QQQQQQQQQQQQ, M.D.

123 Main Street, New York, NY 11111
Telephone: (123) 345-7890
Fax: (123) 345-7891

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Re: Mr. First Last
Last v. WWWWW

Dear Mr. Attorney:

Pursuant to your request, I am documenting my findings regarding Mr. First Last and the above matter.

MATERIALS REVIEWED

In forming my opinions, I reviewed New York State Department of Correctional Services ("DOCS") medical records bearing Bates Nos. 1 through 1190, the transcript of Mr. FFFF's 2008 deposition, the radiologic studies provided by DOCS, UUUU Hospital, and PPPP Medical Center, and the following documents:

February 28, 2007, Inmate Injury Report
February 28, 2007, Memorandum from First Last to Sgt. ZZZZZ
February 28, 2007, memorandum from Lt. L. KKKKK to D.S.S. YYYYY
March 5, 2007, Grievance
March 5, 2007, letter from Mr. Last to DOCS Investigator General
March 7, 2007, letter to DOCS CommissionerWWWW
March 26, 2007, report of interview of DDDDD CCCCC, R.N.
May 11, 2007, letter from Mr. Last
October 3, 2007, Investigative Report

I also examined Mr. Last today at the Metropolitan Correctional Center, 150 Park Row, New York, New York.

BRIEF FACTUAL HISTORY

Mr. Last is a 41-year-old right handed male with a chief complaint of years of low back pain. The medical records do not indicate any complaints of back pain between 2005, and February 28, 2007. Mr. Last reported an assault that occurred on February 28, 2007, and presented with new back symptomatology at the next day's sick call. Mr. Last described the incident as him being put into a head lock, forced to the ground, hitting a desktop with his head and, significantly, torquing his lower back.

Since February 28, 2007, his condition has not improved despite pain management (epidural steroid injections, transforaminal injections, caudal epidural injections, medication and bracing). He was evaluated by a neurosurgeon on October 15, 2008, who recommended a single level discetomy.

DIAGNOSTIC STUDIES

The following diagnostic studies were also reviewed:

- An April 19, 2007, x-ray showed degenerative disc disease at L4-L5 and L5-S1, with mild degenerative lower lumbar spondylosis.

- A May 10, 2007, MRI of the lumbar spine showed large left transforaminal/far lateral focal disc herniation at L4-L5 impinging on the L4 nerve root, a congenitally shallow lumbar canal, and multi-level facet osteoarthropathy most severely affecting L4-L5 and L5-S1.

Findings from the above films were compared with radiology reports related to Mr. Last's back taken on April 27, 1998, April 28, 1999, June 15, 2000, and August 20, 2003. All of these reports noted normal disc space height and alignment. I also compared these findings with the findings of a November 12, 2008, report regarding a November 11, 2008, lumbar spine MRI.

EXAMINATION

I) HISTORY

He notes the pain to be in the mid to low back and that it is band-like (i.e., wrapping around his lower back) with radiation to the left buttock and outer left thigh. There is no radiation below the knee. There is a sensation of numbness to the outer aspect of left thigh. He voiced no current complaints related to his right lower extremity.

He describes the pain level to be 7/10 and that it is hard to sleep. He notes that it is hard to sit or stand for a long period of time. He is unable to perform labor or recreational activities. He requires pain medication on a daily basis. He utilizes a brace on a daily basis. He also limps.

He noted his neck will ache on occasion. No other complaints were voiced.

II) PAST MEDICAL AND SURGICAL HISTORIES

Medical: A review of Mr. Last's medical records indicates a history of medical complaints and treatments apparently unrelated to his back pain, as well as ongoing migraines.
Medication: Medication for migraine and unknown medication for low back pain.
Surgery: No recent surgeries.
Allergies to Medications: Keflex.

III) PHYSICAL EXAMINATION

Mr. Last is 5'10" tall and weighs 195 lbs.

A) Lumbar Spine

Gait:
He had a slight limp on left.

Posture:
His posture was asymmetric with prominence of right paravertebral musculature and associated spasm.
He was able to stand on toes and able to stand on heels.
He was able to remove his outer clothes without significant discomfort.
He was utilizing an elastic lumbo-sacral support.
He did not demonstrate atrophy to his calf or thigh.

Palpation:
He was tender to the mid-lumbar area and interspinous area L3-sacrum.
He was nontender to the right sacro-iliac joint.
He was tender to the left sacro-iliac joint.

Range of Motion:
He was able to forward flex 40 degrees and place hands on thighs. (Normal being greater than 90.)
He was able to extend 20 degrees. (Normal being greater than 30.)
He was able to rotate 40 degrees. (Normal being greater than 40.)
He assumed the seated position without problem. He was able to straight leg raise in the seated position. He was able to cross his right leg over the left knee. He was unable to cross his left leg over the right knee.

Neurologic:
His motor function was normal through the right and left lower extremity. It was 5/5 and included hip flexion, rotation and extension, knee flexion and extension, ankle flexion and extension and toe flexion and extension.

His reflexes were symmetrical. They included the knee jerks and ankle jerks. His sensory

examination demonstrated decreased sensation to light touch to the outer aspect of left thigh. He had intact sensation to the entire right and left leg. He had intact sensation to the entire right and left foot/ankle.

Special Tests:
He has a positive FABER sign (flexion abduction and external rotations to hip/extremity) on the left side. He had a negative FABER sign on the right side.

B) Cervical Spine

Inspection:
Normal appearing skin with no asymmetry and no atrophy.

Palpation:
Nontender to muscles and bony prominences.

Range of Motion:
Rotation to 80 degrees, right and left (normal) with flexion to 30 degrees and extension to 30 degrees (normal).

Neurologic:
Intact motor, sensation and reflexes.

Special tests:
Negative distraction, compression and Spurling test.

ANALYSIS/CONCLUSIONS

Mr. Last is a 41-year-old male with chronic low back pain and radiculopathy. He has discogenic disease with a herniated nucleus propulsis at L4-L5. He also has objective findings consistent with a left sacro-iliac joint derangement.

His back pain is axial with a radicular component. He has discogenic disease that causes pain localized to the lumbar area and left thigh which has numbness and tingling. He has an abnormal segment between the L4-L5 vertebral bodies. Motion to the disc space and facet produces pain. Prolonged forces across the disc space will also cause pain. This is responsible for him having discomfort with prolonged sitting or standing. The compressive effect of the left herniated disc at L4-L5 is the causative factor.

Based on the history of the incident provided by Mr. Last, the traumatic event of February 28, 2007, re-ignited a chronic low back condition that had been symptomatically dormant. The increased force to the diseased disc spaces caused disc disruption and subsequent ongoing pain.

Mr. Last's prognosis is fair. He will require ongoing treatment to consist of appropriate medication, physical therapy, additional bracing, pain management intervention with

spinal injections, possible single level discectomy, spine surgical consultations and additional MRI testing to assess progression.

In sum, although he had pre-existing low back pain, he was asymptomatic at the time of the incident. Essentially, he went from having no pain to having pain of 7 out of 10 following the incident. This temporal concurrence between the incident of February 28, 2007, and the acute onset of significant (7/10) pain, his description of that episode, the radiologic findings on the 2007 films, the failure of both medical therapy and spinal interventional procedures, and the treating spine surgeon's recommendation of discectomy are all fully consistent with the conclusion that, to reasonable medical certainty, the incident of February 28, 2007, caused his current symptomatology, including radiculopathy to his left buttocks and left leg, numbness of his left thigh, his lumbar spine pain and potential need for discectomy.

Very Truly Yours,

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