

Narrative Summary

Mr. XXXXXX, a 50-year-old male, was involved in a head-on motor vehicle collision on December 23, YYYY. He was attended by medical personnel from City of XYZ Municipal Ambulance Service for the first aid of his collision injuries. Upon their arrival, he was ambulatory as he had extricated himself. He had sinus tachycardia and complained of pain in his left flank and low back. There were contusions on his thorax and minor abrasions in his upper and lower extremities observed. An intravenous access was established through which Normal Saline was infused. His neck and back was secured with complete spinal precautions. He was transported to XXXX West XYZ Memorial Hospital for the further treatment of his injuries (**PDF REF: 78-79**).

Mr. XXXXXX was subsequently received in the Emergency Department of XXXX XYZ Memorial Hospital. A triage assessment was performed by Ms. XXXX, R.N. He was evaluated by Dr. XXXXX. He had severe pain and was dazed. He located the pain in his head, face, chest, abdomen and low back. A physical examination revealed moderate tenderness, swelling and a subcutaneous laceration measuring 5 cm in his right parietal area. There was tenderness of his chest and left upper quadrant of his abdomen. His left thigh was evident for soft tissue tenderness. A laceration of 3 cm on his left elbow and 2 cm on his left hand were observed. Under asepsis and local anesthesia, the lacerations on his scalp, left elbow and left ring finger were repaired with staples and skin adhesives, respectively. The procedures were uneventful. (**PDF REF: 103-106, 91-100**).

On the same day, a series of diagnostic imaging studies were obtained for the evaluation of his injuries. A CT scan of his head revealed soft tissue swelling and laceration along the left parietal scalp region. A CT scan of his neck revealed a multilevel degenerative disc disease and cervical spondylosis, most pronounced at C6-7 disc space level with no evidence of acute radiographic abnormality. An X-ray of his chest revealed no evidence of acute cardiopulmonary injuries. A CT scan of his chest revealed left posterior 11th rib fracture with adjacent probable blood in the abdomen. A CT scan of his abdomen and pelvis revealed nondisplaced fractures were present involving the posterior left 12th and 11th ribs. There was a laceration involving the lower pole of the spleen. There was small amount of perisplenic hemorrhage noted with blood present in the left paracolic gutter. There was also a small amount of blood noted adjacent to the lower pole of the right lobe of the liver. A small amount of fluid was present within the floor of the pelvis. An X-ray of his left femur and pelvis was normal. He was diagnosed to have back pain due to lumbar contusion, blunt injury to abdomen causing contusion to abdominal wall, splenic injury, intra-abdominal, hemorrhage, concussion, multiple rib fractures, multiple lacerations to scalp and left elbow and left ring finger, cervical strain, contusion to the chest and abdomen. In view of the extent of his injuries, he was admitted in-hospital for observation purposes. (**PDF REF: 137, 136, 132, 138, 134-135, 139, 140**).

Splenic injury

Chest wall contusion

On the same day, Mr. XXXXXX was seen by Dr. XXXXX III. He had headache and pain on his scalp. He was admitted for monitoring his hemoglobin and hematocrit. His hemoglobin and hematocrit

was 14.6 g/dL and 40.9%, respectively. He was recommended to obtain an X-ray of his chest on the next day (**PDF REF: 89-90**).

On December 24, YYYY, an X-ray of his chest was obtained which revealed, no evidence of acute cardiopulmonary injuries. His hemoglobin and hematocrit was 11.2 g/dL and 30.8%, respectively. He was discharged home the same day and was advised to follow-up with Dr. XXXXX III for the removal of staples from his scalp (**PDF REF: 107, 133, 141-144, 88**).

On December 26, YYYY, Mr. XXXXXX presented to the Emergency Department of ABCD Medical Center. He had pain in his abdomen and left flank with distension of his abdomen. A triage assessment was performed by Ms. XXXX, R.N. He was evaluated by Dr. XXXX. He complained of pain in his head, chest and abdomen. He appeared to be a little anxious. His left parietal scalp appeared to be stapled. There was tenderness and mild distension of his abdomen on examination. A CT of his abdomen and pelvis was obtained which revealed no evidence of injury to solid organs or a hemoperitoneum. No signs of a splenic laceration were observed. A lesion in the left flank with protrusion of peritoneal fat and stranding of the adjacent fat was present. There was no evidence of a subcutaneous hematoma and he had a fatty liver. A CT scan of his head revealed no evidence of acute intracranial pathology. An X-ray of his chest revealed no evidence of acute cardiopulmonary injuries. His hemoglobin and hematocrit were 11.1 g/dL and 31.6 %, respectively. He was diagnosed to have contusion, possible left flank hernia possibly due to trauma. He was prescribed Norco for pain relief and was discharged home subsequently (**PDF REF: 25, 27-38, 54, 52-53, 51**).

On March 11, YYYY, Mr. XXXXXX obtained an MRI of his right shoulder from McAllen MRI Center. The study revealed a normal glenohumeral alignment associated with partial separation of the anterior labrum from its base. Subtle features for cartilaginous Bankart versus a variation of a GLAD (Glenolabral Articular Disruption) lesion of the anterior inferior labrum was suspected. There was a minimal glenohumeral ligamentous strain and bone bruise in greater tuberosity. A full thickness tear of the supraspinatus aponeurosis, proximal and mid-supraspinatus tendon and a suspected full thickness tear of the distal tendon at its anterior margin were observed. The findings would account for the escape of joint fluid into the subacromial and subdeltoid bursal spaces. A deltoid muscular strain was evident. There were no evidences of HAGL (Humeral Avulsion of Glenohumeral Ligament), SLAP (Superior Labrum Anterior Posterior), ALPSA (Anterior Labroligamentous Periosteal Sleeve Avulsion) or osseous Bankart deformity seen. Type II acromion associated with capsular atrophy in the acromioclavicular joint was observed. MRI features supported a clinical diagnosis of shoulder impingement. There was no separation of acromioclavicular joint seen or there was an evidence of os acromiale detected. A subacute arthritic change at acromioclavicular joint was obvious. On the same day, an MRI of his left hip was also obtained which was a normal study (**PDF REF: 74-76, 72-73**).

On May 6, YYYY, Mr. XXXXXX presented to Mr. XXXXX, P.A. at XYZ Back Institute and Orthopedics. He had pain in his right shoulder, both hands, upper, mid and low back, knees and left ankle. He quantified his pain to be 10/10 and described it as sharp, stabbing and aching. His symptoms were constant and worsened with squatting, kneeling, sitting, bending, stairs, twisting, moving, lying in bed and standing. He also complained of chronic headaches as well as pain in his left lower quadrant of his abdomen. A physical examination revealed moderate right subacromial crepitus and tenderness. The

movement of his right shoulder was restricted due to pain. There was mild spasm of the muscles of his low back with limited movement due to pain. A left-sided L4-5 dermatomal paresthesia was noted. His neck muscles on either sides were tender and had restricted movement due to pain. There was a marked lateral joint tenderness of his left knee. His gait was slightly antalgic favoring the affected side. He was diagnosed to have right rotator cuff tear, lumbar herniated nucleus pulposus, cervical disc herniation and left lateral meniscal tear. At that point, his attempts with conservative treatments such as physical therapy and pain medications were unsuccessful in alleviating his pain and discomfort. He was recommended to obtain CT of his abdomen and pelvis to evaluate the left lower quadrant mass and tender spot and an MRI of his left knee for possible meniscal tear. He was suggested to receive a series of 3 epidural steroid injections for his neck and low back. Further, he was recommended to undergo microdiscectomy at L5-S1 and right rotator cuff repair if the injections failed to relieve his pain (**PDF REF: 3-7**).