaticbraininjury/factsheets_reports.html)) can help inform TBI prevention strategies, identify research and education priorities, and support the need for services among those living with a TBI

National TBI Estimates

Each year, an estimated 1.7 million people sustain a TBI annually.¹ Of them:



- 52,000 die,
- 275,000 are hospitalized, and
- 1.365 million, nearly 80%, are treated and released from an emergency department.

TBI is a contributing factor to a third (30.5%) of all injury-related deaths in the United States.¹

About 75% of TBIs that occur each year are concussions or other forms of mild TBI.²

*The number of people with TBI who are not seen in an emergency department or who receive no care is unknown.

- Learn about the leading causes (</traumaticbraininjury/causes.html>) of TBI.
- For additional tables, figures and information about TBI in the United States, see the full report Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002 – 2006 ([/traumaticbraininjury/tbi_ed.html](/traumaticbraininjury/tbi_ed.html)).
- New Report – Surveillance for Traumatic Brain Injury–Related Deaths – United States, 1997–2007, MMWR Surveillance Summaries (http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6005a1.htm?s_cid=ss6005a1_w)

TBI by Age¹

- Children aged 0 to 4 years, older adolescents aged 15 to 19 years, and adults aged 65 years and older are most likely to sustain a TBI.

- Almost half a million (473,947) emergency department visits for TBI are made annually by children aged 0 to 14 years.
- Adults aged 75 years and older have the highest rates of TBI-related hospitalization and death.

TBI by Gender¹

- In every age group, TBI rates are higher for males than for females.
- Males aged 0 to 4 years have the highest rates of TBI-related emergency department visits, hospitalizations, and deaths.

Learn more about:



- Preventing Older Adult Falls (<http://wwwdev.cdc.gov/HomeandRecreationalSafety/Falls/index.html>)
- Preventing TBIs in Older Adults (<http://wwwdev.cdc.gov/traumaticbraininjury/seniors.html>)
- Concussion in Youth Sports (<http://wwwdev.cdc.gov/concussion/sports/index.html>)
- Preventing Child Injuries (<http://wwwdev.cdc.gov/HomeandRecreationalSafety/index.html>)

TBI Estimates by State

CDC currently funds 30 states to conduct basic TBI surveillance through the CORE state Injury Program (<http://www.cdc.gov/injury/stateprograms/index.html>).

To find TBI-related death and hospitalization data by participating CORE states, see State Injury Indicators Web-based Query System (http://ga.nccd.cdc.gov/DACH_SII/Default/Default.aspx). (Note: Not all states participate in the submission of TBI- and other injury-related data compiled in this report.)

Costs of TBI

Direct medical costs and indirect costs such as lost productivity of TBI totaled an estimated \$60 billion in the United States in 2000.³

References

1. Faul M, Xu L, Wald MM, Coronado VG. Traumatic brain injury in the United States: emergency department visits, hospitalizations, and deaths. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2010.
2. Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control. Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem. Atlanta (GA): Centers for Disease Control and Prevention; 2003.
3. Finkelstein E, Corso P, Miller T and associates. The Incidence and Economic Burden of Injuries in the United States. New York (NY): Oxford University Press; 2006.

Related Links

- *Traumatic Brain Injury in the United States: Emergency Department Visits, Hospitalizations and Deaths 2002 – 2006* (/traumaticbraininjury/tbi ed.html)
- *State Injury Indicators Report Fourth Edition—2005 Data* 
(http://apps.nccd.cdc.gov/DACH_SII/Resources/201699-A_InjuryIndicatorsReport_LowRes.pdf)
- *Surveillance for Traumatic Brain Injury–Related Deaths — United States, 1997–2007. MMWR Surveillance Summaries*
(http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6005a1.htm?s_cid=ss6005a1_w)

Page last reviewed: March 17, 2010

Page last updated: May 5, 2011

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA
30333, USA

800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov





Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

What are the Potential Long-Term Outcomes of TBI?

The severity of a TBI may range from "mild," i.e., a brief change in mental status or consciousness, to "severe," i.e., an extended period of unconsciousness or amnesia after the injury.

TBI can cause a wide range of functional short- or long-term changes affecting thinking, sensation, language, or emotions.

- **Thinking** (i.e., memory and reasoning);
- **Sensation** (i.e., touch, taste, and smell);
- **Language** (i.e., communication, expression, and understanding); and
- **Emotion** (i.e., depression, anxiety, personality changes, aggression, acting out, and social inappropriateness).¹

TBI can also cause epilepsy and increase the risk for conditions such as Alzheimer's disease, Parkinson's disease, and other brain disorders that become more prevalent with age.¹

About 75% of TBIs that occur each year are concussions or other forms of mild TBI (</concussion/index.html>).²

Repeated mild TBIs occurring over an extended period of time (i.e., months, years) can result in cumulative neurological and cognitive deficits. Repeated mild TBIs occurring within a short period of time (i.e., hours, days, or weeks) can be catastrophic or fatal.³

General Tips to Help Aid in Recovery:

- Get lots of rest. Don't rush back to daily activities such as work or school.
- Avoid doing anything that could cause another blow or jolt to the head.
- Ask your health care professional when it's safe to drive a car, ride a bike, or use heavy equipment, because your ability to react may be slower after a brain injury.
- Take only the drugs your health care professional has approved, and don't drink alcohol until your health care professional says it's OK.
- Write things down if you have a hard time remembering.
- You may need help to re-learn skills that were lost. Your health care professional can help arrange for these services.⁴

References

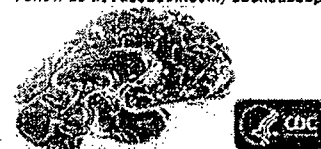
1. National Institute of Neurological Disorders and Stroke. Traumatic brain injury: hope through research. Bethesda (MD): National Institutes of Health; 2002 Feb. NIH Publication No.: 02-158.
2. Centers for Disease Control and Prevention (CDC). National Center for Injury Prevention and Control. Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem. Atlanta (GA): Centers for Disease Control and Prevention; 2003.
3. Centers for Disease Control and Prevention (CDC). Sports-related recurrent brain injuries—United States. *MMWR* 1997;46(10):224–227.
4. Centers for Disease Control and Prevention (CDC). Facts about concussion and brain injury: Where to Get Help. 2010.

Related Links

- [Facts about Concussion and Brain Injury: Where to Get Help \(/concussion/get_help.html\)](/concussion/get_help.html)

CDC's Heads Up on Brain Injury

Follow us at [Facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup)



Share your stories with other brain injury survivors, their family members and caregivers. Become a Partner for better Prevention, Recognition and Response to TBI.

[facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup) 
<http://www.facebook.com/cdcheadsup/>

Page last reviewed: March 8, 2010

Page last updated: March 8, 2010

Content source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov





Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People. Saving Money Through Prevention.

CDC's Heads Up on Brain Injury

Follow us at [Facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup)



Share your stories with other brain injury survivors, family members and caregivers.

[facebook.com/cdcheadsup](https://www.facebook.com/cdcheadsup) 
(<http://www.facebook.com/cdcheadsup/>)

CDC Injury Center and Lifetime Television Partner to Raise Awareness about Traumatic Brain Injury

In a July 2010 episode of Lifetime Television's show *Army Wives*   (<http://www.mylifetime.com/shows/army-wives/traumatic-brain-injury-awareness>), lead character Joan, played by Wendy Davis, was diagnosed with a Traumatic Brain Injury (TBI) sustained from a bomb blast while on active duty in Iraq. The leading cause of injury among U.S. forces serving in Afghanistan and Iraq is TBI.

CDC's Injury Center helped to provide TBI information for this show. CDC subject matter experts consulted with *Army Wives* writers and producers on prevention strategies and the importance of early diagnosis and treatment for TBI survivors. The resulting storyline is an example of the partnership between CDC and Hollywood Health & Society, which exists to provide entertainment industry professionals with accurate and timely health information, like TBI, through consultations with experts for their scripts. Lifetime television ran this story line in July 2010 and showed how Joan and her loved ones coped with the challenges of treatment and recovery for TBI.

armywives

From 2002-2006, an estimated average of 1.7 million people in the U.S. annually sustained a TBI; that's more people than the populations of Dallas and Miami combined.

Related Links

- [CDC TBI web site \(http://www.cdc.gov/traumaticbraininjury\)](http://www.cdc.gov/traumaticbraininjury)
- [CDC Heads Up - Brain Injury Awareness Facebook Page](https://www.facebook.com/cdcheadsup)  (<http://www.facebook.com/cdcheadsup>)

If you are active duty military service member, veteran, or family member or caregiver:

- [Defense & Veterans Brain Injury Center](http://www.dvbic.org/)  (<http://www.dvbic.org/>)
- ["Army Wives" Supports Traumatic Brain Injury \(TBI\) Awareness](http://www.mylifetime.com/shows/army-wives/traumatic-brain-injury-awareness)  
(<http://www.mylifetime.com/shows/army-wives/traumatic-brain-injury-awareness>)

Page last reviewed: June 29, 2010

Page last updated: December 2, 2010

Content source: [Centers for Disease Control and Prevention, National Center for Injury Prevention and Control](#)

Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA
800-CDC-INFO (800-232-4636) TTY: (888) 232-6348, 24 Hours/Every Day -
cdcinfo@cdc.gov



THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM CHESTERFIELD COUNTY
Court of Common Pleas

The Honorable Paul M. Burch, Circuit Court Judge

Case No.: 2012-213511

South Carolina Second Injury Fund,..... Appellant,
v.
American Home Assurance,..... Respondent.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

PROOF OF SERVICE

The undersigned employee of Dilligard Edwards, LLC, Attorney for the Respondent, does hereby certify that service of the **Final Brief of Appellant, Record on Appeal and Certificate of Counsel** to the South Carolina Court of Appeals in the above-captioned matter was made upon counsel of record for Respondent John F. Stroud & Sons, Inc., Employer and American Home Assurance, Carrier, and the South Carolina Workers' Compensation Commission, by placing same in the United States Mail, first class postage prepaid, at the below listed address clearly indicated on said envelope on this 8th day of July, 2013, addressed as follows:

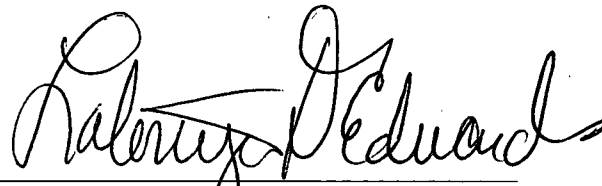
RECEIVED

JUL 08 2013

SC Court of Appeals

Jared M. Pretulak, Esquire
Robert C. Rogers, Esquire
Gallivan, White & Boyd, P.A.
Post Office Box 10589
Greenville, South Carolina 29601

The Honorable Virginia Crocker, Judicial Director
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

A handwritten signature in black ink, reading "Latonya Dilligard Edwards". The signature is fluid and cursive, with the first name "Latonya" being more prominent and the last name "Edwards" following in a similar style.

Latonya Dilligard Edwards, Esquire
Dilligard Edwards, LLC
3790 Fernandina Road, Suite 103
Columbia, South Carolina 29210
(803) 750-2214 (phone)
(803) 750-2377 (fax)

ATTORNEY FOR APPELLANT

THE STATE OF SOUTH CAROLINA

In the Court of Appeals

APPEAL FROM CHESTERFIELD COUNTY
Court of Common Pleas

The Honorable Paul M. Burch, Circuit Court Judge

Case No.: 2012-213511

South Carolina Second Injury Fund,..... Appellant,
 v.
 American Home Assurance,..... Respondent.

(In Re: John Stroud v. John F. Stroud & Sons, Inc.)

CERTIFICATE OF COUNSEL

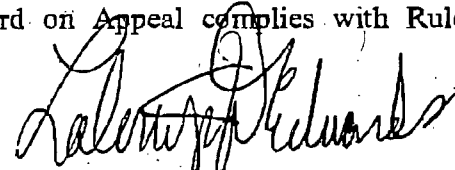
RECEIVED

OCT 18 2013

SC Court of Appeals

The undersigned certified that this Record on Appeal complies with Rule 210(c),
 SCACR.

October 18, 2013



Latonya Dilligard Edwards, Esquire
 Dilligard Edwards, LLC
 3790 Fernandina Road, Suite 103
 Columbia, South Carolina 29210
 S.C. Bar #: 14593
 (803) 750-2214 (phone)
 (803) 750-2377 (fax)

ATTORNEY FOR APPELLANT