[redacted]

July 31, 2016

[redacted]

Re: [redacted]

Dear Mr. [redacted],

At your request, I have reviewed the documents you have provided me:

- ords for [redacted] n se from family [redacted] to [redacted] l, radiology ([redacted] orthopedic referral, and pharmacy records ([redacted] to [redacted].)

You have asked me to prepare a narrative report for the above-named client with respect to his situation prior to his motor vehicle accident (MVA) on [redacted], and since then.

Representations of the Expert

[redacted]

porated Transferable Skills Assessments into my practice four years ago. My attached curriculum vitae details my clinical and educational background.

Claimant History

[redacted] is currently [redacted] of age. When he was [redacted] years old ([redacted]), [redacted] was a passenger in the front seat of a car when the car was hit head-on by an oncoming vehicle that crossed the median at highway speed. [redacted] was taken to [redacted] Hospital by Emergency Medical Services, on a backboard. In emergency, [redacted] mined by a physician, had X-rays taken and was subsequently discharged home. After his accident, Mr. [redacted] wore a prescribed wrist splint and participated in a physiotherapy program, attending three times p On his return to work, he continued physiotherapy treatment twice per week, and he participated in a work-hardening program. Prior to this accident, Mr. [redacted] worked 8 hour shifts in a factory, performing manual labour. Sometimes he was on a line requiring long periods of standing; so eti was required to move heavy pallets. [redacted] (replacing [redacted] for vacation) indicated that [redacted]. [redacted] was anxious to return to work for financial reasons. Approximately, three months after his accide t, [redacted] returned to work. He did so, for full 8 hour shifts, and subsequently suffered an increase in symptoms. According to provided records, Mr. [redacted] has remained off work since December 20, [redacted] Mr. [redacted] experienced significant social and emotional hardships growing up, related to [redacted]' discordant relationship and marital breakdown complicated by a diagnosis of ADHD and ODD. Mr. [redacted] medical history includes the following diagnoses, treated over time with various medication:

- pain – Tylenol # 3 (Tylenol plus codeine), Ibuprofen (non-steroidal anti-inflammatory/analgesic)
- asthma – Montelukast Sodium/Singulaire (treats asthma and nasal allergic/infection conditions)
- acne – Stievamycin gel (antibiotic), Minocin (antibiotic), Accutane (Isotretinoin, also Roaccutane) is a form of Vitamin A effective in acne treatment)
- allergic rhinitis – Nasonex (anti-inflammatory steroid nasal spray),
- sinusitis – Prednisone (anti-inflammatory steroid), doxycycline (antibiotic)
- viral/bacterial illnesses – Zithromax (antibiotic), Aerius (antihistamine that controls itching/hives), Celestoderm (steroid anti-inflammatory cream for dermatological conditions), Biaxin (Clarithromycin - antibiotic)
- rash/Herpes Dermatitis – Minocin (antibiotic), Doxycycline (antibiotic), Stievamycin gel (antibiotic), Valtrex (treatment of herpes viral symptoms), HC (Hydrocortisone cream used for anti-inflammatory properties)
- bumps/bruises/sprains – Naprosyn (anti-inflammatory/analgesic), Vimovo (non-steroidal anti-inflammatory/analgesic)
- ADHD (Attention Deficit Hyperactivity Disorder) – Ritalin (Methylphenidate) and more specifically of late, Concerta (central nervous system stimulant to assist with focus)
- ODD (Oppositional Defiant Disorder) – treated with therapy and positive parenting.
- depression – Amytryptiline (a tricyclic antidepressant)

Background Medical Information

A *fracture* (#) indicates a break in a bone. In this case, references are made to fractures of Mr. [redacted] 3rd lumbar vertebra and to his right hand/wrist. The *lumbar vertebrae* is a lower part of the spine that stabilizes and supports the upper thoracic and cervical vertebrae and allows for flexibility with other parts of the body, including muscles. [redacted] lumbar fracture resulted from a high-impact collision that imposed great force upon his spine and his wrist was fractured from hitting his right hand during the MVA. On impact, Mr. [redacted] was seat belted; his lower body was restrained and his upper body (neck and head) moved forward and backward. The combined restraint and movement caused what is known as a *flexion/distraction* (*chance*) fracture where the vertebra is literally pulled apart (it is often caused by a violent forward motion). An injury of this type would cause pain and decreased functionality not just in the location of the single vertebra, but additionally, it would cause increase work and stress to the rest of the spine [redacted] complaints of back pain from his thoracic spine area to his lumbar area, post MVA, would be concordant with such an injury).

The bones of the hand/wrist mentioned in various medical reports, forms and X-ray findings include the *scaphoid*, the *triquetrum* and *pisiform*. Some notes refer to STT fractures, referring to the Scaphoid, Trapezoid and

Trapezium bones. A break in any of these bones result in pain and disability, depending on the extent of the break and the number of involved bones. (There is inconsistency in the medical records as to which bones have been fractured.)

Attention Deficit Hyperactivity Disorder (*ADHD*) is a condition manifested by persistent inattention, hyperactivity, and often impulsivity. Treating ADHD is a complex challenge requiring a combination of medication and psychological therapy. Some of the medications that are effective in treating ADHD include Ritalin, Methylphenidate and Concerta, all of which are central nervous system stimulants used to help the patient focus to improve their functionality and mitigate impulsivity. Risperidone is a tranquilizer and is often prescribed to counter the stimulant effect of ADHD drugs at the end of the day so that patients can sleep. Amitriptyline is an antidepressant medication.

The Medical Findings

On [redacted], [redacted] subsequent to the motor vehicle accident, Mr. [redacted] complained of pain to his right wris ef He had a laceration to his right eyebrow area, 3 meters in length. It was noted that Mr. [redacted] c-spine was tender at the midline and that his right wrist was painful and positive for a deformity. Mr. [redacted] left lower leg was painful and his back was tender at midline from T8-L4. The radiological results from this day include the following notes:

- Left Ankle: The bony structures are intact with no evidence of fracture.
- Right hand and wrist: There is a fracture of the pisiform and possible fracture of the triquetrum.
- Lumbar Spine: There is some slight depression of the end plate of L3 which may be in keeping with mild compression fracture.
- Thoracic Spine: The vertebral bodies, spinous processes and pedicles are intact with no evidence of fracture.

Mr. [redacted] was referred to plastic surgery to be evaluated but it is unclear if that appointment took place.

Following that assessment, on December 30, [redacted] radiological results from this day noted that [redacted] chest X-ray was normal, that the right wrist X-ray showed no fracture to the right scaphoid or wrist, and that, in terms of his lumbar spine, "transverse fracture of the mid-body of the L3 with some sclerosis indicating early healing … Non-displaced Chance fracture L3, compression injury to anterior portion of vertebral body and transverse fracture through posterior elements of vertebra and posterior position of vertebral body."

[redacted] indicated [redacted]. [redacted] had a sore low back, tender scaphoid and questionable fracture of his L3 ver- t r e also noted he complained of chest wall pain. A diagnosis of "?#wrist" was made. The patient was referred to [redacted], an orthopedic surgeon, and was prescribed a wrist splint.

On January 8, [redacted] Mr. [redacted] was seen by [redacted], who noted the patient had "pain all over his whole wrist and hand. It is mainly in the radiocarpal joint. He has slight tenderness to palpation over the right pisiform, snuffbox and the wrist in general. His active range of motion at 80 degrees and 80 degrees for flexion/extension …" of the right wrist. [redacted] noted that there may be a pisiform fracture but that this was not an obvious fracture. [redacted] prescribed a volar wrist splint and physiotherapy to get motion and strength back in Mr. [redacted] wrist. [redacted] diagnosis was of a right wrist sprain.

When Mr. [redacted] was subsequently seen by his family [redacted] for "bad sprain wrist" on January 13, [redacted] noted ed flexion at Mr. [redacted] L3 area an erenced a fractured 3rd lumbar vertebra he next day, Mr. [redacted] had a repeat X-ray for his right scaphoid. No definite fracture was seen.

On February 1, [redacted] report for Mr. [redacted] application for disability indicated that Mr. [redacted] primary diagnos as Fr e lumbar 3 verte is severe". He noted a secondary diagnosis a

[redacted]

ture Rt Triquetrum (Wrist)" that was "moder n severity. s objective findings were: "tender /swelling wrist. tender L3++paravertebral areas." The noted Mr. had never had a similar condition and that a referral had been made for the patient to se (ortho rgeon). With respect to Mr. injuries and symptoms, listed the following work restrictions for that time:"avoid ladder climbing, prolonged sitting, squatting, repetitive gripping/rotational movement, work at elevation, pulling, pushing, excessive walking/standing, repetitive twisting/bending, overhead reaching, lifting over 10 lbs. and reaching."

stated that Mr. had severe back pain and was "unable to use his (casted) right hand. Treatment listed was for physiotherapy, and the noted that the patient had been compliant with this treatment plan. indicated he ught that M prognosis was to return to work in possibly 8 weeks. notes on ry 4, that Mr. has decreased grip strength to his right hand, and had back but M. was nding phys y and was to be off work until March 3rd. On February 12, Wes eted a Short Term Disability Claim form for Mr. where the indicated th . wrist was slowly improving but that the patient had persistent low back pain which may develop into ro ain, s ary to the fractured ar vertebra sustained in the motor vehicle accident of December , The indicates that Mr. job is manual labor that requires heavy lifting and that his dis- ili solely ult of the described

The February 25, visit to notes that Mr. continues with physiotherapy and that his right wrist shows improvement. On March 13, note e patient has a fracture of L3, a severe sprained rig w and that the wrist is "good" but that Mr. continues to have back pain with decreased flexibility. ordered a return to work with light duties weeks with no lifting more than 20 pounds.

On March 20, (the vacation replacement for) noted that Mr. attempted a return to work, working 8 hour Mr. did not do well and it is noted that he had pain in his back. The note goes on to say that Mr. has decreased physiotherapy fro o two times per week since returning to work with light dutie e was noted tenderness over Mr. right sacroiliac joint and right lumbar area with stiffness and a decreased range of motion when mo suggested being off work for two weeks with a gradual return to work.

completed an application for disability behalf March 25, and on the m noted a number of issues. Firstly, Mr. ms began after the or vehicle accident and njuries were to his low back, left ankle, nd right wrist. wrote that it was the emergency room who originally suggested Mr. stop working, stating the reason behind gg his "inability to function at Mr. was in too much pain to do anything at first. recommended that Mr. undergo therapy until his symptoms were manageable.

went on to write that when Mr. returned to work on March, he did so on a full-time basis (8 hour shifts) at which point, he experienced a flare in pain to his back, secondary to a healing vertebral fracture. The suggested that when the pain settled down, Mr. could attempt a return to work, on a part-time basis and gradually increase his hours.

wrote that Mr. injuries were not chronic, that his primary diagnosis was a compression fracture of the vertebra and his secondary diagnosis was a possible carpal bone fracture of the right wrist. Mr. sympt t that time were per ower back pain, a tender right sacroiliac joint and stiff lumbar movement. The indicated that Mr. should avoid lifting, stayin place too long that he should stay mobi d not sit or stand for ed times, advising that Mr. should participate in a work-hardening program.

note that a wrist splint helped the patient, that the patient was compliant with treat and that Mr. treatment could change with work hardening, once his symptoms improved. The was of the

nion that Mr. [redacted] had not reached maximal medical improvement (mmi) at that point but that Mr. [redacted] could improv mentally within 2-3 weeks and recovery, without impairment, might be expected n eeks from then. [redacted] wrote that Mr. [redacted] was a candidate for trial employment for his job if he restarted at reduced hours and that part-time hour return-to-work plans had been discussed with Mr. [redacted] depending on his physiotherap gress. [redacted] noted Mr. [redacted] wanted to work six hours per day, not four, to pay his bills. The [redacted] noted better range of motion, decreased pain and that he feels better at work.

On August 7, [redacted], the family [redacted] noted that Mr. [redacted] had back pain after trying to move palettes at work. He was unable to do heavy duty and noted Mr. [redacted] paravertebrals were " ++ tight", and that he had decreased flexibility. [redacted] wrote that Mr. [redacted] could not yet work 8 hours, only 6 hours per day for 4 weeks, at light duties.

Summary

Subsequent to Mr. [redacted] motor vehicle accident (MVA) of [redacted], [redacted] he developed the following symptoms:

Lower Back Pain

Before the MVA, Mr. [redacted] had only one incident of lower back pain on May 27, 2010 and none between then and the accident. Prior to the accident, Mr. [redacted] had been physically active – he had been a runner and worked full-time in a physically-deman job as a labourer. Immediately after the MVA, Mr. [redacted] complained of tenderness to his back from [redacted] and eventually a diagnosis of a fractured [redacted] v s confirmed. Over time, in spite of active par ion in physiotherapy and work hardening, r. [redacted] back pain, tightness and decreased range of motion to his back and right sacroiliac remained. Mr. [redacted] inues to have back pain, tenderness, a decreased ability to stand or sit for long periods of time and to lift weight. As Mr. [redacted] job was as a physical labourer, he has been unable to work since March [redacted] due to pain, stiffness and decreased mobility to his lower back.

Right Wrist/Hand Pain

or to the MVA, Mr. [redacted] had never sustained an injury to his right hand or wrist. I VA, Mr. [redacted] sustained a right wrist sprain and possible fracture. Immediately after the MVA, Mr. [redacted] complained pain to this hand, in general, including his wrist area. The pain has persisted since the d additionally, [redacted] noted that Mr. [redacted] has decreased grip strength in his right hand. There is conflicting information between the radiologist's opinion of Mr. [redacted] post-MVA wrist X-rays versus that of [redacted]. Mr. [redacted] manufacturing job required him to ei ours per day on a line, as well as lifting [redacted]. He has been unable to perform his job since [redacted]

Chest Wall Pain

Before this accident, in 2012, [redacted] had one documented episode by his family [redacted] of chest wall pain or "pain in his side", possibly related to ten nit eatment was provided and there is no indication of further chest-wall pain until just after the MVA [redacted]. [redacted] complained of chest wall pain on December 30, [redacted]

Left Knee Pain

Before this accident, [redacted] worked 8 hour shifts in a factory performing manual labour. Mr. [redacted] had previously been a run 009 had developed patello-femoral syndrome which was treated w d Naprosyn. In April, [redacted] Mr. [redacted] again had bilateral knee pain and his X-rays were found to be normal.

[redacted]

There is no indication that Mr. [redacted] was further bothered by knee pain until [redacted] had symptoms to his left knee subse the MVA. The physical demands of Mr. [redacted] j red standing for long periods of time and moving heavy [redacted] which would be a cha s ne with a sore knee.

Left Ankle Pain

Before the MVA, Mr. [redacted] had sprained his left ankle several times with an X-ray of same being normal as of June [redacted] In [redacted] after his MVA, Mr. [redacted] family [redacted] indicated that Mr. [redacted] was suffer- left ankle pain. As his job at the factory requires l periods of standing as well as heavy lifting, Mr. [redacted] has been unable to work at his job since March, [redacted]

Despite Mr. [redacted] having had significant challenges growing up, he acquired and maintained a full-time job until he was a victim of a motor vehicle accident on [redacted], [redacted] Injuries and sym ustained in and still present since the motor vehicle accident include: pain and disability from a fractured [redacted] vertebra, pain and disability from a severe sprain, query fracture of his right hand/wrist, chest-wall pain, e pain and left ankle pain. The nature of his injuries and resultant symptoms have prevented [redacted] from returning to his [redacted] job even though he was compliant with his physician's and physiotherapist's plan for a return to full-time work program. In fact, Mr. [redacted] conveyed to the family physician that he wanted very much to return to full-time work to pay his bills.

Thank you for the opportunity to assist you with this matter. Should any additional records or information become available in the future, I reserve the right to review same and revise my opinion.

Respectfully,

[redacted]

[redacted]

APPENDIX A