

September 6, 2023

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RE: James Abrams

DOB: 09/22/1949

DOA 07/01/2019

Dear Mr. Gerlanc:

HISTORY:

I had the pleasure of seeing the above-captioned patient in my office today, September 6, 2023. As you know, he was previously seen in our office on June 15, 2016 and August 11, 2021. At the time of the examination today, he was a 73-year-old male who was in his usual state of health until July 1, 2019, when he sustained a traumatic event while going about his usual daily activities. On that day, he was involved in a motor vehicle accident and suffered injuries to his neck and low back when he was the restrained driver of his vehicle stopped in traffic and was struck twice from behind by a commercial vehicle owned by Service & Maintenance Corporation. At that time, he was working as a biology teacher for the Jersey City Board of Education and as a NJ licensed chiropractor with a private practice. He did not seek immediate medical attention. He went home and then to a local softball field where his daughter was playing, and his wife was in attendance. His wife drove him to the ER for an evaluation.

He has a past surgical history of a cholecystectomy in 1994, bilateral carpal tunnel release in 2000 and 2001 and bilateral knee arthroscopic surgery in 2005 and 2007.

He has a past history of a work-related neck injury on November 1, 2002 and had MRIs and EMGs that showed lower cervical degenerative changes, as well as left C5 radiculopathy and bilateral carpal tunnel syndrome. He underwent physical therapy and epidural injections in 2003-04 and 2007. He then underwent left C5-6 foraminotomy on August 20, 2007. He continued to be symptomatic and underwent additional imaging studies that showed findings necessitating surgical intervention. He underwent C4-6 ACDF surgery on June 5, 2008 and C3-6 and C7-T1 posterior decompressive laminectomy and foraminotomy on December 14, 2014. He received Order Approving Settlements for the neck injury on September 27, 2012 and September 27, 2017.

He has a long-standing history of lower back problems and had imaging studies in 2008 and 2013 that showed a L5-S1 disc herniation and left L5 radiculopathy. He had a skiing accident in mid-2018 and suffered an injury to his lower back. Lumbar spine x-rays dated June 28, 2018 showed moderate lumbar degenerative arthritis and spondylosis and moderate bilateral SI joint degenerative arthritis. A lumbar spine MRI scan dated July 28, 2018 showed multilevel spondylosis, bulging discs at L2-4 and herniated discs at L4-S1. He underwent left L4-S1 microdiscectomy surgery on November 2, 2018. He attended postop physical therapy through mid-2019.

He reported an injury which occurred on May 1, 2019, when he banged into a car mirror while walking, impacting his left shoulder. He developed back pain at that time, which was temporary.

He was seen by Carl Stopper APN-C on May 1, 2019 with complaints of worsening left leg pain. He was treated with a Medrol Dosepak with some relief the week prior. He had pain radiating down the left leg to his calf. He was participating in physical therapy twice weekly. Muscle testing revealed normal strength in the lower extremities. Reflexes were 2+ and symmetric. He was diagnosed with lumbar disc herniations with radiculopathy from L1-L5. He had a history of low back pain and left leg pain with a history of L4-5 and L5-S1 surgery. An MRI of the lumbar spine with and without contrast was ordered. The patient was also seen by Dr. Meyer.

He was feeling good and had a productive year with a good income when he bought the BMW convertible, which was the car that was rear-ended.

Following his July 1, 2019 MVA, he presented to the ER at Saint Clare’s Denville Hospital via walk-in for an evaluation regarding his neck and lower back pain. A CT scan of his cervical spine was obtained, which demonstrated no acute fracture or dislocation. He was status post ACDF at C4-5. The cervical vertebral alignment appeared within normal limits. Multilevel degenerative changes were observed, most pronounced at C5-T1. Bilateral carotid atherosclerotic changes were noted. A CT scan of his lumbar spine was performed, which demonstrated multilevel degenerative changes. There was no acute fracture or destructive bony change. There was mild Grade I degenerative anterolisthesis of L3 on L4. Central stenosis was seen at the L3-4 and L4-5 levels. Lesser central stenosis was noted at L2-3. Pronounced posterior spondylosis was seen towards the left with a disc herniation in the left foramen at

L5-S1. There was extrinsic impression upon the exiting and traversing left-sided L5 and S1 nerve root sleeves. He was diagnosed with cervical strain and lumbar strain. He was treated, prescribed medications and discharged to home in stable condition.

On July 3, 2019, he saw Carl Stopper, APN-C, at Atlantic Neurosurgical Specialists for evaluation of his neck and lower back pain. The assessment was lumbar disc prolapse with radiculopathy, lumbar radiculopathy and lumbar herniated disc. He was prescribed medications and physical therapy.

On July 22, 2019, an MRI scan of his lumbar spine was performed, which demonstrated mild bilateral facet arthropathy and hypertrophy at L2-3 contributing to mild bilateral foraminal narrowing. There was a diffuse disc bulge at L3-4 causing compression of the ventral aspect of the thecal sac and moderate bilateral facet arthropathy and hypertrophy causing mild central canal stenosis and mild to moderate bilateral foraminal narrowing. There was a left-sided L4-5 laminectomy with a mild disc bulge and a small focal central region of enhancing granulation tissue. There was a central disc herniation causing mild compression of the ventral aspect of the thecal sac and mild bilateral facet arthropathy and hypertrophy causing mild to moderate bilateral foraminal narrowing. There was a left-sided L5-S1 laminectomy with a small amount of enhancing granulation tissue within the left lateral recess. There was a small to moderate-sized, broad left neural foraminal disc herniation causing moderate left foraminal narrowing.

On July 29, 2019, he saw Dr. Scott Meyer at Atlantic Neurosurgical Specialists and complained of left leg radicular symptoms. His lumbar spine MRI scan results were reviewed, and he was referred to pain management for epidural injections.

On August 7, 2019, he saw Dr. Michael Rudman at New Jersey Pain Consultants and reported persistent left low back, left buttock and left lower extremity complaints. His lumbar spine MRI scan results were reviewed, and he was recommended a left L5 transforaminal epidural steroid injection.

He did not undergo the recommended LESI due to lack of insurance authorization. He returned to Dr. Meyer on September 23, 2019, and was recommended surgical intervention.

On October 10, 2019, he underwent re-operative left L5-S1 METRX microdiscectomy, L5-S1 PHL and microscopic microdiscectomy, performed by Dr. Meyer at Morristown Medical Center.

On November 6, 2019, he followed up with Dr. Meyer for a postop evaluation. He reported some low back weakness and neck pain with numbness/tingling to his bilateral fingers. He was recommended lumbar physical therapy and a cervical spine MRI scan.

On March 2, 2020, he saw Dr. Gina Rizzo at Atlantic Neurosurgical Specialists and reported significant improvement with physical therapy. However, he started to have intermittent left leg radiculopathy after stopping it. He was prescribed an additional course of physical therapy.

He attended physical therapy sessions at Four3 Rehab and Performance Lab.

On June 10, 2020, he saw Dr. Meyer and reported continued left leg weakness despite additional therapy. He was recommended a repeat lumbar spine MRI scan.

On July 13, 2020, an MRI scan of his lumbar spine was performed, which demonstrated postoperative changes at L4-5 and L5-S1. There was a moderate left lateral/foraminal disc herniation at L5-S1 with probable nerve root impingement. Diffuse disc bulge at

L2-3 and L3-4 were noted. There was multilevel central stenosis, greatest at L3-4. Multilevel neural foraminal narrowing was seen. There were questionable bilateral renal cysts and marked bladder wall thickening.

On July 20, 2020, he saw Dr. Meyer at Altair Health Spine and Wellness Center for a review of his lumbar spine MRI scan results. The option of revision L3-S1 surgery was discussed with him. He was recommended flexion/extension lumbar spine x-rays.

On July 20, 2020, x-rays of his lumbar spine with flexion/extension views were performed, which showed severe facet hypertrophy from the L3 to S1 levels. There was no evidence of instability. Dr. Meyer reviewed this report in a follow-up on

November 2, 2020 and felt there was some mild instability at the L3-4 level. He was recommended to proceed with surgery.

On January 12, 2021, he underwent re-operative left L5-S1 microdiscectomy,

TLIF L5-S1 instrumented fusion with O Arm, L3-4 posterolateral arthrodesis, L4-5 decompression, decompression L4-5 PHL and L5-S1 PHL, fusion L3-S1, instrumentation L3-S1 and morselized autograft and demineralized bone matrix, performed by Dr. Meyer at Morristown Medical Center.

Postoperatively, he was seen periodically for follow-up evaluation and wound care and was sent for physical therapy. He did have some symptoms of bilateral calf weakness and tightness. He was continued on physical therapy and was recommended imaging and diagnostic studies.

On July 13, 2022, Dr. Meyer submitted a narrative report regarding his treatment course and present condition in relation to the July 1, 2019 MVA. Dr. Meyer opined that it was highly likely that he would develop adjacent level disease in the future at the L2-3 level and might ultimately require an additional spinal fusion at that level.

On July 28, 2022, an EMG nerve conduction study of the bilateral lower extremities was performed, which demonstrated electrodiagnostic evidence of lumbosacral multilevel polyradiculopathy.

On October 3, 2022, he underwent diagnostic sacroiliac joint blocks, performed by Dr. Rudman to assess for symptomatic sacroiliitis.

On October 13, 2022, an MRI scan of his lumbar spine was performed, which demonstrated postoperative changes. There were diffuse disc bulges at the L1-5 levels. There was central stenosis at L2-3 and L3-4. There was multilevel neural foraminal narrowing. There was a questionable right renal cyst.

On October 24, 2022, he saw Dr. Meyer for a review of the lumbar spine MRI scan results. He also reported severe pain in his bilateral posterior thighs, low back pain and right quadriceps pain. He was recommended a lumbar CT scan.

Ultimately, Dr. Meyer reviewed the CT scan results dated November 10, 2022, which demonstrated progression of the arthrodesis, but not convincing evidence of solid arthrodesis at the L5-S1 level. There was also confirmation of adjacent level disease. He was recommended revision surgery.

On February 23, 2023, he underwent L2-3 laminectomy with extension of fusion to L2, performed by Dr. Meyer.

Postoperatively, he was seen periodically for follow-up evaluation and wound care and was sent for physical therapy. He continued to have low back pain and functional limitations related to the surgery.

On May 1, 2023, Dr. Meyer submitted a supplemental report and opined that the latest fusion surgery would put additional stress and he would likely develop adjacent level disc disease that might require possible additional spinal fusion surgery. Dr. Meyer also added that the medical care provided to him since July 1, 2019, including the last three surgeries, had been reasonable, necessary and causally related to the July 1, 2019 MVA.

On July 11, 2023, he underwent a right sacroiliac joint injection.

On August 10, 2023, he underwent a caudal lumbar steroid injection performed by

Dr. Rudman.

On September 1, 2023 he underwent a cervical epidural steroid injection by Dr. Lester.

Dr. Meyer authored a narrative report in which she summarized treatment for injuries sustained in the 2019 motor vehicle collision. He noted a precipitous change in condition following the traumatic injury. He noted underlying disc disease and history of surgery in 2018 which made him more susceptible to injury. The traumatic injuries from the motor vehicle collision were the most reasonable explanation for his worsening condition and necessitated surgeries in 2019, 2021, and 2023. His prognosis was thought to be poor.

PRESENT SYMPTOMATOLOGY:

Mr. Abrams complains of pain in his neck and back. The neck pain is rated 7 out of 10 in severity. It travels to his chest on the left side. Symptoms are described as stabbing. Pain is noted sometimes. He notices numbness and tingling in the right forearm.

The back pain ranges from 7-9 out of 10 in severity. Symptoms are described as burning and stabbing. Pain is noted sometimes. He notices numbness and tingling in his feet. He gets spasms in his left hamstring at night.

He takes Motrin 800 mg for pain relief, as well as Neurontin for the nerve pain.

He works as a high school biology teacher and part-time chiropractor.

He reports difficulty with activities at work such as bending, lifting and carrying objects. He has trouble at home with doing laundry, going up and down stairs, using a vacuum cleaner, mowing the lawn, gardening and performing repairs. He has difficulty with leisure activities such as walking the dog and working out at the gym. He has trouble with daily activities such as driving, getting dressed, sleeping, walking and sexual activity.

PHYSICAL EXAM:

The patient is a well-developed, well-nourished adult of the stated age. The patient follows commands well and is cooperative with the examination. The patient is alert and oriented to person and place and time.

Psych eval reveals normal mood and affect. HEENT is normocephalic and atraumatic. Extraocular motions are intact. Respirations are regular and unlabored.

The patient pushes off the arms of the chair to rise from a seated position. He ambulates with a forward leaning posture. He is unstable with toe walking. He is able to heel walk. He is able to crouch partially and rise with his hands on his knees. He is able to forward flex his spine to reach his hands to the level of his knees. He is restricted with lumbar extension as well.

Examination of the cervical spine reveals 30° left and right-sided cervical rotation. He has severe restriction with cervical extension and moderate restriction with cervical flexion. There is evidence of a healed anterior cervical incision on the left side and a midline posterior cervical incision as well. There is a contour abnormality noted posteriorly. Positive tenderness to palpation is noted in the lower cervical region. There is asymmetry of the paraspinals with diminishment of the right-sided cervical paraspinals and scarring noted related to the surgery. Kyphotic deformity is noted at the cervicothoracic junction.

Examination of the upper extremities reveals no restriction with forward flexion of the shoulders. The patient is able to reach his hands to the back of his head and behind his back with external and internal rotation testing. Intact sensation is noted in the digits. Diminished sensation is noted in the right forearm. Grip strength is intact. Well-healed carpal tunnel incisions are noted bilaterally. Upper extremity reflexes are 2+ and symmetric. A negative Hoffmann sign is noted bilaterally.

Examination of the lumbar spine reveals a well-healed midline incision, which is rather large. There is tenderness to palpation noted diffusely and about the bilateral sacroiliac joints.

Examination of the lower extremities reveals an absent left Achilles reflex, a 1+ right Achilles reflex and 2+ patellar reflexes. Hyperesthesia is noted in the lateral right lower leg. Tight hamstrings are noted bilaterally. Negative straight leg raise testing is noted bilaterally. There is weakness noted with left hip flexion, 4+ out of 5. No clubbing, cyanosis or edema is noted in the lower extremities.

RECORDS REVIEWED:

Plaintiff, Dr. James E. Abrams, Answers to Uniform Form A Interrogatories

Plaintiff, Dr. James E. Abrams, Answers to Supplemental Interrogatories

Deposition Transcript of Mrs. Deborah Abrams, September 1, 2022

Deposition Transcript of Dr. James Abrams, September 1, 2022

Records of Atlantic Neurosurgical Specialists, March 13, 2008 to

Records of Dr. Z. Hussain, September 25, 2018

Records of Propel Physical Therapy and Athletic Performance, February 14, 2019 and March 26, 2019

Records of Saint Clare's Denville Hospital ER, July 1, 2019

Records of New Jersey Pain Consultants, August 7, 2019

Records of AHS Hospital Corporation MMH, September 23, 2019 and

December 29, 2020

Records of Four3 Rehab and Performance Lab, April 23, 2020 to October 29, 2020

Records of Altair Health Spine and Wellness Center, July 20, 2020 to July 28, 2022

Report of Dr. Scott Meyer, July 13, 2022 and May 1, 2023

Billing Records of Atlantic Neurosurgical Specialists

Billing Records of Denville Diagnostics Imaging and Open MRI

Billing Records of Saint Clare’s Denville Hospital

Billing Records of AHS Hospital Corporation MMH

Billing Records of New Jersey Pain Consultants

Billing Records of Cardiovascular Health Consultants

Billing Records of Morristown Pathology Associates

Billing Records of Anesthesia Associates of Morristown

Billing Records of Radiology Associates Hackettstown

X-ray of lumbar spine, June 28, 2018, October 9, 2019, and July 20, 2020

X-rays of lumbar spine, April 5, 2021, images and report

X-ray of chest, September 10, 2018, September 23, 2019 and December 29, 2020

CT of cervical spine, July 1, 2019

CT of lumbar spine, July 1, 2019

MRI of lumbar spine, July 28, 2018, images and report

MRI of lumbar spine, July 22, 2019

MRI of lumbar spine, July 13, 2020, images and report

MRI of lumbar spine, October 13, 2022, images and report

EMG/NCS, July 28, 2022

Operative report, November 2, 2018, October 10, 2019 and January 12, 2021

Collision photos

Postop photos of back

Report of Scott A. Meyer, MD, September 6, 2023

DIAGNOSES:

Aggravation of pre-existing cervical degenerative disc disease with history of cervical stenosis and radiculopathy at C5-6 with foraminotomy at the left at C5-6, infection of the cervical spine postsurgical, disc herniations at C4-5 and C5-6, status post anterior cervical discectomy and fusion at C4-5 and C5-6 and status post right-sided decompression lamina foraminotomies at C3-4, C4-5, C5-6, and C7-T1

Cervical strain

Lumbar strain

Lumbar disc herniation at L5-S1

Lumbar radiculopathy

Aggravation of pre-existing lumbar degenerative disc disease with stenosis, instability

and lumbar adjacent segment disc disease at L2-3

Status post re-operative left L5-S1 microdiscectomy, re-operative left L5-S1 microdiscectomy with TLIF and L3-S1 posterolateral arthrodesis and L2-3 laminectomy with extension of fusion to L2

Bilateral sacroiliitis

DISCUSSION:

Work-related disability: Dr. Abrams was out of work for a couple of days after the car accident. He was out of work for about one month after each of the surgeries.

PERMANENCY, PROGNOSIS AND RECOMMENDATIONS:

Mr. Abrams was involved in a motor vehicle collision, which occurred on July 1, 2019. He was rear-ended at that time. He has an extensive history of prior musculoskeletal issues with his cervical and lumbar spine. He had prior cervical spine surgery with a history of cervical radiculopathy. He had anterior cervical discectomy and fusion at C4-5 and C5-6. He had a history of a postoperative infection. He also had posterior cervical surgery with decompressive lamina foraminotomies from C3-T1.

In the lumbar region, he also has a history of a prior injury and had pre-existing lumbar radiculopathy and a history of lumbar L4-S1 microdiscectomy for disc herniations at

L4-5 and L5-S1. He had sought treatment for his lumbar spine and symptoms of lumbar radiculopathy two months prior to the motor vehicle collision.

The forces imparted on his body during the July 1, 2019 collision caused flexion and extension of his cervical and lumbar spine. He sustained significant compressive forces to the anterior structures and tensile forces on the posterior structures. The forces imparted on the spine resulted in aggravation of multilevel cervical and lumbar degenerative disc disease and spondylosis and aggravation of postoperative state for prior cervical fusion and decompression and for prior lumbar decompression. He developed aggravation of cervical and lumbar radiculopathy. The forces imparted on the lumbar spine resulted in a disc herniation at L5-S1. The tensile forces on the posterior structures of his spine resulted in straining in the cervical and lumbar regions. As a result of the damage to the lumbar spine, he required additional surgical intervention with microdiscectomy x 2 with TLIF and L3-S1 posterolateral arthrodesis with subsequent laminectomy and extension of arthrodesis to L2 as a result of adjacent level disease.

The structure and function of his cervical spine and lumbar spine have been permanently altered by the traumatic injuries, as well as by the surgical treatment. Any healing that is expected to occur over time has already occurred. His present symptoms and limitations are permanent. The damage to his cervical spine and lumbar spine is permanent. His prognosis for further recovery or improvement is poor. He can expect accelerated degeneration at the injured levels in his spine, with progressive disc disease and spondylosis. He will develop accelerated adjacent level disease at the regions above and below the fusion. He is more susceptible to re-injury in the injured regions of his body as a result of even minor trauma.

I recommend treatment with physical therapy for his spine 3 times a week for 8-12 weeks per year on an ongoing basis. Therapy is recommended in order to maintain flexibility and function and to control his symptoms. Therapy sessions are expected to cost $200 each.

For the cervical spine, I recommend referral to a pain management specialist and treatment with cervical epidural steroid injections, radiofrequency ablations and nerve block procedures. Procedures should be performed twice per year as appropriate. The estimated cost per treatment is $5,000.

For the lumbar spine, I also recommend referral to a pain management specialist and treatment with epidural steroid injections, facet blocks and radiofrequency ablation procedures. These treatments can be performed twice per year. The estimated cost per injection is $5,000. I also recommend treatment with sacroiliac joint injections to be performed once to twice per year as appropriate. The estimated cost per injection is $1,500.

APPORTIONMENT:

I apportion the damage to the cervical spine 70% pre-existing and 30% to the motor vehicle collision. I apportion the damage to the lumbar spine 35% pre-existing and 65% related to the motor vehicle collision.

CONCLUSION:

With a reasonable degree of medical probability, it is my professional opinion that the injuries noted, and treatment received are reasonable and necessary and directly and causally related to the accident noted above.

These injuries have produced demonstrable medical evidence, of an objective nature, of restriction in the function, and in the material lessening, of the patient's working ability. These injuries have also produced an interference with the patient's ability to fully perform activities of daily life.

All treatment was reasonable and necessary, and all billing including that from physicians and facilities, was usual and customary. I reserve the right to amend my opinions should any additional objective diagnostic studies, documents, history, or prior medical records become available for my review, or should further treatment or surgical intervention proceed in the future.

The above captioned patient was examined at the request of his attorney for the sole purpose of generating a report. This patient consents to the release of this report to the referring attorney. It should be noted that the patient was examined, with respect to the specific complaints, emanating from the claimed injury in accordance with the restrictive rules concerning an independent medical examination. It is to be understood that no treatment was given or suggested, and no doctor to patient relationship exists.

A copy of this report will remain in our files. Background documents and medical records, however, exceed our capacity for permanent storage and are discarded upon completion of this report.

If I can be of any further assistance in this matter, please feel free to contact me.

Sincerely,

A signature on a white background

Description automatically generated

Alan S. Nasar, M.D.

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