IN THE SUPREME COURT OF THE STATE OF NEVADA

ALBERT H. CAPANNA, M.D., Appellant/Cross-Respondent, vs. BEAU R. ORTH, Respondent/Cross-Appellant.	Case No. 69935 District Court Case No. A648041
ALBERT H. CAPANNA, M.D., Appellant, vs. BEAU R. ORTH, Respondent.	Case No. 70227

APPENDIX TO RESPONDENT/CROSS-APPELLANT'S COMBINED OPENING AND ANSWERING BRIEF

VOL. 2 PART 2

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CHRONOLOGICAL INDEX TO RESPONDENT/CROSS-APPELLANT'S APPENDIX

NO.	DOCUMENT	DATE	VOL.	PAGE NO.
1.	Medical records from McKenna, Ruggeroli and Helmi Pain Specialists / Surgical Arts Center (Plaintiff's Trial Exhibit 7/9)	2/23/2010 (first DOS)	1	1 - 208
2.	MRI Report from Steinberg Diagnostic Medical Imaging	10/6/2010	2	209
3.	Medical records from Desert Institute of Spine Care (Plaintiff's Trial Exhibit 3)	10/12/2010 (first DOS)	2	210 - 335
4.	Scheduling Order from Case No. A-11-648041-C	3/27/2012	2	336 - 338
5.	Initial Expert Witness Disclosure Statement of Defendant Albert H. Capanna, M.D.	11/14/2014	2	339 - 360
6.	Plaintiff's 2nd Supplement to Designation of Expert Witnesses	4/8/2015	2	361 - 399
7.	Plaintiff's 3rd Supplement to Designation of Expert Witnesses	5/8/2015	2	400 - 403
8.	Plaintiff's 7th Supplement to the Early Case Conference List of Documents and Witnesses and NRCP 16.1(a)(3) Pretrial Disclosures	5/15/2015	2	404 - 424
9.	Report by Kevin Yoo, M.D. (provided at May 26, 2015 deposition)	5/26/2015	2	425
10.	Supplemental Expert Witness Disclosure Statement of Defendant Albert H. Capanna, M.D.	5/29/2015	2	426 - 452
11.	Plaintiff's Motion in Limine No. 4: Permit Treating Physicians to Testify as to Causation, Diagnosis, Prognosis, Future Treatment, and Extent of Disability Without a Formal Expert Report	6/22/2015	3	453 - 461
12.	Defendant's Response and Opposition to Plaintiff's Motion in Limine No. 4: Permit Treating Physicians to Testify as to Causation, Diagnosis, Prognosis, Future Treatment, and Extent of Disability Without a Formal Expert Report	7/9/2015	3	462 - 465

17. Confirms compliance with the agreed upon treatment plan
18. Reduces risk of regulatory agency scrutiny and investigation by documenting that the physician is monitoring and evaluating prescribed medications
19. Provides measurements that objectify pharmacotherapeutic regimens for reporting to workers' compensation boards, medical boards, providers, DEA, and other regulatory agencies
20. **Assists in complying with DEA's current Interim Policy Statement which requires doctors to minimize the potential for abuse and diversion**
21. **Assists in complying with The Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain"** which suggests in part that the medical records of patients contain "diagnostic, therapeutic and laboratory results
22. Makes patient aware that testing for drug substance is an integral and essential part of a comprehensive pharmacotherapeutic treatment plan

Physicians must treat patients according to their professional judgment and for legitimate medical purposes using generally accepted medical standards including informed consent. Practitioners also have a responsibility to minimize the potential for abuse and diversion and outline treatment risks/benefits regarding the use of controlled substances, special issues, and treatment alternatives. Pertinent questions may arise regarding patient function, responsibility with medications, medication levels from urine drug test reports, and behavioral health issues.

Using scientifically sound urine drug testing can be an effective means to augment pharmacotherapy and assist with the variety of complex medical/legal aspects of treating the pain patient in the current health care environment. The demand for clinical urine drug testing for the field of pain management has increased dramatically as clinicians, regulatory agencies and payers seek objective measures to regulate compliance and support clinical diagnoses. In the diagnosis of pain, assessment is essential. Methods for objectifying and measuring these parameters such as quantitative clinical urine drug testing should be utilized.

It is noted in the CA MTUS Chronic Pain Medical Treatment Guidelines- Drug Testing that screening is recommended to differentiate between dependence and addiction with opioids and indicates the screening instruments which have been developed or are in the development stages to aid in differentiation between drug dependence and addiction. It is recommended to utilize a urine drug screen to assess for the use or the presence of illegal drugs. It is recommended as a step to take before a therapeutic trial of opioids and as steps to avoid misuse/addiction. A urine drug screen is recommended to assess for the use or the presence of illegal drugs. It is noted that **steps to avoid misuse/addiction include frequent random urine toxicology screens.**

Drug testing via urine specimens is also used to assist in monitoring adherence to a prescription drug treatment regimen (which may include controlled substances), to diagnose substance misuse (or abuse), to diagnose dependence, addiction and/or other aberrant drug-related behavior, to guide treatment for patients, to determine if the patient is under/over-medicated, to advocate for patients, to ensure the efficacy of the prescribed medication treatment program, to consider whether increased oversight of the patient's pain medication is required by a pain management specialist, to determine whether alternative pain management therapies (including less invasive therapies such as acupuncture, electric stimulation or sound/heat therapies) are

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advisable for the patient, to determine whether the prescribed medication treatment program enhances or interferes with the patient's treatment and/or recovery and to ascertain whether blood work or other diagnostic procedures are warranted.

Additional support for urinary drug screens includes:

Winter 1998, Clinical Practice, "*Prescribing Opioids Wisely: Strategies for helping your patients and avoiding problems with regulators*", B. Elliot Cole, MD, MPA: "Rule out drug diversion by urine screens which also show that you are alert to a patient's potential use of illicit substances."

July/August 2002, The Clinical Journal of Pain, "*Role of Urine Toxicology Testing in the Management of Chronic Opioid Therapy*," Nathaniel Katz, MD, Gilbert Fanciullo, MD. "Monitoring the behavior alone of patients on chronic opioid treatment will fail to detect potential problems revealed by urine toxicology testing. ... urine toxicology testing may reveal the presence of illicit drugs, such as heroin or cocaine, or controlled substances not prescribed by the physician ordering the test (e.g., hydromorphone in a patient prescribed oxycodone).".

April 2005 Practical Pain Management "*Urinary Drug Testing in Pain Management*," Orlando G. Florete, MD: "Drug testing should never be used as a punitive measure but rather to enhance patient care... the Federation of State Medical Boards (FSMB) adopted a policy for prescribing controlled substances stressing the critical importance in documenting, evaluating and monitoring controlled substances in the management of pain patients. This is consistent with the guidelines set forth by federal agencies including the Drug Enforcement Agency (DEA)."

Chelminski, Multi-disciplinary Pain Management Criteria: (Chelminski, 2005) indicates the criteria used to define serious substance misuse in a multi-disciplinary pain management program include: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); and urine toxicology screen positive on at least two occasions for opioids not routinely prescribed.

CDC, *Morbidity and Mortality Weekly Report*- Feb. 9, 2007. "Use of the best available evidence to support a medical professional's decision making is often referred to as evidence-based medicine the objective of which has been defined as to minimize the effects of bias in determining an optimal course of care. In this case, bias means lack of objectivity and other factors that may distort conclusions. A comprehensive drug screen conducted is predicated on the idea of evidence-based medicine."

In Henry's Clinical Diagnosis and Management by Laboratory Methods, 21st edition, 2007, it is noted that testing for the presence of drugs in the body fluids of patients has undergone a vast increase over the past 20 years. It has become recognized that it is critical that the levels of many of the therapeutic drugs administered to patients be frequently determined, both because of the possible toxic side effects of many of these medications and because, often, lack of patient compliance results in subtherapeutic levels of the drugs. Furthermore, it is important for the physician when initiating drug therapy to ascertain when the serum levels of the drug have achieved a stable therapeutic level.

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In the Agency Medical Directors Group (AMDG) Interagency Guideline on Opiod Dosing for Chronic Non-cancer Pain, published by the Washington State Agency Medical Directors' Group, March 2007, it is recommended that routine urine drug toxicology screening should be performed. It is stated that "Urine drug toxicology screening can improve the prescriber's ability to safely and appropriately manage opioid treatment. Urine toxicology can verify if the patient is taking the prescribed medications. It can also identify if other psychoactive substances are consumed, but not reported, which may impact the patient's safety, function and treatment." The AMDG further states that "Positive results from a urine toxicology screen should be interpreted with caution. Over-the-counter medication may occasionally cause a positive result, particularly in the amphetamines and opioids classes."

On 08/28/12 , a qualitative drug screen was administered for the drugs delineated on the Lab Form attached hereto and the results were as delineated on the Analysis Protocol Report kept in the patient's records. Unless providing these results will violate or possibly violate HIPAA/HITECH privacy rules and regulations as currently in effect, they are attached hereto.

In preparation of this report, I have reviewed all test results, as well as the patient's medical chart. Time spent reviewing records, preparing and editing report: thirty-five (35) minutes.

Disclosure Statement:

Upon presentation to me of the final report, I thoroughly reviewed the document prior to affixing my signature. Under penalty of perjury, I declare that (1) the information contained in this report and its attachments is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others, for which, as to that information, the information accurately describes the information provided to me, as noted herein, I believe it to be true and (2) I have not offered, delivered, received or accepted any rebate, refund, commission, preference, patronage, dividend, discount or other consideration, whether in the form of money or otherwise, as compensation or inducement for the referral of this evaluation or consultation and (3) this report is true and correct to the best of my knowledge and that I have not violated any laws or regulations in the state of Nevada in the preparation of this report.

Sincerely,

Andrew M. Cash, M.D.
NV Lic. #: 11944
NPI #: 1689784852

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Ameritox℠
Medication Monitoring Solutions

Rx Guardian℠ Results Report

9930 W. Highway 80
Midland, TX 79706
Phone: (866) 287-7584
Fax: (432) 561-8450

CLINIC INFORMATION

Name: Desert Institute of Spine Care-Las Vegas
Account: 213854
Address: 9339 W SUNSET RD #100 LAS VEGAS, NV 89148
Fax: 702-946-5115
Provider: Cash, Andrew M

PATIENT INFORMATION

Name: ORTH, BEAU
DOB:
Height: 74 in.
Weight: 200 lbs.
Gender: Male
ID: n/a

SPECIMEN INFORMATION

Requisition Number: W293161
Lab Accession Number: 7101034823
Date Collected: 10/12/2010
Date Received by Lab: 10/15/2010 3:55 PM
Date Reported: 10/18/2010 5:58 PM
Report Version: 1

Test Performed	Lab Result (ng/mL)	Assay Cutoff (ng/mL)	Normalized Value	Expected Range Low	Expected Range High	Range Comparison	Medication Comparison
DRUGS OF ABUSE							
Phencyclidine							
Phencyclidine (IA)	Negative	25					
OPIATES							
Opiates							
Opiates (IA)	Positive	50					
Codeine (MS)	Negative	100					Consistent
Morphine (MS)	Negative	100					Consistent
Hydrocodone (MS)	746	100					REVIEW
Hydromorphone (MS)	255	100					REVIEW
RESULTS EXPLANATION	The presence of both Hydrocodone and Hydromorphone has been confirmed. This is evidence of taking a Hydrocodone medication. Hydromorphone is a metabolite of Hydrocodone as well as a prescription drug. Possible sources include (but are not limited to) Lortab, Lorcet or Vicodin. Detection time for these drugs is 2-3 days.*						
Oxycodone/Oxymorphone							
Oxycodone/Oxymorphone (IA)	Negative	100					Consistent
Oxycodone (MS)	Negative	100					Consistent
Oxymorphone (MS)	Negative	100					Consistent
Noroxycodone (MS)	Negative	100					Consistent
SYNTHETIC OPIOIDS							
Fentanyl							
Fentanyl (IA)	Negative	2					
Methadone							
Methadone (IA)	Negative	130					
EDDP (IA)	Negative	150					
SEDATIVES/HYPNOTICS							
Benzodiazepines							
Benzodiazepines (IA)	Positive	40					
Nordiazepam (MS)	399	75					Consistent
Oxazepam (MS)	Negative	75					Consistent
Lorazepam (MS)	Negative	75					Consistent
Alprazolam (MS)	Negative	75					Consistent
Alphahydroxyalprazolam (MS)	Negative	75					Consistent
Barbiturates							

CASH 0021

Ameritox℠
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Rx Guardian℠ Results Report

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Test Performed	Lab Result (ng/mL)	Assay Cutoff (ng/mL)	Normalized Value	Expected Range Low	Expected Range High	Range Comparison	Medication Comparison
SEDATIVES/HYPNOTICS							
Barbiturates (IA)	Negative	200					
Carisoprodol							
Carisoprodol (IA)	Negative	100					
STIMULANTS							
Amphetamines							
Amphetamines (IA)	Negative	800					

Specimen Validity Testing	Value	Reference Range	
Specific Gravity	1.0088	1.0030	1.0350
pH	7.2	4.5	8.9
Creatinine (in mg/dL)	76.2	5.0	300.0

Prescribed Drug	Drug name	Drug Class	Dose (mg)	Frequency Low/High	Number Dose Low/High	PRN
Diazepam	Diazepam	Sedatives/Hypnotics	5	Q6H/Q6H	1/1	Yes
Oxycontin Controlled Release Tablets	Oxycodone	Opiates	10	Q6H/Q6H	1/1	Yes
Valium Tablet	Diazepam	Sedatives/Hypnotics	5	Q6H/Q6H	1/1	Yes
Demerol Hydrochloride Tablets	Meperidine Hydrochloride	Synthetic Opioids	50	Q6H/Q6H	1/1	Yes

IA = Immunoassay
MS = Mass Spectrometry

* Disclaimer: The normalized values for drug and/or metabolites using quantitative mass spectrometry results are based on standard lean body mass calculations and specific properties of the drugs of interest. These normalized values are compared to ranges developed from known compliant patients. These comparative results are only meant to be used as a guide in conjunction with other clinical and behavioral information known to the treating physician. Due to many factors no single method can be accurate for all individuals.

Range Comparison REVIEW: Indicates that the normalized urine drug level is above or below range.

Medication Comparison REVIEW: Indicates that the drugs provided on the Requisition Form do not match the drugs or metabolites detected through our testing.

*** End of Report ***

CASH 0022

DSO

DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,

Plaintiff,

v.

ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive,

Defendants.

CASE NO. A648041
DEPT NO. XXII

SCHEDULING ORDER
(Discovery/Dispositive Motions/Motions to Amend or Add Parties)

NATURE OF ACTION: **Medical malpractice**

DATE OF FILING JOINT CASE CONFERENCE REPORT(S): **3/16/12**

TIME REQUIRED FOR TRIAL: **5-7 days**

DATES FOR SETTLEMENT CONFERENCE: **None Requested**

Counsel for Plaintiff:
Dennis M. Prince, Esq., Prince & Keating

Counsel for Defendant:
John J. Savage, Esq., John H. Cotton & Associates

Counsel representing all parties have been heard and after consideration by the Discovery Commissioner,

IT IS HEREBY ORDERED:

1. all parties shall complete discovery on or before 9/9/13.

. . .

2. all parties shall file motions to amend pleadings or add parties on or before 6/10/13.

3. all parties shall make initial expert disclosures pursuant to N.R.C.P. 16.1(a)(2) on or before 6/10/13.

4. all parties shall make rebuttal expert disclosures pursuant to N.R.C.P. 16.1(a)(2) on or before 7/10/13.

5. all parties shall file dispositive motions on or before 10/9/13.

Certain dates from your case conference report(s) may have been changed to bring them into compliance with N.R.C.P. 16.1.

Within 60 days from the date of this Scheduling Order, the Court shall notify counsel for the parties as to the date of trial, as well as any further pretrial requirements in addition to those set forth above.

Unless otherwise directed by the court, all pretrial disclosures pursuant to N.R.C.P. 16.1(a)(3) must be made at least 30 days before trial.

Motions for extensions of discovery shall be made to the Discovery Commissioner in strict accordance with E.D.C.R. 2.35. Discovery is completed on the day responses are due or the day a deposition begins.

. . .

. . .

. . .

Unless otherwise ordered, all discovery disputes (except disputes presented at a pre-trial conference or at trial) must first be heard by the Discovery Commissioner.

Dated this 26 day of March, 2012.

DISCOVERY COMMISSIONER

CERTIFICATE OF SERVICE

I hereby certify that on the date filed, I placed a copy of the foregoing DISCOVERY SCHEDULING ORDER in the folder(s) in the Clerk's office or mailed as follows:

Dennis M. Prince, Esq.
John J. Savage, Esq.

COMMISSIONER DESIGNEE

DOWE
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
LAURIA TOKUNAGA GATES & LINN, LLP
601 South Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633; Fax: (702) 387-8635
Attorneys for *Defendant ALBERT H. CAPANNA, M.D.*

DISTRICT COURT

CLARK COUNTY NEVADA

BEAU R. ORTH, Plaintiff, v. ALBERT H. CAPANNA, M.D.; DOES I THROUGH X; ROE BUSINESS ENTITIES I THROUGH X, Defendants.	CASE NO. : A-11-648041-C DEPT. NO. : 3 **INITIAL EXPERT WITNESS DISCLOSURE STATEMENT OF DEFENDANT ALBERT H. CAPANNA, M.D.**

Pursuant to N.R.C.P. 16(a)(2), Defendant ALBERT H. CAPANNA, M.D., through his attorneys, Anthony D. Lauria, Esq., and Kimberly L. Johnson, Esq., of the law firm of Lauria Tokunaga Gates & Linn, LLP, hereby serves this initial expert witness disclosure statement.

DATED: November 14, 2014.

LAURIA TOKUNAGA GATES & LINN, LLP

By: */s/ ANTHONY D. LAURIA*
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
601 S. Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633
Attorneys for Defendants

RETAINED EXPERTS

A Reynold L. Rimoldi, M.D.
Nevada Orthopedic & Spine Center
2650 N. Tenaya Way, Suite 301
Las Vegas, Nevada 89128
(702) 258-3773

1. SUMMARY OF PROFESSIONAL EDUCATION, TRAINING AND EXPERIENCE: See Dr. Rimoldi's Curriculum Vitae, fee schedule and list of trial/deposition testimony attached hereto as Exhibit "A."

2. SUMMARY OF OPINIONS:

See Dr. Rimoldi's report attached hereto as Exhibit "B."

B. Allan Joel Belzberg, B.SC, M.D., FRCSC
Associate Professor of Neurosurgery
The John Hopkins School of Medicine
Baltimore, Maryland
(410) 955-5810

1. SUMMARY OF PROFESSIONAL EDUCATION, TRAINING AND EXPERIENCE: See Dr. Belzberg's Curriculum Vitae, fee schedule and list of trial/deposition testimony attached hereto as Exhibit "C."

2. SUMMARY OF OPINIONS:

See Dr. Belzberg's report attached hereto as Exhibit "D."

C. Marc D. Kaye, M.D.
Collier Radiology Consultants
2805 East Oakland Park Blvd., #452
Fort Lauderdale, FL 33306
(866) 878-1997

1. SUMMARY OF PROFESSIONAL EDUCATION, TRAINING AND EXPERIENCE: See Dr. Kaye's Curriculum Vitae, fee schedule and list of trial/deposition testimony attached hereto as Exhibit "E."

2. SUMMARY OF OPINIONS:

See Dr. Kaye's report attached hereto as Exhibit "F."

NON-RETAINED EXPERTS

1. Albert H. Capanna, M.D.
c/o Lauria, Tokunaga, Gates & Linn, LLP

Dr. Capanna will testify as to his care and treatment of Beau R. Orth.

///

2. Michael Milligan, M.D.
5546 Fort Apache Road
Suite 100
Las Vegas, Nevada 89148

Dr. Milligan, will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

3. Asif Ahmad, M.D.
Charles Hales, M.D.
and/or person most knowledgeable
Desert Radiologists
P.O. Box 3057
Indianapolis, IN 46206

Dr. Ahmad will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

4. Anthony Ruggeroli, M..D.
McKenna and Ruggeroli Pain Specialists
6070 S. Fort Apache Road
Suite 100
Las Vegas, Nevada 89148

Dr. Ruggeroli will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

5. Leo Germin, M.D.
Clinical Neurology Specialists
132 S. Rainbow Boulevard, Suite 240
Las Vegas, Nevada 89146

Dr. Germin will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

6. Ashesh Patel, M.D. and/or
Person Most Knowledgeable
Axiom Imaging of Las Vegas
6460 Medical Center Street
Suite 150
Las Vegas, Nevada 89148

Dr. Patel will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

7. Person Most Knowledgeable
University Medical Center
1800 W. Charleston Boulevard
Las Vegas, Nevada 89102

The person most knowledgeable from University Medical Center will testify as to the care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

8. Steve C. Wong, M.D.
and/or Person Most Knowledgeable
PBS Anesthesia
7326 W. Charleston Boulevard
Las Vegas, Nevada 89129

Dr. Wong and/or Person Most Knowledgeable will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

9. Stephen Chen, M.D.
David Kuo, M.D.
and/or Person Most Knowledgeable
Steinberg Diagnostic Medical Imaging
2767 N. Tenaya Way
Las Vegas, Nevada 89128

Dr. Chen and/or Person Most Knowledgeable will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

10. Person Most Knowledgeable
Southern Hills Hospital
9300 W. Sunset Road
Las Vegas, Nevada 89148

The person most knowledgeable from Southern Hills Hospital will testify as to the care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

11. Keith Kleven, M.S., P.T. and /or
Person Most Knowledgeable
Keith Kleven Physical Therapy
3820 S. Jones Boulevard, Suite, B & C
Las Vegas, Nevada 89103

Keith Kleven, M.S., P.T. and/or Person Most Knowledgeable will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

12. Andrew Zak, M.D.
P.O. Box 93358
Las Vegas, Nevada 89193

Dr. Zak, will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

13. Kyle S. Wilson, M.Ed.
Director of Athletic Training
University of Nevada Las Vegas
4505 S. Maryland Parkway
Las Vegas, Nevada 89145

Kyle S. Wilson, M.Ed., will testify as to his care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

14. Person Most Knowledgeable
Surgical Arts Center
9499 W. Charleston Blvd., #250
Las Vegas, Nevada 89117-7148

The person most knowledgeable from Surgical Arts Center, will testify as to the care and treatment of Beau R. Orth. However, this deposition has yet to be taken and defendant will supplement once the deposition has been completed.

Defendants reserve the right to call as a witness any and all of the healthcare providers who were involved in any way in the care and treatment provided to Beau R. Orth, and who are timely identified by any party to this litigation. These healthcare providers are expected to testify about all aspects of the care and treatment they provided to Beau R. Orth, including, but not limited to, their findings and the opinions they formed.

DATED: November 14, 2014.

LAURIA TOKUNAGA GATES & LINN, LLP

By: */s/ ANTHONY D. LAURIA*
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
601 S. Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633
Attorneys for Defendants

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P. 5(b), I certify that I am an employee of Lauria Tokunaga Gates & Linn, and that on the 14th day of November, 2014, I served a true and correct copy of the foregoing, INITIAL EXPERT WITNESS DISCLOSURE STATEMENT OF DEFENDANT ALBERT H. CAPANNA, M.D.:

:

☐ By placing same to be deposited for mailing in the United States Mail, in a sealed envelope upon which first class postage was prepared in Las Vegas, Nevada; and/or

X Via electronic mail; and/or

☐ Via facsimile; and/or

☐ Via Receipt of Copy to the interested parties

as follows:

Dennis M. Prince, Esq.
Prince & Keating
3230 South Buffalo Drive, Suite 108
Las Vegas, Nevada 89117
Attorneys for Plaintiff
BEAU R. ORTH

MARISA PEREZ, an employee of
Lauria Tokunaga Gates & Linn

EXHIBIT B

EXHIBIT B

NEVADA Orthopedic & Spine Center

2650 N. Tenaya Way, Ste 301
Las Vegas, NV 89128

1505 Wigwam Pkwy., Ste 330
Henderson, NV 89074

Patient Name: Beau Orth
Patient ID: 496711
Date of Birth: 11/02/1989
Date of Examination/Report: 07/17/2013

INDEPENDENT MEDICAL EVALUATION

Beau Orth was seen for an Independent Medical Evaluation in my office at Nevada Orthopedic & Spine Center at 2650 N. Tenaya, Suite 301, Las Vegas, Nevada 89128 on 7/17/13 for the purposes of my rendering opinions in the way of an Independent Medical Evaluation. Prior to performing the Independent Medical Evaluation, I explained to him that I would not be entering in to a formal physician/patient relationship and that I was seeing him on a one-time basis to perform an evaluation of alleged complaints that he states arose out of a 9/17/10 surgical procedure that was performed by Dr. Albert Capanna. Once Mr. Orth understood that I would not be entering in to a formal physician/patient relationship, I proceeded with the Independent Medical Evaluation which consisted of taking a history from Mr. Orth which included a history of the chief complaint as well as a past medical history, reviewing medical records, performing a physical exam, reviewing diagnostic imaging, and formulating opinions in this matter.

HISTORY OF PRESENT ILLNESS: Mr. Orth is a 23-year-old gentleman. He is employed as a store manager. He indicates that while participating in athletic activities, namely football, at the University of Nevada Las Vegas, he sustained a lower back injury. He complained of back pain and left-sided lower extremity pain. After receiving conservative treatment, he presented to Dr. Capanna on 9/1/10. Dr. Capanna had reviewed an MRI scan which noted an L5-S1 disc protrusion. Dr. Capanna ordered nerve conductions and EMGs which suggested a left-sided S1 radiculopathy. Based on the patient's clinical impression and the diagnostic studies, Dr. Capanna elected to proceed with a left-sided decompression at L5-S1. On 9/17/10, Dr. Capanna performed, what was dictated as, a left L5-S1 microdiscectomy. Apparently the patient had persistent pain and a follow up MRI with gadolinium showed postoperative scar tissue at L4-5. It appears that no surgery was performed at L5-S1. The patient went on to have a second surgery in October of 2010 by Dr. Andrew Cash in which a two-level decompression was performed, that being at L4-5 and L5-S1. The patient continues to have back and left leg pain. For further details regarding the treatment the patient received for his lumbar spine and left lower extremity pain, please see the medical record review listed below.

PAST SURGICAL HISTORY: Remarkable for the two lumbar spine surgeries that I have mentioned, one in September of 2010 and the other in October of 2010.

PAST MEDICAL HISTORY: Unremarkable.

MEDICATIONS: Multivitamins only.

ALLERGIES: Penicillin.

REVIEW OF SYSTEMS: Noncontributory.

FAMILY HISTORY: Unremarkable.

SOCIAL HISTORY: He denies tobacco use. He drinks ethanol on rare occasions. The patient is employed as a store manager having received a degree in Marketing from the University of Nevada Las Vegas.

MEDICAL RECORD REVIEW:

8/25/08 through 10/22/10 – Handwritten notes from the UNLV athletic training facility as well as the general medical assessment team at University of Nevada Las Vegas. This Claimant is seen on multiple occasions for various conditions between 8/25/08 and 10/22/10. Approximately 130 visits are noted between these two dates. The patient is seen for multiple issues. He is an UNLV football player and is seen for upper extremity symptoms, ankle sprains, injuries to his left great toe, as well as general medical issues such as upper respiratory tract infections; however, the majority of these visits are for issues pertaining to his lumbar spine. It appears from looking at other notes that this patient sustained, as a result of his football activities, issues with his lumbar spine and left lower extremity. These handwritten notes over the approximate two-year period noted from August of 2008 through October of 2010 concern athletic trainer and evaluations as well as referrals to various healthcare specialists for treatment regarding his lower back and his left leg.

2/3/09 – MRI scan of the lumbar spine from 2/3/09 and it shows a very small left L5-S1 disc protrusion.

2/19/10 – MRI of the lumbar spine is comparable to the 2009 scan, that is a small left-sided L5-S1 disc protrusion.

2/23/10 – Ruggeroli, M.D., pain specialist – The patient is seen and diagnosed with a left L5-S1 disc hernia versus protrusion and recommends a left-sided L5-S1 epidural steroid injection.

2/24/10 – Ruggeroli, M.D. – Performs left-sided L5-S1 transforaminal epidural steroid injection.

3/9/10 – Ruggeroli, M.D. – The patient is seen status post the injection. The injection has helped him with regards to his back and left leg pain. The patient will follow up on an as-needed basis.

8/11/10 – Ruggeroli, M.D. – The patient is seen and the diagnosis is left-sided L5-S1 disc herniation. He recommends additional injections into the lumbar spine.

8/13/10 – Ruggeroli, M.D. – Performs a left-sided L5-S1 transforaminal epidural steroid injection.

8/26/10 – Ruggeroli, M.D. – The patient is seen with the L5-S1 disc herniation. There was no relief with the epidural steroid injection. No further injections are recommended.

9/1/10 – Capanna, M.D. – The patient is seen and Dr. Capanna notes in his history that he is complaining of back and left leg pain. It seems to be related when he switched from a wideout to a linebacker. Discussions regarding L5-S1 microdiscectomy were made. Dr. Capanna recommends EMGs and flexion/extension MRI prior to making final decisions regarding surgery.

9/2/10 – MRI scan of the lumbar spine with flexion/extension views shows an L5-S1 disc protrusion, only mild stenosis.

9/8/10 – Germin, M.D. – Performs nerve conductions and EMGs left lower extremity, suggest left-sided S1 radiculopathy.

9/17/10 – Capanna, M.D. – Performs a left-sided L5-S1 microdiscectomy. This is done after the patient undergoes a preoperative evaluation. Apparently, the patient does not do well. There are multiple phones call into Dr. Capanna's office indicating that the patient has persistent pain.

10/6/10 – MRI with gadolinium shows postoperative scar tissue and a recurrent L4-5, which is the first time that the L4-5 level is mentioned having an issue. All the previous MRIs suggested L5-S1 as the problematic level. This states L4-5 was operated on on the left side and there is a recurrent disc herniation there.

10/12/10 – Cash, M.D. – The patient is seen status post surgery by Dr. Capanna. The patient had one week of relief, but now has persistent left leg pain. He recommends surgery for a recurrent disc herniation.

10/19/10 – Cash, M.D. – Performs a preoperative evaluation.

10/22/10 – Cash, M.D. – Performs revision left-sided L4-5 discectomy. There is epidural fibrosis noted at L4-5. There is a disc herniation at L4-5 and a bulge at L5-S1. Dr. Cash decompresses both levels, L4-5 and L5-S1 on the left.

Dr. Cash sees the patient in postoperative visit two weeks postop and approximate six-week postop on 11/3/10 and 12/1/10 respectively. On 12/1/10, he recommends physical therapy and utilizing a brace when out of bed.

12/9/10 – The patient is seen for physical therapy modalities by physical therapist Keith Kleven.

4/19/11 – Cash, M.D. – The patient is seen and the diagnoses are postlaminectomy syndrome and lumbar radiculopathy. The patient is indicated as doing well and will follow up in three months.

8/28/12 – Cash, M.D. – The patient is seen and the diagnoses are postlaminectomy syndrome and left lower lumbar radiculopathy. MRI scan of the lumbar spine with and without contrast is recommended.

8/31/12 – MRI of the lumbar spine with and without gadolinium contrast shows a small left-sided L5-S1 disc protrusion and a bulge at L4-5 as well as postoperative changes.

9/4/12 – Cash, M.D. – The patient is seen and Dr. Cash notes the MRI findings. He notes that there is disc dehydration at L4-5 and L5-S1. The patient is diagnosed with a postlaminectomy syndrome and lumbar radiculopathy. Recommendations are to follow up on an as-needed basis.

CURRENT COMPLAINTS: The patient's current complaints are of a lumbar spine pain eccentrically placed to the left of the midline with a pins and needles, stabbing, and numbness in his left leg. He indicates that currently his pain is a 2 out of 10 on a visual analog scale with 0 being no pain and 10 being the worst pain that he can imagine. At its worst, it is a 10 out of 10. He indicates that 70% of his pain is in his back and 30% is in his left leg. He indicates that he can sit for 30 minutes, stand for 30 minutes, ride in a car for one hour, and walk two to three blocks. He indicates that exercise, sitting too long, and activities such as washing a car make his pain worse. He indicates doing nothing makes it better.

PHYSICAL EXAMINATION: On physical examination, the patient is observed to be ambulating without use of lateral support. He is not using any type of lumbar spine a brace. On inspection, his lumbar spine shows a well-healed midline incision consistent with the two previous decompressions. He has diffuse tenderness that is difficult to localize throughout his lumbar spine. He has 10% limitation of lumbar spine range of motion based on my estimate. Sensory and motor evaluations in key dermatomes and myotomes tested from L3 through S1are intact. Reflexes are 2/4 and symmetric at the patella and Achilles. Straight leg raising is negative for radicular findings.

I have reviewed previous studies:

The diagnostic imaging that I have reviewed in chronological order presented to me on DVD disc are as follows.

9/2/10 – MRI scan of the lumbar spine shows a small left-sided L5-S1 disc protrusion.

10/6/10 – MRI scan of the lumbar spine shows a left L4-5 laminotomy that was done. There is no laminotomy at L5-S1.

10/12/10 – X-rays of the lumbar spine show changes consistent with an L4-5 laminotomy.

11/3/10 – Radiographs of the lumbar spine that show two-level decompression, left-sided, by Dr. Cash.

12/1/10 – X-rays of the lumbar spine show changes consistent with left-sided L4-5 and L5-S1 laminotomy.

2/8/11 – X-rays of the lumbar spine show disc height diminution L4-5 and L5-S1 and postoperative changes.

8/28/12 – X-rays of the lumbar spine with flexion/extension views of the lumbar spine that show no instability, disc height diminution L4-5 and L5-S1.

DIAGNOSIS: Left-sided L5-S1 disc herniation with a postlaminectomy syndrome.

DISCUSSION/OPINIONS: As is noted based on my evaluation, this patient had an L5-S1 disc protrusion on 9/2/10. He had surgery to his lumbar spine. It was stated it was done at L5-S1. However, postoperative scans show that the surgical procedure was performed at L4-5. Apparently the patient did not improve and the patient had a second decompression at L4-5 and L5-S1. Follow up radiographs show postoperative changes. The patient is now here for evaluation and it is clear that he has ongoing symptoms subjectively and the objective findings on his scans show postlaminectomy changes.

This patient did have an L5-S1 disc protrusion. It was appropriate for Dr. Capanna to make the recommendation for surgery. However, the surgical procedure was done at the wrong level, one level cephalad, that is the L4-5 level. Certainly the patient required a second surgery. In my opinion, the patient's condition postoperatively is satisfactory indicating that the patient has normal neurologic function and can perform all activities of daily living; although, he complains of subjective pain. Certainly the patient required a second surgical procedure by Dr. Andrew Cash after the first surgical procedure was done at the wrong level. Certainly, to a reasonable degree of medical probability, this patient would have had ongoing symptoms to some degree even if the surgical procedure was done at the correct level the first time. Certainly the patient was subjected to a second anesthetic and had a longer time to reach maximum medical improvement secondary to the need for a second decompressive surgery. The patient is quite functional and performing activities as a manager that he is able to perform without restriction.

He is on no medications at this time and, in my opinion, has had a satisfactory result status post the two previous lumbar spine procedures, albeit the first one being performed at the incorrect level, that being one level cephalad to what was meant to be.

If could be of any further assistance, please feel free to contact me.

REYNOLD L. RIMOLDI, M.D.

RLR/rp

EXHIBIT D

EXHIBIT D

Allan Joel Belzberg, B.Sc., M.D., FRCSC

Associate Professor of Neurosurgery
The Johns Hopkins School of Medicine

Dear Mr. Cotton:

I write this report based upon my review of the records of Beau Orth who underwent a back surgery performed by Albert Capanna, M.D. on September 17, 2010. This report provides a summary of my opinions to date regarding the applicable standard of care of Beau Orth.

CREDENTIALS AND QUALIFICATIONS

I am a medical doctor licensed to practice medicine in the State of Maryland.
I am board certified in Neurological Surgery.

In 1982, I received my medical degree from the University of Calgary in Calgary, Alberta. I completed a one-year surgical internship (1983) at McGill University Teaching Hospitals in Montreal, Quebec. I completed a five-year neurosurgical residency at University of Calgary Teaching Hospitals in Calgary, Alberta. I also completed neurosurgical fellowships at University of Calgary and Johns Hopkins School of Medicine.

Since 1990, I have held academic appointments in the Department of Neurosurgery at Johns Hopkins School of Medicine. I have also worked as an attending neurosurgeon at The Johns Hopkins Hospital and Bay View Hospital since 1990.

As a result, I am qualified by experience, education and training with regard to the standard of care, methods, procedures, and treatments that are relevant to the allegations at issue in this case. Attached is my current Curriculum Vitae.

I have reviewed the following materials in this matter:

1. Plaintiff's Complaint with supporting affidavit of Kevin Yoo, M.D.
2. Dr. Capanna's Operative Report (0168-0169)
3. Dr. Cash's Operative Report (0312-0313)
4. Medical Records – Dr. Capanna (0076-0193)
5. Medical Records – University Medical Center (0202-0263)
6. Medical Records – Dr. Cash (0287-0354)
7. Medical Records – Southern Hills Hospital (0365-0605)
8. CD of Pre-operative lumbar spine MRI dated September 2, 2010 from Axiom
9. CD of Post-operative lumbar spine MRI date October 6, 2010 from Steinberg Diagnostics

10. CD of Post-operative L-Spine X-rays dated 10/12/2010; 11/3/2010; and 12/1/2010 from Desert Institute of Spine Care
11. CD of Post-operative L-Spine X-rays dated 2/8/2011 and 8/28/2012 from Desert Institute of Spine Care

SUMMARY OF EVENTS

Beau Orth sustained a low back injury while playing collegiate football at UNLV.

On February 3, 2009, Mr. Orth underwent an MRI of the lumbar spine, which revealed a small (5 mm) left paracentral disc protrusion at L5-S1 causing very mild left lateral displacement of the left S1 nerve root.

On February 18, 2010, Mr. Orth underwent another MRI of the lumbar spine. There was no significant interval change in the appearance of a shallow left paracentral disk protrusion at L5-S1.

On September 1, 2010, Mr. Orth presented to Dr. Capanna with complaints of left leg pain. He described his pain as shooting pain, numbness, tingling in left leg, and right toe numbness. In the past, Mr. Orth had some minimal pain, but it had always cleared. Diagnostic studies showed small focal left L5-S1 disc which touched the nerve root just prior to going into the foramen. Dr. Capanna showed the films to Mr. Orth and Mr. Orth's father and explained the findings. He also had a talk with them about the available treatment options.

On September 2, 2010, Mr. Orth underwent his third MRI of the lumbar spine, which revealed: (1) L5-S1, disc protrusion that abuts the thecal sac without significant spinal canal narrowing, the neuroformina was patent, disc measurements: neutral 2.9 mm, flexion 2.9 mm, extension mild; and (2) straightening of the lumbar lordosis which may be due to myospasm.

On September 8, 2010, Mr. Orth presented to Dr. Leo Germin for an EMG/Nerve Conduction study, which revealed (1) S1 radiculopathy on the left; (2) distal symmetric predominantly sensory demyelinating more than axonal mild to moderate in severity peripheral neuropathy as an incidental finding; (3) no electrodiagnostic evidence for peroneal neuropathy at the fibular neck or tibial neuropathy at the popiteal fossa; and (4) no electrodiagnostic evidence for overt axonal loss L2 through S2 radiculopathy on the right.

On September 15, 2010, Mr. Orth presented to Dr. Capanna for follow-up. Dr. Capanna explained the EMG and MRI results to Mr. Orth's father. Treatment options were discussed. Dr. Capanna recommended microdiscectomy. Informed consent was signed for the procedure.

On September 17, 2010, Mr. Orth presented to Dr. Capanna at UMC for a left L5-S1 microlumbar laminotmy and left L5-S1 microdiscectomy. Dr. Capanna's pre-operative diagnosis was focal left lumbar L5-S1 disc. Intraoperative fluoroscopic x-rays were taken to ensure surgery was being performed at the correct level.

On September 22, 2010, Mr. Orth inquired about recovery time. Dr. Capanna advised it may take a few weeks, but he did not want to release him too soon.

On September 29, 2010, Mr. Orth presented to Dr. Capanna. Mr. Orth said his back was better, but he had back spasms if he lay down too long. Leg pain & numbness were gone.

On October 6, 2010, Mr. Orth was complaining of severe pain so Dr. Capanna referred him to Steinberg Diagnostics for a post-operative MRI of the lumbar spine. This MRI is consistent with Dr. Capanna's surgical approach. There was a small focal protrusion pre-operatively at L5-S1 that is gone post-operatively. There were also surgical tracks at L5-S1 and L4-L5. Additionally, there was a small bony defect at the superior aspect of L5. There are post-operative changes at the L4-5 foramen. These findings are not explained in the MRI report from Steinberg Diagnostics that is dated October 6, 2010.

The October 6, 2010 MRI report from Steinberg Diagnostics indicates there was small disc fragment within the post-surgical scar at L4-L5. It also indicates there was a laminectomy performed on the left at L4-L5.

STANDARD OF CARE

It is my understanding that Dr. Capanna's anticipated testimony will acknowledge his operative report was dictated as a general template report and omitted specific details explaining why he left a surgical footprint at the level of L4-L5. It is also my understanding that Dr. Capanna's anticipated testimony will explain the following:

> During surgery, Mr. Orth's fascia and muscles were larger and tighter than usual so Dr. Capanna made a small microlaminotomy in L5-S1. Laterally, where the disc would be was at an angle and he could not reach the fragment, so Dr. Capanna went above the L5 lamina and angled laterally to see if he could reach the disc space under the lamina or take a portion off. This necessitated extending the incision up the L4-5 interlaminar area to angle down. Ultimately, the small fragment was removed at L5-S1 without removing intradiscal material. The anatomy required Dr. Capanna to approach the L5-S1 disc fragment from both below and above the L5 lamina.

While reserving my right to supplement and modify this opinion as needed upon a review of Dr. Capanna's actual sworn testimony, should the jury find Dr. Capanna's recitation of facts to be a true and accurate account of his surgical procedure, it would be my opinion that the care Dr. Capanna provided to Beau Orth met the standard of care.

All of the statements made herein have been made to a reasonable degree of medical probability. I reserve the right to supplement my opinions as additional information becomes available, including but not limited to any statement or testimony from any of the parties and/or any other experts designated in this case.

Allan Belzberg, M.D.

EXHIBIT F

EXHIBIT F

MARC D. KAYE, M.D.

August 5, 2013

John J. Savage, Esq.
Cotton DriggsWalch Holley Woloson Thompson
400 South Fourth Street
3rd Floor
Las Vegas, Nevada 89101

Re: Beau Orth v Albert Capanna, M.D./adv. Orth
Case No: A-11-648041-C

Dear Mr. Cotton;

I write this report based upon my review of the records of Beau Orth who underwent spinal surgery performed by Albert Capannc, M.D. on September 17, 2010. This report provides a summary of my opinions to date regarding the interpretation of Beau Orth's pre-operative and post-operative radiological studies.

CREDENTIALS AND QUALIFICATIONS

I am a medical doctor licensed to practice medicine in Florida, Virginia, and South Carolina. I am board certified in Diagnostic Radiology as well as Vascular and Interventional Radiology.

In 1976, I received my medical degree from the University of Miami School of Medicine. I completed a one-year internship (1977) and a three-year residency (1980) at Stanford University Medical Center.

From 1980 – 1990, I a partner in a private Radiology practice in Jacksonville, Florida. In 1991 I joined the Cleveland Clinic in Florida and served as Chairman of Radiology between 1991 through 2006. In 2007 I was appointed Chief of Radiology at Physicians Regional Medical Center in Naples, FLorida. A complete copy of my CV is attached to the report.

On the basis of my education, experience, and training I am qualified to interpret and render opinions regarding the studies, methods, procedures, and treatments that are relevant to the allegations at issue in this case.

I have reviewed the following materials in this matter:

1. Plaintiff's Complaint with supporting affidavit of Kevin Yoo, M.D.
2. Dr. Capanna's Operative Report (0168-0169)
3. Dr. Cash's Operative Report (0312-0313)
4. CD of Pre-operative lumbar spine MRI dated September 2, 2010 from Axiom

5. Hard Copy Film of Pre-operative lumbar spine MRI dated September 2, 2010 from Axiom
6. CD of Post-operative lumbar spine MRI date October 6, 2010 from Steinberg Diagnostics
7. CD of Post-operative L-Spine X-rays dated 10/12/2010; 11/3/2010; and 12/1/2010 from Desert Institute of Spine Care
8. CD of Post-operative L-Spine X-rays dated 2/8/2011 and 8/28/2012 from Desert Institute of Spine Care
9. Medical Records – Dr. Capanna (192-193, 78-90)
10. CD of Pre-operative lumbar spine MRI dated February 3, 2009 from Desert Radiologists
11. MRI Report dated February 3, 2009 from Desert Radiologists (110-111)
12. CD of Pre-operative lumbar spine MRI dated February 18, 2010 from Desert Radiologists
13. MRI Report dated February 18, 2010 from Desert Radiologists (109)
14. MRI Report dated September 2, 2010 from Axiom Imaging of Las Vegas (145-146)
15. Intraoperative Fluoroscopy Report dated September 17, 2010 from University Medical Center of Southern Nevada (100)
16. MRI Report dated October 6, 2010 from Steinberg Diagnostics (92-93)

SUMMARY OF EVENTS

Beau Orth sustained a low back injury while playing collegiate football at UNLV.

On February 3, 2009, Mr. Orth underwent an MRI of the lumbar spine, which revealed a very small (5 mm) left paracentral disc protrusion at L5-S1 causing very mild left lateral displacement of the left S1 nerve root.

On February 18, 2010, Mr. Orth underwent another MRI of the lumbar spine. There was no significant interval change in the appearance of a shallow left paracentral disk protrusion at L5-S1.

On September 1, 2010, Mr. Orth presented to Dr. Capanna with complaints of left leg pain. He described his pain as shooting pain, numbness, tingling in left leg, and right toe numbness. In the past, Mr. Orth had some minimal pain, but it had always cleared. Diagnostic studies showed small focal left L5-S1 disc which touched the nerve root just prior to going into the neuroforamen.

On September 2, 2010, Mr. Orth underwent his third MRI of the lumbar spine, which revealed: (1) L5-S1, disc protrusion that abuts the thecal sac without significant spinal canal narrowing.

On September 17, 2010, Mr. Orth presented to Dr. Capanna at UMC for a left L5-S1 microlumbar laminotmy and left L5-S1 microdiscectomy. Dr. Capanna's pre-operative

diagnosis was focal left lumbar L5-S1 disc. Intraoperative fluoroscopic x-rays were taken to ensure surgery was being performed at the correct level.

Mr. Orth underwent a lumbar MRI on October 6, 2010. There was a small focal protrusion pre-operatively at L5-S1 absent post-operatively. There is evidence of some disc degeneration and bulging. There were are also changes in the soft tissues and posterior elements at both the L5-S1 and L4-L5 levels. There are post operative bony changes at both the L4/L5 & L5/S1 levels. The later findings are not reported in the October 6, 2010 MRI report from Steinberg Diagnostic Medical Imaging Centers.

The October 6, 2010 MRI report from Steinberg Diagnostic Medical Imaging Centers indicates there was small disc fragment within the post-surgical scar at L4-L5. It also indicates there was a laminectomy performed on the left at L4-L5. The mild diffuse disc bulge at L5-S1 that was reported on this MRI is simply a degenerative change not equivalent to the small disc fragment Dr. Capanna targeted and removed.

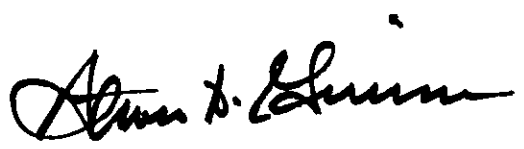
INTERPRETATION OF MRI

In my opinion to a reasonable degree of medical probability, Mr. Orth's MRI from October 6, 2010 shows that Dr. Capanna did operate at L5-S1 and did remove the small disc fragment seen on the pre-operative MRI exams. The small disc left protrussion at L5-S1 was compressing the Left L5/S1 pre-operatively. The post-operative MRI shows that Dr. Capanna removed enough of the disc fragment to allow for decompression of the left L5/S1 nerve root.

All of the statements made herein have been made to a reasonable degree of medical probability. I reserve the right to supplement my opinions as additional information becomes available, including but not limited to any statement or testimony from any of the parties and/or any other experts designated in this case.

Sincerely yours,

Marc D. Kaye, M.D.



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Beau R. Orth

DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,

Plaintiff,

vs.

ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive,

Defendants.

CASE NO. : A-11-648041-C
DEPT. NO. : XXVI

PLAINTIFF'S SECOND SUPPLEMENT TO DESIGNATION OF EXPERT WITNESSES

Plaintiff Beau Orth, by and through his attorneys of record, Prince | Keating, hereby supplements his designation of expert witnesses as follows:

1. Andrew Cash, M.D.
Desert Institute of Spine Care
9339 W. Sunset Road
#100
Las Vegas, Nevada 89148

In addition to the prior expert designation of Andrew Cash, M.D., Dr. Cash will also testify regarding the attached report dated April 1, 2015, a copy of which is attached as **Exhibit 1.**

DATED this 8 day of April, 2015.

PRINCE | KEATING

By: _____

DENNIS M. PRINCE
Nevada Bar No. 5092
JOHN T. KEATING
Nevada Bar No. 6373
9130 W. Russell Road
Suite 200
Las Vegas, Nevada 89148
Attorney for Plaintiff
Beau R. Orth

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b) and Administrative Order 14-2 of the Eighth Judicial District Court, I hereby certify that I am an employee of PRINCE | KEATING and that on the 8th day of April, 2014, I served the above and foregoing **PLAINTIFF'S SECOND SUPPLEMENT TO DESIGNATION OF EXPERT WITNESSES** on the following parties in compliance with the Nevada Electronic Filing and Conversion Rules:

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Albert H. Capanna, M.D.

an Employee of PRINCE | KEATING

PRINCE | KEATING
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9339 West Sunset Road Suite 100
Las Vegas, Nevada 89148
Telephone: (702) 630-3472 Facsimile: (702) 946-5115

April 1, 2015

Dennis M. Prince, Esq.
Prince/Keating Attorneys
9130 West Russell Road, Suite 200
Las Vegas, Nevada 89148

REGARDING: **ORTH, BEAU**
Date of Birth: 11/02/1989
Date of Loss: 09/17/2010

MEDICAL RECORDS REVIEW

08/25/2008-
10/05/2010 UNLV Athletic Training
Daily Treatment, Rehabilitation, and Progress Reports, handwritten.

Injury: Low back.

10/18/2008 UNLV Athletic Training
Injury/Illness Report, handwritten.

Injury: Right ankle.

10/19/2008 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: R ankle, L calf, low back.

01/12/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U R ankle/shin.

01/26/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back.

02/02/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back pain.

02/03/2009 Desert Radiologists
MR report lumbar without contrast.

Referring physician: Michael D. Milligan, MD.

History: Low back pain, athlete.

Impression:
1. Very small (5mm) left paracentral disk protrusion at L5-S1 with mild left-sided displacement of left S1 nerve root. I see no evidence of foraminal stenosis or central canal stenosis.
2. Findings of superimposed and mild congenital narrowing to the lumbar spine.

02/04/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back MRI.

03/02/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

Sick-sore throat.

03/04/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U pharyngitis/vestibulitis.

03/06/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U pharyngitis/vestibulitis.

03/19/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: L great toe.

03/23/2009 UNLV Athletic Training
Injury/Illness Report, handwritten.

Injury: Right shoulder instability.

10/13/2009 UNLV Athletic Training
Injury/Illness Report, handwritten.

Injury: Low back.

10/14/2009 UNLV Athletic Training/Michael D. Milligan, MD
General Medical Assessment, handwritten.

Chief complaint: Low back.

Prescription for Lortab 5 mg #30, prednisone 20 mg.

10/15/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back.

10/18/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: Low back.

11/03/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: Sick.

11/08/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: R hand.

11/10/2009 NCAA Group Basic Accident Medical Program
Preliminary Accident Details Information Form.

11/12/2009 UNLV Athletic Training/Michael D. Milligan, MD
General Medical Assessment, handwritten.

Chief complaint: Left thumb.

Billing for $232.

11/12/2009 Michael D. Milligan, MD
History and Physical.

He presents for an initial evaluation for an injury to his left thumb 2 days ago while at football practice. No significant past medical history. Assessment: Gamekeeper thumb equivalent. Treatment with thumb spica cast for 6 weeks.

11/12/2009-05/24/2010 Billing.

11/16/2009 Michael D. Milligan, MD
Progress Note.

He presents for a new cast. He has a UCL sprain w/avulsion. New thumb spica cast applied today.

11/23/2009 Michael D. Milligan, MD
Progress Note.

He presents for a cast change for the UCL injury.

11/30/2009 Michael D. Milligan, MD
Progress Note.

He presents for re-evaluation of his left UCL injury.

12/14/2009 Michael D. Milligan, MD
Progress Note.

He presents for a cast change in reference to the UCL sprain.

12/31/2009 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U left thumb.

02/16/2010 NCAA Group Basic Accident Medical Program
Preliminary Accident Details Information Form.

02/16/2010 UNLV Athletic Training
Injury/Illness Report, handwritten.

Injury: Low back.

02/17/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: Low back.

02/18/2010 Desert Radiologists/Asif Ahmad, MD
MRI report of the lumbar spine without contrast.

Referring physician: Michael D. Milligan, MD.

History: Low back pain. Followup.

Comparison: February 2009.

Impression: No significant interval change in the appearance of a shallow left paracentral disk protrusion at L5-S1.

Billing.

02/18/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U Lumbar sacral MRI.

02/22/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back pain.

02/23/2010 McKenna and Ruggeroli Pain Specialists/Anthony Ruggeroli, MD
New Patient Consultation.

Chief complaint: Lumbar and left leg pain.

History notable for lumbar and posterior thigh and calf pain since freshman year. He has modified his lifts. Most of the pain increase occurs during drills, lateral, and planting with the left. Continues to work with the trainers.

Areas and description of pain:
Lumbar Spine (Left Side): pain described as numbness, pins and needles, stabbing with a current pain level of 7

Leg (Left Side): pain described as numbness, pins and needles with a current pain level of 4
The pain is described as continuous, aching, sharp, throbbing, shooting, numb, stabbing.

At its WORST, the pain is rated a 10 on a 0-10 scale (0 being no pain).

At its LEAST, the pain is rated a 4 on a 0-10 scale (0 being no pain).

On AVERAGE, the pain is rated a 5 on a 0-10 scale (0 being no pain).

AT THIS TIME, the pain is rated a 6 on a 0-10 scale (0 being no pain).

Pain is made BETTER by: physical therapy, ice.

Pain is made WORSE by: running, sitting for long periods of time, standing for long periods of time.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:

Knees: Right: absent Left: absent
Ankles: Right: normal Left: normal
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact bilaterally

Lumbosacral Exam
Gross Exam Lumbosacral: normal; no deformities; no lesions; no surgical or other scars, normal contour

Palpation of Lumbosacral Soft Tissues:
Left/right: Lumbosacral tender

Lumbar Range of Motion:
Extension limited with pain
Assessment:
Lumbar disk herniation/protrusion/bulge

New problem assessed today:
Pain limited, primarily, to the lumbar (left greater than right) with radiation into the posterior thigh and calf (paresthetic), consistent with MRI finding of disc protrusion at L5-S1 with left S1 encroachment and probable dynamic impingement. Pain to date has been refractory to more conservative treatment attempts, intervention warranted at this juncture.

Plan:
left S1 and L5-S1 transforaminal epidural steroid injections
follow up in office in two weeks for post injection and condition reassessment
activity as directed/modified per the trainers
follow up with Dr. Milligan as scheduled

02/23/2010-08/26/2010 Billing.

02/24/2010 Surgical Arts Center/Anthony Ruggeroli, MD
Operative Report.

Preoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Postoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Procedures:
1. Left L5-S1 transforaminal epidural steroid injection.
2. Left S1 transforaminal epidural steroid injection.
3. Fluoroscopic needle localization/guidance and spinal exam.
4. Intravenous conscious sedation, moderate.

Handwritten records in reference to the procedure.

02/24/2010-
05/14/2014 Surgical Arts Center
Billing.

03/09/2010 McKenna and Ruggeroli Pain Specialists/Anthony Ruggeroli, MD
Followup visit.

Chief complaint: Lumbar and leg pain.

No interval history pertaining to primary pain problem.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: absent Left: absent
Ankles: Right: normal Left: normal
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact bilaterally

Lumbosacral Exam
Gross Exam Lumbosacral: normal; no deformities; no lesions; no surgical or other scars, normal contour

Palpation of Lumbosacral Soft Tissues:
Left/left: Lumbosacral tender

Lumbar Range of Motion:
Normal; within normal limits of flexion, extension, left and right lateral flexion, left and right rotation, without pain

Comments: range of motion restored relative

Assessment:
Assessed lumbar disc herniation/protrusion/bulge as improved

Assessment of established problem(s):
Status post left S1 and L5-S1 transforaminal epidural steroid injection; patient doing well and happy with the outcome. At practice without limitations, performing well, much less pain following workouts.

Plan:
follow up as needed
see Dr. Milligan as scheduled

Billing for $106.09.

03/10/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U low back pain (epidurography 02/24/10).

03/18/2010 UNLV Athletic Training
Injury/Illness Report, handwritten.

Injury: Concussion.

03/22/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

Chief complaint: Possible concussion.

03/24/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U concussion.

08/10/2010 UNLV Athletic Training/Michael D. Milligan, MD
General Medical Assessment, handwritten.

F/U low back.

Prescription for prednisone 20 mg and Lortab 5 mg #40.

08/11/2010 McKenna and Ruggeroli Pain Specialists/Anthony Ruggeroli, MD
Followup visit.

Chief complaint: Left glute and leg pain.

Interval history notable for recent, last few days, of typical pain return, involving the left glute (worse pain), with radiation into the posterior thigh and calf, where the distal lower extremity has a significant "numbness" character. He had been doing very well since his injection in February, tolerating spring training, until recently, with no known event, the pain returned. He is being carefully monitored by the team trainers and Dr. Milligan.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.
Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: normal Left: absent
Ankles: Right: normal Left: decreased
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact
Left: S1 diminished

Lumbosacral Exam
Gross Exam Lumbosacral: normal; no deformities; no lesions; no surgical or other scars, normal contour

Palpation of Lumbosacral Soft Tissues:
Left: Sacral tender

Lumbar Range of Motion:
Normal; within normal limits of flexion, extension, left and right lateral flexion, left and right rotation, without pain

Comments: range of motion within normal limits with pain increase, left lower extremity, with extension and to a greater extent, left lateral flexion

Assessment:
Assessed lumbar disc herniation/protrusion/bulge as deteriorated

Assessment of established problem(s):
Known disc protrusion at L5-S1 with left eccentricity and S1 impingement, no follow up scans, identical pain relative to his last office visit, pain that responded very well to spinal injections. It is reasonable to repeat the injections in an effort to accelerate his progress.

Plan:
left L5-S1 and S1 transforaminal epidural steroid injections
follow up in office in two weeks for post injection and condition reassessment
continue modified training and observation with team trainers and Dr. Milligan

08/13/2010 Surgical Arts Center/Anthony Ruggeroli, MD
Operative Report.

Preoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Postoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Procedures:
1. Left L5-S1 transforaminal epidural steroid injection.
2. Left S1 transforaminal epidural steroid injection.
3. Fluoroscopic needle localization/guidance and spinal exam.
4. Intravenous conscious sedation, moderate.

Handwritten records in reference to the procedure.

08/13/2010 Surgical Arts Center
Billing for $4,048.

08/26/2010 McKenna and Ruggeroli Pain Specialists/Anthony Ruggeroli, MD
Followup visit.

Chief complaint: Left leg pain.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: normal Left: absent
Ankles: Right: normal Left: decreased
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact
Left: S1 diminished

Lumbosacral Exam
Gross Exam Lumbosacral: normal; no deformities; no lesions; no surgical or other scars, normal contour

Palpation of Lumbosacral Soft Tissues:
Left: Lumbosacral tender

Lumbar Range of Motion:
Normal; within normal limits of flexion, extension, left and right lateral flexion, left and right rotation, without pain

Assessment:
Assessed lumbar disk herniation/protrusion/bulge as unchanged

Assessment of established problem(s):
Status post left L5-S1 and S1 transforaminal epidural steroid injections; no significant relief, the pain in the left lower extremity is still impairing performance on the field. Neuro exam today benign, no concerns neurologically. The pain is consistent with left eccentric disc protrusion at L5-S1 with S1 abutment/impingement. The technique was optimal, I do not think it would be beneficial to repeat the injections.

Plan:
follow up with Dr. Milligan as scheduled
consider surgical opinion with Dr. Capanna
follow up with me as necessary

08/27/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U lower back.

09/01/2010 Albert Capanna, MD
Neurosurgical Consultation-Extensive with Review of Records and X-Rays.

This 20 year old male is seen in the office for left leg pain. The problem started when he switched from wideout to linebacker. He is a patient of Dr. Michael Milligan and Kyle Wilson, head trainer UNLV Football. He had some minimal pain in the past that always cleared. No blocks, etc. His mother has had spinal surgery and his father says his low back has been a pain problem for many years. No bowel or bladder problems. Not carrying backpack now to school.

PAST HISTORY: Low back problems; shoulders and arms surgery.
SOCIAL HISTORY: UNLV student football player.

PHYSICAL EXAMINATION:
NEUROLOGICAL EXAM: Oriented x 3; alert. Cranial nerves II through XII grossly normal. DTRs absent left patella (present with Jandrassik Response) and decreased left Achilles. Sensory decreased left S1. Motor normal. Vibratory sense is normal. SLR positive left. Romberg's is normal. Tandem walk normal.

DIAGNOSIS: Focal Left Lumbar L5-S1 Disc

RECOMMENDATION: The patient, his father and I had a long discussion. I showed them the films and explained them. I answered all of their

questions. I showed them a model and explained the possible surgeries of arthroscopic discectomy and microdiscectomy. We will get an EMG and an upright MRI with flexion and extension ASAP. Can not suit up this Saturday. RTC as soon as studies done. He understands and concurs.

Prescription for EMG-LLE; upright MRI with flexion and extension.

09/01/2010-09/17/2010 Billing.

09/02/2010 Axiom Imaging of Las Vegas/Ashesh Patel, MD
MRI report of the lumbar spine with flexion and extension.

Referring physician: Albert Capanna, MD.

History: Low back pain.

Impression:
1. L5-S1, disk protrusion that abuts the thecal sac without significant spinal canal narrowing. The neuroforamina are patent. Disk measurements: NEUTRAL: 2.9 mm, FLEXION: 2.9 mm, EXTENSION: Mild.
2. Straightening of the lumbar lordosis which may be due to myospasm.

Billing for $2,250.

09/08/2010 Clinical Neurology Specialists/Leo Germin, MD
EMG/Nerve Conduction Study.

Referred by Michael Milligan, MD.

The patient presents for neurophysiological consultation for the assessment of:

1. Pain in the left leg.
2. Tingling and numbness sensation in both feet.
3. MRI of the LS spine dated February 18, 2010, revealed mild multi-level central disk canal narrowing secondary to the L5 through S1 left paracentral disk protrusion.

Impression:
1. S1 radiculopathy on the left.

2. Distal symmetric predominantly sensory demyelinating more than axonal mild to moderate in severity peripheral neuropathy as an incidental finding.
3. No electrodiagnostic evidence for peroneal neuropathy at the fibular neck or tibial neuropathy at the popliteal fossa.
4. No electrodiagnostic evidence for overt axonal loss L2 through S1 radiculopathy on the right.

Billing for $2,200.

09/14/2010 UNLV Athletic Training
General Medical Assessment, handwritten.

F/U lower back.

09/15/2010 Albert Capanna, MD
Prescription for Flexeril 10 mg #50.

09/16/2010-
09/17/2010 University Medical Center of Southern Nevada
Billing totaling $15,085.38.

09/17/2010 **DATE OF LOSS**

09/17/2010 Albert Capanna, MD
History and Physical-Extensive with Review of X-rays.

This 20 year old male is admitted for left leg pain and for a microdiscectomy. The problem started when he switched from wideout to linebacker. He is a patient of Dr. Michael Milligan and Kyle Wilson, head trainer UNLV Football. He had some minimal pain in the past that always cleared. First block help, second did nothing and thus stopped. His mother has had spinal surgery with a post op CSF leak for an ACF, and his father says his low back has been a pain problem for many years. No bowel or bladder problems. Not carrying backpack now to school.

PAST HISTORY: Low back problems; shoulders and arms surgery.
SOCIAL HISTORY: UNLV student football player.

PHYSICAL EXAMINATION:
NEUROLOGICAL EXAM: Oriented x 3; alert. Cranial nerves II through XII grossly normal. DTRs absent left patella (present with Jandrassik

Response) and decreased left Achilles. Sensory decreased left S1. Motor normal. Vibratory sense is normal. SLR positive left. Romberg's is normal. Tandem walk normal.

DIAGNOSIS: 1. Focal Left Lumbar L5-S1 Disc

RECOMMENDATION: The patient, his father and I had a long discussion. I showed them the films and explained them. I explained the EMG. I answered all of their questions. I showed them models and explained the possible surgeries of arthroscopic discectomy and microdiscectomy. The arthroscopic will likely not work in my opinion and thus he is admitted for a microdiscectomy. He is well aware of all risks, complications, expectations and alternate therapy, including, but not limited to hemorrhage, paralysis, CSF leak, infection, death and multiple others. He understands and concurs.

09/17/2010 University Medical Center of Southern Nevada/Albert Capanna, MD
Operative Report.

Preoperative diagnosis: Herniated lumbar disk left L5-S1.

Operation:
1. Left L5-S1 microlumbar laminotomy.
2. Left L5-S1 microdiskectomy.
3. Microtechnique.
4. Local anesthetic-0.25% Marcaine w/epinephrine.
5. Intraoperative fluoroscopic x-ray interpretation by the surgeon Dr. Capanna.

09/17/2010 University Medical Center of Southern Nevada/Dianne Mazzu, MD
Intraoperative fluoroscopy report.

09/17/2010 University Medical Center of Southern Nevada/Steve Wong, MD
Anesthesia Record, handwritten.

Billing.

09/17/2010 Albert Capanna, MD
Discharge Summary.
Operation: (1) Left L5-S1 microlumbar laminotomy (2) Left L5-S1 microdiscectomy (3) Microtechnique (4) Local anesthetic-0.25% Marcaine w/Epinephrine (5) Intraoperative fluoroscopic x-ray. Interpretation by the surgeon Dr. Capanna.
final diagnosis: (1) Herniated lumbar disc left L5-S1.

This patient was admitted for elective surgical intervention. This was carried out without incident.

He is doing well he is tolerating diet and ambulating well.

He is discharged on Tylenol #3. He is to follow up in our office in 7-14 days.

He will keep his wound clean and dry.

09/17/2010 University Medical Center of Southern Nevada
Voluminous records in reference to patient's surgery.

09/28/2010 UNLV Athletic Training/Michael D. Milligan, MD
General Medical Assessment, handwritten.

Chief complaint: Low back.

Prescription for Flexeril 10 mg #30.

09/29/2010 Albert Capanna, MD
Prescriptions for Tylenol No. 3 #50 and Valium 5 mg #50.

09/29/2010 International Neuroscience/Albert Capanna, MD
Billing for $250.

10/06/2010 Albert Capanna, MD
Prescriptions for MRI lumbar spine, Demerol 50 mg #50, Decadron and Lortab 10 #50.

10/06/2010 Steinberg Diagnostic Medical Imaging Centers/David Kuo, DO
MRI report of the lumbar spine.

Referring physician: A.H. Capanna.

History: Lower back and left leg pain.

Impression: Postsurgical changes from left L4 laminectomy and microdiscectomy. Postsurgical enhancing granulation tissue left paracentral anterior to the thecal sac, however, there is a 4 mm nonenhancing fragment within the enhancement, most likely a small residual/recurrent disc fragment within the postsurgical scar.

Billing for $1,360.

10/12/2010 Desert Institute of Spine Care/Andrew Cash, MD
Initial Consultation: Lumbar.

HISTORY OF PRESENT ILLNESS: The patient is a 21-year-old male that is a UNLV football player. He is status post microscopic lumbar discectomy L5-S1 per Dr. Capanna's op note from 09/17/2010. The patient had good relief for a week and then felt back pain and recurrent left leg pain. Back disability index is 94% with pain 6-10/10.

PRIOR INJURIES: Broken hand and shoulder surgery 2007.

ALLERGIES: PENICILLIN (VOMITING).

MEDICATIONS: Meperidine, azithromycin, diazepam, Medrol Dosepak.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Shoulder surgery December 2007, back as above.

SOCIAL HISTORY: Single, student, high school, drinks once a month.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Review of systems reveals pain at night.

PHYSICAL EXAMINATION:
ON physical examination the patient has a painful stance. He lists to the right in standing. The patient has an antalgic gait and is unable to walk very well. He has a limp. He has weakened toe and heel walk. He has diminished left Achilles reflex. He has numbness down the lateral aspect of his leg and thigh.

RADIOLOGY/LAB: X-rays four-view taken today show laminotomy defect. MRI shows status post laminectomy left L4 with a 4-mm nonenhancing fragment surrounding by enhancing scar tissue.

IMPRESSION:
1. Lumbar radiculopathy.
2. Recurrent disc herniation.

RECOMMENDATIONS:

1. The patient appears to be crippled at this time from the recurrent disc herniation and I would recommend surgical intervention. The patient realizes a second operation will most likely yield a successful result. The patient also recognizes if this is a recurrent disc herniation at L4-5 and he has another injury at this level, he most likely will require fusion surgery.
2. The patient is not to return to any football activities.
3. The patient's restrictions are no bending, twisting, no lifting more than 10 pounds.
4. The patient will be scheduled for surgery.

10/12/2010-03/18/2014 Billing totaling $40,256.

10/12/2010 Ameritox
Rx Guardian Results Report.

10/19/2010 Desert Institute of Spine Care/Andrew Cash, MD
Preoperative History & Physical Examination.

Followup: Lumbar.

"This supplements the one in the chart."

Chief complaint: Lower back pain.

The pain is severe, 10/10, lasting morning, night and during the day, lasting all day. Worse with standing, sitting, lying down and walking. Nothing makes it feel better. The patient has taken Tylenol and Valium.

Review of systems reveals unintentional weight gain and abdominal pain.

On physical examination, the patient has a benign abdomen. The patient has severe aching and sharp pain in his back that radiates down his left posterior aspect of the left.

RECOMMENDATIONS:
Follow up two weeks after surgery.

Prescriptions for Valium 5 mg #90, Demerol 50 mg #90.

10/22/2010 Southern Hills Hospital/Andrew Cash, MD
Operative Report.

Preoperative diagnosis:

1. Disk herniation material at L4-L5.
2. Disk bulge at L5-S1.
3. Epidural fibrosis.
4. Posterolateral at L4-5, ____ .

Postoperative diagnosis:
1. Disk herniation material at L4-L5.
2. Disk bulge at L5-S1.
3. Epidural fibrosis.
4. Posterolateral at L4-5, ____ .

Procedure:
1. Revision posterior lumbar diskectomy, left L4-5.
2. Hemilaminectomy L5.
3. Microscopic lumbar diskectomy L5-S1.
4. Fluoroscopy.
5. Neural monitoring.
6. Epidural steroid injection L5-S1 and L4-5.
7. Anulex iliac tissue repair system.

10/22/2010 Southern Hills Hospital/Ronald Sauer, MD
Intraoperative fluoroscopy report.

10/22/2010 Andrew Zak, MD
Billing.

10/22/2010 Southern Hills Hospital/Sang Tran, MD
Billing for $344.80.

10/22/2010 Southern Hills Hospital
Anesthesia Record, handwritten.

10/22/2010-
10/23/2010 Southern Hills Hospital
Voluminous records in reference to patient's surgery.

Billing totaling $33,537.

10/23/2010 Southern Hills Hospital/Sang Tran, MD
Discharge Summary.

FINAL DIAGNOSIS:
Lumbar disk disease, status post revision microscopic lumbar diskectomy and laminectomy.

Radiculopathy chronic pain syndrome.

This is a 20-year-old man with a history of lumbar disk disease admitted for revision of microscopic lumbar diskectomy L4-L5 and laminectomy. The surgery went uneventfully. The patient was admitted for observation and pain control. He did well during the hospitalization, tolerating diet, __ ambulating diet. On the day of discharge, he was alert and oriented x3, in no acute distress. His temperature was 97.4, blood pressure 132/65. Respirations 20. Pulse 79. HEENT: Normocephalic, atraumatic. Pupils equal, reactive to light, extraocular muscles intact. TMs are clear and patent. Oral mucosa moist. No lesion noted. Neck: No lymph nodes palpable, no thyromegaly. No bruit, no JVD. Heart: Regular rate and rhythm. S1, S2, no murmur, no gallop, no rub. Lungs are clear to auscultation bilaterally, no wheezes, no rhonchi, no rales. Abdomen: Soft, normal bowel sounds. Extremities are without clubbing, cyanosis or edema. Incision clean, dry and intact. Discharged home in stable condition.

DISCHARGE MEDICATION:
Include Valium 5 every 4 hours as needed, Demerol 50 as needed, Soma 350 three times daily by Dr. Cash 90 quantity with no refill.

PAST MEDICAL HISTORY:
Chronic lumbar disk disease.

11/03/2010 Desert Institute of Spine Care/Andrew Cash, MD
Followup: Lumbar.

CHIEF COMPLAINT: Back and leg pain.

The patient notes severe on the intake form, but it is mild, 1/10 at night and in the morning. It is made better with lying down with pillows. The patient has not required any pain medications today.

The patient has numbness and tingling in the left lower extremity.

On physical examination, the patient's incision is healing. No signs or symptoms of infection.

X-rays two-view lumbar taken in the office today for postop evaluation show left laminectomy defect and loss of disc height at L4-5 and L5-S1.

IMPRESSION:
Postlaminectomy syndrome.

RECOMMENDATIONS:
1. The patient is doing well two weeks after surgery and I recommend he continue wearing the brace when out of the house.
2. The patient will follow up in one month. We will start physical therapy at that time with core stabilization and strengthening exercises.

12/01/2010 Desert Institute of Spine Care/Andrew Cash, MD
2nd Postop Visit S/P Microscopic Lumbar Diskectomy.

The patient states that they have relief of leg pain and has been compliant with the brace.

Wound is clean, dry, intact without any evidence of bleeding or infection.

Impression: Herniated nucleus pulposus s/p microscopic lumbar discectomy.

Recommendations:
Continue to wear brace when out of bed.
Initiate physical therapy.
The patient is advised to avoid bending, twisting, and lifting more than 10 pounds.
The patient may return to light duty.
Follow-up in eight weeks.

12/09/2010 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Upper Quarter/Upper Extremity evaluations, handwritten.

Lower Quarter/Lower Extremity evaluations, handwritten.

12/09/2010-07/19/2011 Billing totaling $5,559.53.

12/15/2010-01/07/2011 D. Keith Kleven Institute
Physical Therapy Records, handwritten.

01/07/2011 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Lower Quarter/Lower Extremity evaluations, handwritten.

01/10/2011-02/04/2011 Keith Kleven Institute of Ortho, Sports and Dance Rehab
Physical Therapy Records, handwritten.

01/19/2011-
05/14/2014 Anthony Ruggeroli, MD
Billing totaling $8,461.53.

02/04/2011 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Upper Quarter/Upper Extremity evaluations, handwritten.

Lower Quarter/Lower Extremity evaluations, handwritten.

02/07/2011-
02/28/2011 D. Keith Kleven Institute
Physical Therapy Records, handwritten.

02/08/2011 Andrew Cash, MD
Followup: Lumbar.

CHIEF COMPLAINT: Back pain and numbness.

The pain is moderate in intensity, 5-6/10, usually morning and night. It is worse with sitting, standing, walking, and lying down and made better with ice.

The patient has been attending physical therapy for two months, continuing water therapy and treadmill.

On physical examination, the patient has aching and throbbing in his back with a well-healed scar. The patient has numbness in the anterior and posterior left thigh.

IMPRESSION:
1. Postlaminectomy syndrome.
2. Lumbar radiculopathy.

RECOMMENDATIONS:
1. I had a lengthy discussion with the patient regarding his future and to playing football. I am recommending a more conservative approach for the patient and he will take it under consideration. The patient may not be able to return to his sport this year. He might return for his following year eligibility.
2. The patient will follow up in one month for reevaluation.
3. Continue physical therapy.

03/01/2011 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Upper Quarter/Upper Extremity evaluations, handwritten.

Lower Quarter/Lower Extremity evaluations, handwritten.

03/02/2011-
04/22/2011 D. Keith Kleven Institute
Physical Therapy Records, handwritten.

04/19/2011 Desert Institute of Spine Care/Andrew Cash, MD
Followup: Lumbar.

Chief complaint: Back pain.
Pain is 2-3/10. He completed physical therapy. He has regained 12 of the 40 pounds he lost.

On physical examination, he has dull pain in the back with numbness in the left buttock and pins and needles and tingling in the bilateral heels and left foot.

Impression:
1. Post laminectomy.
2. Lumbar radiculopathy.

Recommendations:
1. The patient is doing well. Anticipate he will have persistent intermittent numbness in the lower extremities. He is taking the next season off to complete school.
2. Follow up in 3 months.

04/21/2011 UNLV Athletic Training
General Medical Assessment, handwritten.

06/15/2011 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Upper Quarter/Upper Extremity evaluations, handwritten.

Lower Quarter/Lower Extremity evaluations, handwritten.

06/28/2011-
07/21/2011 D. Keith Kleven Institute
Physical Therapy Records, handwritten.

09/15/2011 D. Keith Kleven Institute/D. Keith Kleven, MS, PT, LAT, ATC
Upper Quarter/Upper Extremity evaluations, handwritten.

Lower Quarter/Lower Extremity evaluations, handwritten.

12/02/2011 McKenna and Ruggeroli Pain Specialists/Anthony Ruggeroli, MD
Letter to Mr. Ray.

The patient was seen at the request of Dr. Milligan for evaluation in reference to injection treatment of his left leg and lumbar pain on 02/23/2010. Dr. Ruggeroli ended up performing two separate injections, but the patient did not progress to the point that he could perform at an optimal level (football), and Dr. Ruggeroli decided not to pursue any additional injections. At this point, he followed up with Dr. Milligan. Last visit with Dr. Ruggeroli was 08/26/2011 where we discussed the option of obtaining a surgical opinion.

08/28/2012 Desert Institute of Spine Care/Andrew Cash, MD
Followup: Lumbar.

Chief complaint: Low back pain, 1-2/10 pain, mornings and nights. The patient completed his course of exercises and continues to work out and protect his core with the home exercise program.

On physical examination, he has a low-grade backache with numbness down the posterior left thigh and leg.

Impression:
1. Post laminectomy syndrome.
2. Lumbar radiculopathy.

Recommendations:
1. Updated MRI with/without contrast.
2. Follow up in 2 weeks.

Treating Physician's Urine Toxicology Review and Report.

08/31/2012 Desert Radiologists/Charles Hales, MD
MRI report of the lumbar spine with/without contrast.

Referring physician: Andrew Cash, MD.

History: Post laminectomy syndrome.

Comparison: 18 February 2011.

Impression:
1. Small left disk protrusion with radial tear at L5-S1. Are there left S1 symptoms?
2. Diffuse bulge is present at L4-5. There clearly has been interval loss of disk height and signal at this level compared to the prior exam but a focal disk contour abnormality or significant compromise of neural canal or foramina not visualized at this level.

Billing totaling $2,859.

09/04/2012 Desert Institute of Spine Care/Andrew Cash, MD
Followup: Lumbar.

Chief complaint: Low back pain, mild at 1-2/10.

On physical examination, he has aching pain of left buttock and numbness of left posterior leg.
Impression:
1. Post laminectomy.
2. Lumbar radiculopathy.

Recommendations: The patient to follow up as needed.

07/17/2013 Nevada Orthopedic & Spine Center/Reynold Rimoldi, MD
Independent Medical Evaluation.

08/05/2013 Marc D. Kaye, MD
Record review.

03/12/2014 Desert Institute of Spine Care/AJ Turpin, PA-C/Andrew Cash, MD
Followup.

CHIEF COMPLAINT: Back pain 6-8/10, occurs all day with standing, sitting and walking.

The patient reports low back pain with pain, numbness and tingling radiating to the left lateral thigh and leg with numbness and tingling in the left heel and bilateral lateral three toes. The patient states that this began three days ago. The patient states he is not sure why it started and denies any triggering events.

Occupational History: The patient works as a marketing manager for Peppermill, Inc. where he stocks and walks, but cannot stand or walk very well.

Physical examination:
Lumbar Spine: The patient has bilateral paraspinal tenderness with pain, numbness and tingling radiating to the left lateral thigh and leg with numbness and tingling in the left heel and bilateral lateral three toes. The patient has painful forward flexion and extension. Muscle strength is 5/5 bilaterally. Deep tendon reflexes are symmetrical. Negative straight leg raise test. The patient has a list to the right with sitting. The patient has an antalgic gait.

X-rays lumbar spine show laminectomy defect and loss of disc height at L4-5 and L5-S1.

IMPRESSION:
1. Post laminectomy syndrome.
2. Lumbar radiculopathy.

RECOMMENDATIONS:
1. MRI with and without contrast lumbar spine.
2. Prescription for Medrol Dosepak.
3. Follow up in two weeks.

Lumbar restrictions given.

03/13/2014 Steinberg Diagnostic Medical Imaging Centers/Stephen Chen, MD
MRI report of the lumbar spine with and without contrast.

Referring physician: Andrew Cash, MD.

History: Back pain down left leg, left leg weakness and numbness, history of surgery.

Impression:
1. Postsurgical changes at L4-L5 with reduction of scar and/or disc herniation resulting in improved patency of the central spinal canal and lateral recess without neural impingement. Minimal disc bulge present.
2. Disc desiccation at L5-S1 with stable disc bulge and central disc protrusion with annular tear slightly contacts and displaces the descending left S1 nerve root in the lateral recess without impingement. Correlate for potential left S1 radiculopathy.

03/13/2014-
06/11/2014 Billing.

03/18/2014 Desert Institute of Spine Care/AJ Turpin, PA-C/Andrew Cash, MD
Followup.

CHIEF COMPLAINT: Back pain, moderate 3-9/10, occurs in the morning and last 30-45 minutes. It occurs with standing, sitting and walking.

Occupational History: The patient is a marketing director for Peppermill.

Physical examination:
Lumbar Spine: The patient has bilateral paraspinal tenderness with pain, numbness and tingling radiating to the left lateral thigh and leg with numbness and tingling in the left heel and bilateral lateral three toes. The patient has painful forward flexion and extension. Muscle strength is 5/5 bilaterally. Deep tendon reflexes are symmetrical. Negative straight leg raise test. The patient has a list to the right with sitting. The patient has an antalgic gait.

MRI lumbar spine: Post surgical changes L4-5 with minimal disc bulge, disc protrusion with annular tear L5-S1 contacting and displacing the descending left S1 nerve root in the lateral recess without impingement.

IMPRESSION:
1. Post laminectomy syndrome.
2. Lumbar radiculopathy.
3. Disc protrusion with annular tear L5-S1 contacting and displacing the descending left S1 nerve root.

RECOMMENDATIONS:
1. Physical therapy lumbar spine.
2. Transforaminal epidural steroid injection L5-S1.
3. Follow up in one month

Lumbar restrictions given.

03/19/2014 McKenna, Ruggeroli and Helmi Pain Specialists/Anthony Ruggeroli, MD
New Patient Consultation.

Referring physician: Andrew Cash, MD.

Chief complaint: Lumbar and left leg pain.

Pain onset two weeks ago, with no preceding event known. The pain is somewhat better at this time, following a Medrol Dosepak. The residual pain remains at a relatively high level, his physical activity is limited as such. Pain limited, primarily, to the left lumbosacral area, with radiation into the glute and posterior thigh and calf. There is a "numbness and tingling" character to the lower extremity pain as well. The pain is constant, and intensified with normal and usual physical activity. Recently evaluated by Dr. Cash who recommended consideration of injection options.

His past surgical history is noted. He underwent a discectomy in 2010, followed by another decompressive procedure and had done fairly well, though he did experience daily moderate at least pain. This latest exacerbation was the worst pain that he has experienced for a long time.

The pain is described as continuous, aching, burning, exhausting, nagging, numb, sharp, shooting, stabbing, throbbing, tiring, and is worse in the morning, in the evening.

On AVERAGE, the pain is rated a 6 on a 0-10 scale (0 being no pain).

AT THIS TIME, the pain is rated a 3 on a 0-10 scale (0 being no pain).

Pain is made BETTER by: ice, laying down.

Pain is made WORSE by: driving, walking, weather, sitting for long periods of time, standing for long periods of time.

Attorney involved? no

Claiming as work related? no

Prior tests for current problem: MRI, Physical Therapy, X-ray

Past Medical History
Back Problems
The patient denies any contributory past medical history.

Surgeries
Shoulders/Arms
Low back surgery X2

Lower Extremity Exam

Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: normal Left: absent
Ankles: Right: normal Left: decreased
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact
Left: S1 diminished

Lumbosacral Exam
Gross Exam Lumbosacral: surgical scar or other scar present

Palpation of Lumbosacral Soft Tissues:
Left: Mid tender

Lumbar Range of Motion:
extension limited with pain
Assessment:
Assessed lumbar disk herniation/protrusion/bulge as deteriorated

Assessment of established problem(s):
The MRI shows a left eccentric protrusion at L5-S1 with S1 abutment/impingement, consistent with his pain description and exam. An injection to address this is reasonable and medically necessary, due to the high pain levels and functional impairment. I also discussed a gabapentin trial, as well as amitriptyline q.h.s., as the pain has caused a sleep disturbance. His options were offered, and he elects to proceed.

Plan:
Left S1 and L5-S1 transforaminal epidural steroid injections for therapeutic purposes
depo

follow up in office in two weeks for post injection and condition reassessment
gabapentin trial in the interim, precautions discussed at length
amitriptyline trial for sleep enhancement
increase physical activity as pain level improves, as tolerated

New medication(s):
Neurontin 300 mg caps
amitriptyline HCL 10 mg

03/26/2014 Surgical Arts Center/Anthony Ruggeroli, MD
Operative Report.

Preoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Postoperative diagnosis: Lumbar disk herniation/protrusion/bulge.

Procedures:
1. Left L5-S1 transforaminal epidural steroid injection.
2. Left S1 transforaminal epidural steroid injection.
3. Fluoroscopic needle localization/guidance and spinal exam.
4. Intravenous conscious sedation, moderate.

Handwritten records in reference to the procedure.

04/10/2014 McKenna, Ruggeroli and Helmi Pain Specialists/Anthony Ruggeroli, MD
Followup Visit.

Chief complaint: Left lumbar and leg pain.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: normal Left: absent
Ankles: Right: normal Left: decreased
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:

Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:
Right: normal; S1 / L5 / L4 / L3 dermatomes intact
Left: S1 diminished

Lumbosacral Exam
Gross Exam Lumbosacral: surgical scar or other scar present

Palpation of Lumbosacral Soft Tissues:
Right: Lumbosacral tender
Left: Mid tender, Lumbosacral tender

Lumbar Range of Motion:
extension limited with pain, rotation limited with pain

Assessment:
New Problem(s) added today:
Lumbar spondylosis/facet based pain

New Problem(s) Assessed Today:
Status post left S1 and L5-S1 transforaminal epidural steroid injections; no significant benefit noted. He reports that the left lower extremity pain is much more tolerable vs the lumbar pain. The exam and diagnostic studies are consistent with posterior element pain, (facet joint related), and I think that for diagnostic and/or therapeutic purposes, facet joint injections are reasonable and medically necessary at this time. If he has a clear positive response, but short lived, he would be a good candidate for radiofrequency thermal coagulation. This is a reasonable non surgical option to treat his chronic pain condition, he has not responded to medications and physical therapy.

Plan:
left l5-S1 and Ll4-5 facet joint injections
depo
follow up in office in two weeks for post injection and condition reassessment
patient to discuss condition with Dr. Cash, consider dorsal column stimulator trial if no improvement

Discontinued Medication(s):
Neurontin 300 mg and amitriptyline HCL 10 mg

04/16/2014 Surgical Arts Center/Anthony Ruggeroli, MD
Operative Report.

Preoperative diagnosis: Lumbar spondylosis/facet based pain.

Postoperative diagnosis: Lumbar spondylosis/facet based pain.

Procedures:
1. Left L4-5 facet joint injection.
2. Left L5-S1 facet joint injection.
3. Fluoroscopic needle localization/guidance and spinal exam.
4. Intravenous conscious sedation, moderate.

The patient was examined and questioned prior to discharge. His range of motion was restored and he noted none of the typical and presenting left lumbosacral pain.

Handwritten records in reference to the procedure.

05/01/2014 McKenna, Ruggeroli and Helmi Pain Specialists/Anthony Ruggeroli, MD
Followup Visit.

Chief complaint: Left lumbar and leg pain.

Lower Extremity Exam
Gross Exam Lower Extremities: normal; symmetry present, no deformity bilaterally, bulk consistent with body habitus, no ankle edema bilaterally, skin normal appearance bilaterally.

Motor/Strength: Plantar flexion, dorsiflexion, knee extension, and hip flexion against resistance without deficit bilaterally.

Deep Tendon Reflexes:
Knees: Right: normal Left: absent
Ankles: Right: normal Left: decreased
Clonus or Other Pathological Reflexes: Absent

Lower Extremity Pulses:
Foot/Ankle Capillary Refill Right: brisk Left: brisk

Straight Leg Raise: Left: Positive

Sensation to Sharp:

Right: normal; S1 / L5 / L4 / L3 dermatomes intact
Left: S1 diminished

Lumbosacral Exam
Gross Exam Lumbosacral: surgical scar or other scar present

Palpation of Lumbosacral Soft Tissues:
Left: Mid tender, Lumbosacral tender

Lumbar Range of Motion:
extension limited with pain, rotation limited with pain

Assessment:
Assessed lumbar spondylosis/facet based pain as unchanged

Assessment of established problem:
Status post left L4-5 and L5-S1 facet joint injections; he was pain free in the lumbar area for one and a half weeks, then back to baseline. It is also noted that was pain free prior to discharge from the facility. His response is diagnostic for facet mediated mechanical lumbar pain. He is an excellent candidate for radio frequency thermal coagulation treatment. This was explained and offered, and he elects to proceed.

Plan:
left L5-S1 and L4-5 radiofrequency thermal coagulation for therapeutic purposes
follow up in office in two weeks for post injection and condition reassessment
conditioning program

05/14/2014 Surgical Arts Center/Anthony Ruggeroli, MD
Operative Report.

Preoperative diagnosis:
1. Lumbar spondylosis/facet based pain.
2. Positive medial branch local anesthetic blocks and/or facet injections.
3. Short term relief following therapeutic facet joint injection.

Postoperative diagnosis: Same.

Procedures:
1. Radiofrequency thermal coagulation, left medial branch L3.
2. Radiofrequency thermal coagulation, left medial branch L4.
3. Radiofrequency thermal coagulation, left L5 dorsal ramus.

4. Fluoroscopic needle localization/guidance.
5. Intravenous conscious sedation, moderate.

Handwritten records in reference to the procedure.

06/11/2014 Steinberg Diagnostic Medical Imaging/Mitesh Patel, MD
MRI report of the brain.

Physician: Mandy Buttrum.

History: Headaches.

Impression: Unremarkable MRI brain.

UNDATED Allan Belzberg, MD
Record review.

01/15/2015 Albert Capanna, MD
Deposition.

MEDICAL RECORD REVIEW SUMMARY

I have reviewed the medical records for the pre-operative work-up for the planned L5-S1 discectomy. The work-up was appropriate and reasonable. There was a persistent shallow left-sided disc protrusion at L5-S1 as documented by radiographic imaging as early as February 18th 2009. The absence of a severe compressive lesion and the reduction in symptoms with rest and conservative measures allowed the postponement of surgery. The patient was appropriately treated with conservative measures to include repeat left-sided transforaminal epidural steroid injections. The flexion/extension MRI from September 2nd 2010 showed small 2.9-mm minimal disc protrusion without significant spinal canal narrowing and foramina patent. Electrodiagnostic studies corroborated left S1 radiculopathy. Dr. Rimoldi opined that the patient had an L5-S1 disc protrusion for which appropriate recommendations had been made. A left-sided L5-S1 microscopic lumbar laminotomy with microdiscectomy was dictated on September 17th 2010.

The patient was discharged from the hospital with prescription medications. The patient had a reduction in pain as activities were limited. Approximately two weeks after the procedure, the patient had sudden significant pain. Post-surgical changes at L4-5 were consistent with a left-sided hemi-laminectomy at L4 and discectomy at L4-5. He opined that the procedure had been performed at the wrong level, one level cephalad at L4-5 level. I respectfully disagree with the radiographic conclusions of Dr. Belzberg and Dr. Kaye. The left L4-5 disc herniation obliterated the left-sided spinal canal with compression of the nerve root. The revision surgery was necessary for the symptoms

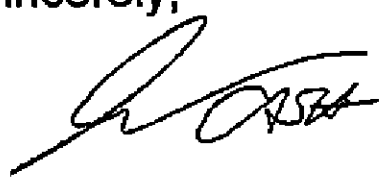
associated with the mass effect exerted on the nerve root. Dr. Rimoldi opined that "clearly the patient required a second surgery." I performed revision surgery at L4-5 and discectomy at L5-S1. Dr. Rimoldi opined the patient's post-operative condition was satisfactory and the patient has normal functioning to perform all activities of daily living; all other complaints are subjective pain. Dr. Ruggeroli performed left L4-5 and left L5-S1 facet injections and radiofrequency ablations in 2014.

Please submit all medical records, actual radiographic imaging, expert reports and testimony as they become available.

This report has been generated to a reasonable degree of medical probability and certainty. I reserve the right to change, modify, alter, or reverse any opinions herein should I be provided additional medical records that would support this decision.

If you have any questions, please feel free to contact me at (702) 630-3472.

Sincerely,



Andrew M. Cash, M.D.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon
Diplomate, American Academy of Orthopedic Surgeons
Diplomate, American Association of Orthopedic Surgeons

AMC/me

DOE
DENNIS M. PRINCE
Nevada Bar No. 5092
TRACY A. EGLET
Nevada Bar No. 6419
GARNET E. BEAL
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EGLET PRINCE
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Attorneys for Plaintiff Beau R. Orth

EGLET PRINCE

DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,

Plaintiff,

vs.

ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive,

Defendants.

CASE NO. : A-11-648041-C
DEPT. NO. : III

PLAINTIFF'S THIRD SUPPLEMENT TO DESIGNATION OF EXPERT WITNESSES

TO: ALL PARTIES AND THEIR RESPECTIVE COUNSEL HEREIN:

Plaintiff, by and through his counsel of record, EGLET PRINCE hereby supplements his designation of expert witnesses as follows:

DOCUMENTS

1. Anthony Ruggerolli, M.D.: Letter of 4/27/2015.

///

Plaintiff reserves the right to supplement the above list as documents as discovery continues.

DATED this 8th day of May, 2015.

Respectfully submitted,

EGLET PRINCE

/s/Dennis M. Prince
DENNIS M. PRINCE, ESQ.
Nevada Bar No. 5092
TRACY A. EGLET, ESQ.
Nevada Bar No. 6419
Attorneys for Plaintiff

EGLET PRINCE

CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of EGLET PRINCE, and that on May 8, 2015, I caused the foregoing document entitled **PLAINTIFF'S THIRD SUPPLEMENT TO DESIGNATION OF EXPERT WITNESSES** to be served upon those persons designated by the parties in the E-Service Master List for the above-referenced matter in the Eighth Judicial District Court eFiling System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules.

Anthony D. Lauria, Esq.
Kimberly L. Johnson, Esq.
LAURIA, TOKUNAGA GATES & LINN, LLP
601 South Seventh Street
2nd Floor
Las Vegas, NV 89101
Office: (702) 387-8633
Fax: (702) 387-8635
Alauria@ltglaw.net
Kjohnson@ltglaw.net
Attorneys for Defendant
Albert H. Capanna, M.D.

John T. Keating, Esq.
Keating Law Group
9130 West Russell Rd., #200
Las Vegas, NV 89148
jkeating@princekeating.com
llee@princekeating.com

/s/Jennifer Buckley
an Employee of EGLET PRINCE

EGLET PRINCE

McKenna, Ruggeroli and Helmi
Pain Specialists

Michael J. McKenna, MD, FIPP

Nader N. Helmi, DO

"the touch of relief"

Anthony C. Ruggeroli, MD

April 27th, 2015

Eglet-Prince
400 S. 7th Street, Suite 400
Las Vegas, NV 89101

Re: Orth, Beau
Requested future medical cost statement

To whom it may concern,

Mr. Orth was last treated for arthritic mechanical lumbar pain on 05/14/2014, which included radiofrequency thermal coagulation (RFA). This procedure was very effective in controlling his pain symptoms. It is expected that the nerves that were lesioned (coagulated) will eventually regenerate with time and that the pain will escalate as a result. Thus, predictably, it will be necessary to repeat the procedure periodically. The frequency of these necessary treatments is estimated at one to two times per year. Based on my training and experience treating similar pain conditions, it is estimated that the length of need of these treatments will be in excess of twenty years, as arthritic pain is not correctable or curable.

My professional fee for RFA involving the three nerves that mediate Mr. Orth's chronic pain condition is $3207.00, the corresponding facility fee is $4610.00 for a total of $7810.00 per treatment. He would also require periodic office visits and reevaluations two to four times per year at a cost of $157.00. At one treatment per year with two office visits, assuming a twenty year treatment span, the cost is $162,620; two treatments per year with four office visits per year (twenty year treatment span) equals $325,240.00.

My opinions and estimates have been formulated within a reasonable degree of medical probability. It is noted that the treatment cost projection described above may change should new or additional information become available.

Sincerely,

Anthony C. Ruggeroli, M.D.
ABA Board Certified in Anesthesiology and Pain Medicine

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Attorneys for Plaintiff Beau R. Orth

EGLET PRINCE

DISTRICT COURT

CLARK COUNTY, NEVADA

BEAU R. ORTH,

Plaintiff,

vs.

ALBERT H. CAPANNA, M.D.; DOES I through X; ROE BUSINESS ENTITIES I through X, inclusive,

Defendants.

CASE NO. : A-11-648041-C
DEPT. NO. : III

PLAINTIFF'S SEVENTH SUPPLEMENT TO THE EARLY CASE CONFERENCE LIST OF DOCUMENTS AND WITNESSES AND N.R.C.P. 16.1 (a)(3) PRE-TRIAL DISCLOSURES

TO: ALL PARTIES AND THEIR RESPECTIVE COUNSEL HEREIN:

Plaintiff, by and through his counsel of record, produce (or will produce where indicated) the identity of non-expert trial witnesses who may be called to testify at the trial of this matter and the non-privileged tangible things, which may be introduced into evidence. For ease of reference, new information is provided in **bold**.

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I.

WITNESSES

1. Beau R. Orth
c/o Eglet Prince
400 S. Seventh Street, Suite 400
Las Vegas, NV 89101

Mr. Orth expected to testify regarding the facts and circumstances surrounding this incident, the injuries he sustained and the care and treatment received as a result of this incident.

2. Albert Capanna, M.D.
c/o Lauria, Tokunaga, Gates & Linn, LLP
601 South Seventh St., 2nd Floor
Las Vegas, NV 89101

Dr. Capanna is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

3. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Michael Milligan, M.D.
5546 Fort Apache Road
Suite 100
Las Vegas, NV 89148
(702) 898-2663

Dr. Milligan is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

4. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Asif Ahmad M.D.
Charles Hales, M.D.
Desert Radiologists
P.O. Box 3057
Indianapolis, IN 46206
(866) 750-3229

Dr. Ahmad and/or Dr. Hales and/or the person most knowledgeable from Desert Radiologists is expected to testify regarding Plaintiff's injuries, the medical care and treatment rendered to Plaintiff.

5. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Anthony Ruggeroli, M.D.
McKenna and Ruggeroli Pain Specialists
6070 S. Fort Apache Road
Suite 100
Las Vegas, NV 89148
(702) 307-7700

Dr. Ruggeroli is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

6. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Leo Germin, M.D.
Clinical Neurology Specialists
1321 S. Rainbow Boulevard, Suite 240
Las Vegas, NV 89146
(702) 804-6555

Dr. Germin is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

7. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Ashesh Patel, M.D.
Axiom Imaging of Las Vegas
6460 Medical Center Street
Suite 150
Las Vegas, NV 89148
(702) 868-2781

Dr. Patel and/or person most knowledgeable from Axiom Imaging is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

8. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
University Medical Center
Albert Capanna, M.D.
Steve Wong, M.D.
Rebecca Staples, R.N.
Lorna Trinidad, R.N.
Chau Ngu, R.N.
1800 W. Charleston Boulevard
Las Vegas, NV 89102
(702) 383-2424

The person most knowledgeable from University Medical Center is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

9. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Steve C. Wong, M.D.
PBS Anesthesia
7326 W. Cheyenne Ave.
Las Vegas, NV 89129
(702) 386-4700

Dr. Wong and/or the person most knowledgeable from PBS Anesthesia is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

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10. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Stephen Chen, M.D.
David Kuo, M.D.
Steinberg Diagnostic Medical Imaging
2767 N. Tenaya Way
Las Vegas, NV 89128
(702) 240-1200

Dr. Chen and/or Dr. Kuo and/or the person most knowledgeable from Steinberg Diagnostic Medical Imaging is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

11. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Andrew Cash, M.D.
A.J. Turpin, PA-C
Desert Institute of Spine Care
9339 W. Sunset Road
#100
Las Vegas, NV 89148
(702) 630-3472

Dr. Cash is expected to offer expert testimony regarding the Plaintiff's injuries, and the reasonableness, necessity and causal relation of the injuries, care and treatment and associated medical expenses to the subject incident. Additionally, he is expected to offer testimony regarding the diagnosis and prognosis of Plaintiff, as well as his knowledge of the care and treatment rendered to Plaintiff by other physicians and the related charges for said care and treatment.

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12. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Southern Hills Hospital
Sang Tran, M.D.
Andrew Cash, M.D.
Andrew Zak, M.D.
Ronald Sauer, M.D.
Wes Smith, SCFA
Eva Zantua, R.N.
Eduardo David, R.N.
Julie Villaneuva, R.N.
Kathy Bearbower, R.N.
Mia Jones, R.N.
Shauna Lapira, R.N.
Juanita Letten, R.N.
Tess Moser, P.T.
Donna Marinello, O.T.
9300 W. Sunset Road
Las Vegas, NV 89148
(702) 880-2100

The person most knowledgeable from Southern Hills Hospital is expected to testify regarding Plaintiff's injuries, the medical care and treatment rendered to Plaintiff and the charges related to said care and treatment.

13. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Keith Kleven, M.S., P.T.
Keith Kleven Physical Therapy
3820 S. Jones Boulevard, Suites B & C
Las Vegas, NV 89103
(702) 731-0831

Mr. Kleven and/or the person most knowledgeable from Keith Kleven Physical Therapy is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

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14. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Andrew Zak, M.D.
P.O. Box 93358
Las Vegas, NV 89193
(702) 487-6510

Dr. Zak is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

15. Kyle S. Wilson, M.Ed.
Director of Athletic Training
University of Nevada Las Vegas
4505 S. Maryland Parkway
Las Vegas, NV 89145

Mr. Wilson is expected to testify as to the facts and circumstances surrounding this incident and the care and treatment rendered to Plaintiff.

16. Peggy Orth
9156 Lawton Pine Drive
Las Vegas, NV 89129

Mrs. Orth will testify as to the facts and circumstances surrounding this incident, the damages and pain and suffering endured by the Plaintiff, and any related information.

17. Robert Orth
9156 Lawton Pine Drive
Las Vegas NV 89129

Mr. Orth will testify as to the facts and circumstances surrounding this incident, the damages and pain and suffering endured by the Plaintiff, and any related information.

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18. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Surgical Arts Center
9499 West Charleston Blvd., #250
Las Vegas, NV 89117-7148
(702) 933-3600

The person most knowledgeable from Surgical Arts Center is expected to testify regarding Plaintiff's injuries, the medical care and treatment rendered to Plaintiff and the charges related to said care and treatment.

19. Treating Physicians/and or
Treating Nurses and/or
Person(s) Most Knowledgeable and/or
Custodian of Records
Radiology Associates
Ronald Sauer, M.D.
600 S. Rancho Drive, Suite 102
Las Vegas, NV 89106
(702) 938-1102

20. Any and all witnesses identified by Defendant.

21. Any impeachment or rebuttal witnesses who may be deemed necessary.

These medical care providers or their representatives are expected to testify regarding the Plaintiff's injuries resulting from the incident, their treatment, prognosis and the cost of the services rendered.

Plaintiff anticipates that he may require testimony from any and all custodians of records which are necessary to authenticate documents which cannot be stipulated to regarding admissibility by the parties herein.

Plaintiff reserves the right to call any and all expert witnesses which Plaintiff may hereafter select as the need arises during the course of this litigation; and, Plaintiff further

reserves the right to supplement this witness list if any other witnesses become known to Plaintiff as this litigation progresses and as other witnesses are discovered or located.

Plaintiff also reserve the right to call any and all of the Defendants' proposed witnesses, or any other witnesses of same who become known to Plaintiff and/or Defendants as this litigation progresses and as other witnesses are discovered or located.

Plaintiff reserves the right to call rebuttal and/or impeachment witnesses; to call the records custodian for any person(s) or institution(s) to which there is an objection concerning authenticity; and to call any and all witnesses of any other party in this matter.

II.

DOCUMENTS

1. Michael Milligan, M.D., medical records (001-0039);
2. Desert Radiologists, medical records (0040-0041);
3. McKenna and Ruggeroli Pain Specialists, medical records(0042-0059);
4. Clinical Neurology Specialists, medical records(0060-0075);
5. International Neuroscience (Dr. Capanna), medical records(0076-0193);
6. International Neuroscience (Dr. Capanna), billing(0194-0196);
7. Axiom Imaging of Las Vegas, medical records and billing(0197-0201);
8. University Medical Center, medical records(0202-0263);
9. University Medical Center, billing(0264-0268);
10. PBS Anesthesia, medical records and billing (0269-0272);
11. Steinberg Diagnostic Medical Imaging, medical records (0273-0285);
12. Steinberg Diagnostic Medical Imaging, billing(0286);
13. Desert Institute of Spine Care (Dr. Cash), medical records (0287-0354);
14. Desert Institute of Spine Care (Dr. Cash), billing(0355);

15. Southern Hills Hospital, medical records (0356-0605);

16. Southern Hills Hospital, billing(0606-0614);

17. Keith Kleven Physical Therapy, medical records(0615-0732);

18. Keith Kleven Physical Therapy, billing(0733-0742);

19. Andrew L. Zak, M.D., billing(0743-0745);

20. Affidavit of Kevin Yoo, M.D (0746-1061);

21. Any and all x-rays, MRI films, CT Scans and any other diagnostic films in any way related to the care and treatment of Plaintiff;

22. Desert Radiologists, Medical Imaging Report dated 8/31/12 (1062-1063);

23. Desert Radiologists (Zotec Partners) billing for 8/31/12 (1064-1066);

24. Desert Institute of Spine Care (Dr. Cash), updated medical and billing records (1067-1113).

Third Supplement

25. Nevada State Board of Medical Examiners Licensee Details regarding Albert Howard Capanna (1114-1117);

26. Complaint filed on December 24, 2012, Before the Board of Medical Examiners of the State of Nevada, In the matter of Charges and Complaint Against Albert H. Capanna, M.D. (1118-1123);

27. Steinberg Diagnostic Medical Imaging, billing and records which include an MRI of the Lumbar Spine dated 3/21/14 (1124-1141);

28. McKenna and Ruggeroli Pain Specialists, billing statement through 5/14/14 (1142-1143);

29. McKenna, Ruggeroli and Helmi Pain Specialists, medical records (1144-1266);

30. Desert Institute of Spine Care, updated billing statement through 3/18/14 (1267);

31. Desert Institute of Spine Care, Andrew M. Cash, M.D., updated set of medical records (1268-1380);

Fourth Supplement

32. Surgical Arts Center, billing statement including facility for injections by Dr. Ruggeroli on 3/26/14, 4/16/14, and 5/14/14 (1381-1383);

33. Surgical Arts Center, medical records (1384-1469);

Fifth Supplement

34. Desert Institute of Spine Care, / Andrew M. Cash, M.D., revised/ updated billing statement through 3/18/14 (1470);

35. Any and all documents identified by any party to this litigation.

Sixth Supplement

No records produced.

Seventh Supplement

36. Letter dated May 14, 2015 from Andrew Cash, M.D. regarding future medical care and costs.

The following diagnostic imaging studies/films are in the possession of Plaintiff and ***are available for inspection and copying at Defendants' expense***, and are being described and identified pursuant to NRCP 16.1 (a) (1) (B) and 26 (e) (1):

DIAGNOSTIC IMAGING STUDIES PERTAINING TO PLAINTIFF BEAU ORTH:

Provider	Service Date	Type of Film
UNLV	2/08/10	MRI Lumbar
Axiom Imaging	9/02/10	MRI Lumbar
Axiom Imaging	9/02/10	MRI Lumbar
Desert Radiologists	2/03/09	MRI Lumbar
Desert Radiologists	2/18/10	MRI Lumbar
Desert Radiologists	8/31/12	MRI Lumbar
Steinberg Diagnostics	3/13/14	MRI Lumbar
Steinberg Diagnostics	6/11/14	MRI Brain

Steinberg Diagnostics	10/06/10	MRI Lumbar

Plaintiff reserves the right to submit as an exhibit any document or tangible item identified by any other party in this action or obtained from any third party. Plaintiff further reserves the right to amend and/or supplement this list of documents or tangible items as discovery proceeds.

In addition, neither inclusion of any documents or tangible items within this disclosure nor acceptance of documents provided by any other party hereto in a disclosure shall be deemed as a waiver by Plaintiff of any evidentiary rights Plaintiff may have with respect to those documents and/or tangible items, including, but not limited to, objections related to authenticity, materiality, relevance, foundation, hearsay, or any other rights as may be permitted pursuant to the Nevada Rules of Evidence.

III.

PLAINTIFF'S COMPUTATION OF DAMAGES

	Medical Provider	**Charges**
1.	Desert Institute of Spine Care	$40,256.00
2.	Desert Radiologists	$2,959.00
3.	Kleven, Keith, P.T.	$5,559.53
4.	McKenna Pain Specialists	$8,708.78
5.	Southern Hills Hospital	$33,064.00
6.	Steinberg Diagnostic	$2,500.00
7.	Surgical Arts Center	$12,348.00
8.	Zak, Andrew, M.D.	$2,800.00
	TOTAL	**$108,195.31**

Past Medical and Related Expenses	**$108,195.31**
Future Medical Expenses	**$342,401.00**
Total Special Damages	**$450,596.31**

Further, at trial, the Jury will decide upon a sum of money sufficient to reasonably and fairly compensate Plaintiff for the following items:

1. The reasonable medical expenses Plaintiff has necessarily incurred as a result of the accident/incident and the medical expenses which the Jury believes the Plaintiff is reasonably certain to incur in the future as a result of the accident/incident, discounted to present value.

2. Plaintiff's loss of earnings or earning capacity from the date of the accident/incident to the present.

3. Plaintiff's loss of earnings or earning capacity which the Jury believes the Plaintiff is reasonably certain to experience in the future as a result of the accident/incident, discounted to present value. Also, the Jury will include the reasonable value of services performed by another in doing things for the Plaintiff, which, except for the injuries, Plaintiff would ordinarily have performed.

4. The physical and mental pain, suffering, anguish, and disability endured by the Plaintiff from the date of the accident/incident to the present; and

5. The physical and mental pain, suffering, anguish, and disability which you believe Plaintiff is reasonably certain to experience in the future as a result of the accident/incident, discounted to present value.

Plaintiff reserves all rights to seek other damages including, but not limited to, general and exemplary damages, in an amount to be proven at trial.

Plaintiff reserves the right to supplement this Calculation of Damages with any and all other relevant documents and records, which come into their possession during discovery.

Plaintiff reserves the right to supplement this exhibit list with any and all other relevant documents and records, which come into their possession during discovery.

Plaintiff reserves the right to have a medical expert review the medical records and provide an opinion to counsel, but not testify at the time of trial and/or arbitration.

IV.

DEMONSTRATIVE EXHIBITS

Plaintiff may offer at trial, certain Exhibits for demonstrative purposes including, but not limited to, the following:

a. Actual surgical hardware, plates, screws, surgical tools, and surgical equipment as used in Plaintiff's medical treatment and anticipated to be used in future treatment;

b. Demonstrative and actual photographs and videos of surgical procedures and other diagnostic tests Plaintiff has undergone and will undergo in the future;

c. Actual diagnostic studies and computer digitized diagnostic studies;

d. Samples of tools used in surgical procedures;

e. Diagrams, drawings, pictures, photos, film, video, DVD and CD ROM of various parts of the human body, diagnostic tests and surgical procedures;

f. Computer simulation, finite element analysis, mabymo and similar forms of computer visualization;

g. Power point images/drawings/diagrams/animations/story boards, of the related vehicles involved, the parties involved, the location of the motor vehicle accident and what occurred in the motor vehicle accident.

h. Pictures of Plaintiff Prior and Subsequent to the Subject accident;

i. Surgical Timeline;

j. Medical treatment timeline;

k. Future Medical Timeline;

l. Charts depicting Plaintiff's Life Care Plans;

m. Charts depicting Plaintiff's Loss of Hedonic Damages;

n. Photographs of Plaintiff's Witnesses;

o. Charts depicting Plaintiff's Life Expectancy;

p. Story boards and computer digitized power point images;

q. Blow-ups/transparencies/digitized images of medical records, medical bills, photographs and other exhibits;

r. Diagrams/story boards/computer re-enactment of motor vehicle accident;

s. Diagrams of various parts of the human body related to Plaintiff's injuries;

t. Photographs of various parts of the human body related to Plaintiff's injuries;

u. Models of the human body related to Plaintiff's injuries;

v. Samples of a spinal cord stimulator and leads;

w. Sample of an intrathecal drug delivery system and leads;

x. Samples of the needles and surgical tools used in Plaintiffs' various diagnostic and therapeutic pain management procedures.

Plaintiff reserves the right to supplement these disclosures with any and all other relevant information and documents and records that come into their possession during discovery.

Plaintiff further reserves the right to use any and all of any other parties' exhibits at the time of trial of this matter.

Plaintiff reserves the right to supplement his List of Witnesses and Lists of Exhibits with any and all other relevant information and documents and records which come into his possession during discovery.

DATED this 14 day of May, 2015.

EGLET PRINCE

DENNIS M. PRINCE, ESQ.
Nevada Bar No. 5092
TRACY A. EGLET, ESQ.
Nevada Bar No. 6419
Attorneys for Plaintiff

EGLET PRINCE

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CERTIFICATE OF SERVICE

Pursuant to NRCP 5(b), I certify that I am an employee of EGLET PRINCE, and that on May 14, 2015, I caused the foregoing document entitled **PLAINTIFFS' SEVENTH SUPPLEMENT TO THE EARLY CASE CONFERENCE LIST OF DOCUMENTS & WITNESSES AND N.R.C.P. 16.1 (a)(3) PRE-TRIAL DISCLOSURES** to be served upon those persons designated by the parties in the E-Service Master List for the above-referenced matter in the Eighth Judicial District Court eFiling System in accordance with the mandatory electronic service requirements of Administrative Order 14-2 and the Nevada Electronic Filing and Conversion Rules.

Anthony D. Lauria, Esq.
Kimberly L. Johnson, Esq.
LAURIA, TOKUNAGA GATES & LINN, LLP
601 South Seventh Street
2nd Floor
Las Vegas, NV 89101
Office: (702) 387-8633
Fax: (702) 387-8635
Alauria@ltglaw.net
Kjohnson@ltglaw.net
Attorneys for Defendant
Albert H. Capanna, M.D.

John T. Keating, Esq.
Keating Law Group
9130 West Russell Rd., #200
Las Vegas, NV 89148
jkeating@princekeating.com
llee@princekeating.com

an Employee of EGLET PRINCE

EGLET PRINCE

EXHIBIT 36

Desert Institute of Spine Care

9339 West Sunset Road, Suite 100
Las Vegas, Nevada 89148
Telephone: (702) 630-3472 Facsimile: (702) 946-5115

May 14, 2015

Eglet Prince
400 South 7th St, 4th Floor
Las Vegas, NV 89101

RE: Beau Orth
DOB: 11/02/1989
DOI: 09/17/2010

To Whom It May Concern:

I reviewed the deposition of Beau Orth. His rehabilitation focused on re-emergence into competitive collegiate football. Preparing high-caliber athletes to return to sport-specific activities takes longer than the rehabilitation for return recreational and most work-related activities. Lumbar decompressive surgery is an intervention to ameliorate symptoms in the lower extremities but is less successful in reducing low back pain. Beau and his family were adamant about proceeding with the revision procedure as the patient was in intense pain and debilitated. They were given all options, including not undergoing a second lumbar procedure. We discussed the diagnosis, prognosis, surgery plan, risks, benefits and alternatives prior to surgical intervention.

Although his low back pain scores are expected to fluctuate, Beau has experienced an overall gradual worsening of low back pain over time which is consistent with the natural course of a post-operative lumbar microdiscectomy, and he will ultimately undergo accelerated deterioration at L4-5 and L5S1 levels and require a two-level lumbar reconstructive procedure. Beau will require the lumbar reconstruction at L4-5 and L5-S1 within the next ten years. The anticipated cost of a two-level reconstruction is approximately $350,000, which includes facility fee,

(continued)

surgeon fee, assistant surgeon fee, anesthesia, external bone stimulator, home health care, postoperative bracing, postoperative rehabilitation and intraoperative neuromonitoring.

Prior to the lumbar reconstruction, he will require initial spine surgeon consultation ($850) with x-rays four-view lumbar ($400) and pre-operative clearance with a medical provider, including initial consultation, labs, x-rays and a follow-up evaluation ($1,100). He will require six (6) monthly post-operative spine surgeon evaluations ($550 each visit) with x-rays two-view lumbar ($300 each visit).

All treatment at L4-5 is related to the initial surgical discectomy at that level. The microscopic lumbar discectomy at L5-S1 is related to the patient's disc protrusion, and the lumbar facet treatments are related to the deterioration after the microscopic lumbar discectomy at L5S1.

He will require lumbar facet treatments at L4-5 and L5-S1 for the next six to ten years, probably ten years in this case as his levels are deteriorated at L5S1 (from a herniation and a surgical discectomy) and at L45 (from a herniation and two surgical discectomies). The lumbar facet treatments will conclude when the patient has a lumbar fusion at L4-5 and L5-S1 within ten years.

After a microdiscectomy at L5-S1, I anticipate a lumbar reconstruction at L5-S1 ten years later, and a subsequent adjacent level fusion at L4-5 seventeen years after the lumbar reconstruction. After microscopic lumbar discectomies performed at L4-5 and L5-S1, the patient will require a two-level lumbar reconstruction in ten years and a third lumbar reconstruction at L3-4 seventeen years after the two-level lumbar reconstruction.

The cost of the L3-4 procedure will be approximately as follows:

Facility fee	$228,000
Surgeon fee	48,621
Assistant surgeon fee	12,155
Vascular Surgeon	5,600
Anesthesia	4,000
Bone Stimulator	13,125
Post operative bracing	6,800
Home Health	5,600
Post operative therapy	8,000
Neuromonitoring	10,500
	$342,401

This report has been generated to a reasonable degree of medical probability. I reserve the right to change, modify, alter or reverse opinions herein upon further consideration or review of additional records.

If you have any questions, please feel free to contact me at 702-630-3472.

Sincerely,

Andrew M. Cash, M.D.
Board Certified Orthopedic Surgeon
Fellowship Trained Spine Surgeon
Diplomate, American Academy of Orthopedic Surgeons

AMC/lam

RE: Beau R. Orth vs. Albert Capanna, M.D.

To whomever this may concern:

I have reviewed the following documents and from that review can make the opinions below regarding Beau Orth.

1. Desert Radiologists, MRI reports of February 3.2009 and February 18, 2010
2. International Neuroscience Consultants (Albert Capanna, MD), medical records
3. Axiom Medical Imaging, MRI report of September 2, 21010
4. University Medical Center, medical records
5. Steinberg Diagnostic Medical Imaging, MRI report of October 6,2010
6. Desert Institute of Spine Care (Andrew Cash, MD), medical records
7. Southern Hills Hospital, pertinent medical records (without nursing notes)
8. CD of MRIs of February 18, 2010; September 2, 2010; and October 6, 2010
9. Deposition of Orth Beau and Albert Capanna, MD
10. Records of Surgical Arts Center from 2/24/2010 – 5/14/2010

Dr. Albert Capanna diagnosed Beau Orth with L5-S1 disc herniation and stated he performed L5-S1 microdiscectomy on 9/17/2010. Patient continued to be in pain and repeat MRI on 10/6/2010 revealed that Dr. Capanna had actually performed an L4-5 microdiscectomy. This is clearly below standard of care. It is impossible to reach the L5/S1 disc space by performing an L4 laminotomy from above. It was for this reason that Dr. Andrew Cash had to perform a second surgery on Beau Orth on 10/22/2010. Dr. Cash performed re-do microdiscectomy of L4-5 and correct microdiscectomy of L5-S1.

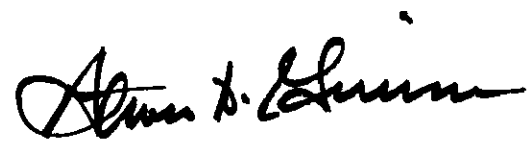
The following are my professional medical opinions to a great degree of certainty on the prognosis of Beau Orth. Because of the first surgery at the wrong L4-5 level and the need for subsequent surgery at L4-5 and L5-S1, Beau Orth will more likely than not have chronic back and leg problems including pain, numbness, and weakness. This is because he now has weakened lumbar structures and disc space at L4-5 and L5-S1. He will more likely that not require constant pain management and pain procedures such as epidural steroid injections, facet blocks and facet rhizotomies, and spinal cord stimulator.

It is also more likely than not Beau Orth will require further surgery to his lumbar spine including L4-5 and L5-S1 fusions. Because Beau Orth is so young, such fusion will more likely than not lead to adjacent disc disease requiring fusion at L3-4 within 5 to 15 years of L4-5 and L5-S1 fusion. The next level of L2-3 and then L1-2 will follow in a similar manner.

Kevin Yoo, M.D.

5/26/15 Kevin Yoo, M.D.

EXHIBIT 2
REPORTER J. WINTERS
WITNESS K. YOO
DATE 5/26/15



DOWE
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
LAURIA TOKUNAGA GATES & LINN, LLP
601 South Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633; Fax: (702) 387-8635

Attorneys for ***Defendant ALBERT H. CAPANNA, M.D.***

DISTRICT COURT

CLARK COUNTY NEVADA

BEAU R. ORTH, Plaintiff, v. ALBERT H. CAPANNA, M.D.; DOES I THROUGH X; ROE BUSINESS ENTITIES I THROUGH X, Defendants.	CASE NO. : A-11-648041-C DEPT. NO. : 3 **SUPPLEMENTAL EXPERT WITNESS DISCLOSURE STATEMENT OF DEFENDANT ALBERT H. CAPANNA, M.D.**

Pursuant to N.R.C.P. 16(a)(2), Defendant ALBERT H. CAPANNA, M.D., through his attorneys, Anthony D. Lauria, Esq., of the law firm of Lauria Tokunaga Gates & Linn, LLP, hereby serves this supplemental expert witness disclosure statement.

DATED: May 28, 2015.

LAURIA TOKUNAGA GATES & LINN, LLP

By: */s/ ANTHONY D. LAURIA*
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
601 S. Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633
Attorneys for Defendants

RETAINED EXPERTS

A Reynold L. Rimoldi, M.D.
Nevada Orthopedic & Spine Center
2650 N. Tenaya Way, Suite 301
Las Vegas, Nevada 89128
(702) 258-3773

1. SUMMARY OF PROFESSIONAL EDUCATION, TRAINING AND EXPERIENCE: **See Dr. Rimoldi's Curriculum Vitae, fee schedule and list of trial/deposition testimony attached hereto as Exhibit "G."**

2. SUMMARY OF OPINIONS:

See Dr. Rimoldi's updated report dated May 26, 2015 attached hereto as Exhibit "H."

Defendants reserve the right to call as a witness any and all of the healthcare providers who were involved in any way in the care and treatment provided to Beau R. Orth, and who are timely identified by any party to this litigation. These healthcare providers are expected to testify about all aspects of the care and treatment they provided to Beau R. Orth, including, but not limited to, their findings and the opinions they formed.

DATED: May 28, 2015.

LAURIA TOKUNAGA GATES & LINN, LLP

By: */s/ ANTHONY D. LAURIA*
Anthony D. Lauria
Nevada Bar No.: 4114
Kimberly L. Johnson
Nevada Bar No.: 10554
601 S. Seventh Street, 2nd Floor
Las Vegas, Nevada 89101
(702) 387-8633
Attorneys for Defendants

CERTIFICATE OF SERVICE

Pursuant to N.R.C.P. 5(b), I certify that I am an employee of Lauria Tokunaga Gates & Linn, and that on the 29th day of May, 2015, I served a true and correct copy of the foregoing, SUPPLEMENTAL EXPERT WITNESS DISCLOSURE STATEMENT OF DEFENDANT ALBERT H. CAPANNA, M.D.:

☐ By placing same to be deposited for mailing in the United States Mail, in a sealed envelope upon which first class postage was prepared in Las Vegas, Nevada; and/or

X Via electronic mail; and/or

☐ Via facsimile; and/or

☐ Via Receipt of Copy to the interested parties

as follows:

Dennis M. Prince, Esq.
Eglet Prince
400 South 7th Street, Box 1, Suite 400
Las Vegas, NV 89101

John T. Keating, Esq.
9130 West Russell Road, Suite 200
Las Vegas, Nevada 89148
Attorneys for Plaintiff
BEAU R. ORTH

MARISA PEREZ, an employee of
Lauria Tokunaga Gates & Linn

EXHIBIT G

EXHIBIT G

NEVADA Orthopedic & Spine Center

Reynold L. Rimoldi, M.D.

Curriculum Vitae

Personal

Address:	2650 North Tenaya Way, Suite 301
	Las Vegas, NV 89128
Phone:	702-878-0393
Fax:	702-878-7035
Date of Birth:	June 17, 1956
Place of Birth:	Grosse Point, Michigan
Martial Status:	Married

Medical License

Nevada:	6287
California:	G62281
Hawaii:	17753
Arizona:	46893
Utah:	8572691-1205
	8572691-8905

Board Certification

American Board of Orthopaedic Surgery, Diplomate
July 1994-Dec. 2004
Recertified: Jan. 2005 - Dec. 2024

American Board of Spine Surgery, Charter Diplomate
Recertified: Oct. 2001 - Dec. 2021

Orthopedic Practice

03/95 - Present	Nevada Orthopedic and Spine Center 2650 North Tenaya Way, Suite 301 Las Vegas, NV 89128
10/94 - 02/95	Thomas-Rimoldi Medical Corporation 1701 West Charleston Avenue, Suite #410 Las Vegas, Nevada 89106
03/92 - 09/94	Western Orthopedic Medical Group 1701 West Charleston Avenue, Suite #410 Las Vegas, Nevada 89106
02/92 - 09/94	Channel Islands Orthopedic Group 905 South "A" Street Oxnard, California 93030
02/91 - 09/94	Downey Orthopedic Group 7700 East Imperial Highway, Suite #R Downey, California 90242

Postgraduate Training

1990 - 1991	Sports Medicine Fellowship Hughston Sports Medicine Center Columbus, Georgia
1989 - 1990	Spine Fellowship Rancho Los Amigos Medical Center Downey, California
1985 - 1989	Surgical and Orthopedic Residency University of Texas, Medical Branch Galveston, Texas
1984 - 1985	Surgical Internship University of Texas, Medical Branch Galveston, Texas

Medical Education

1978 - 1984	Medical College of Wisconsin Milwaukee, Wisconsin Medical Degree

Undergraduate Education

1974 - 1978	California State University Long Beach, California

Current Hospital Affiliations

Centennial Hills Hospital Medical Center
6900 North Durango Dr.
Las Vegas, NV 89149-4409

Mountain View Hospital
3100 North Tenaya Way
Las Vegas, Nevada 89128
702-255-5000

Spring Valley Hospital Medical Center
5400 S. Rainbow Boulevard
Las Vegas, Nevada 89118
702-853-3041

St. Rose Dominican Hospitals
Rose de Lima, Siena & San Martin
102 E. Lake Mead Parkway
Henderson, NV 89015
702-616-5000

Summerlin Medical Center
657 Town Center Drive
Las Vegas, Nevada 89134
702-233-7721