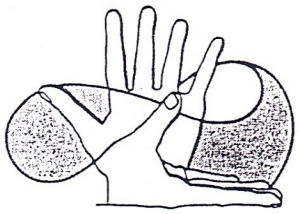

Ric. ,rd M. Braun MD
Dori J. Neill Cage MD
Gregory R. Mack MD

Surgery of the Hand and Upper Extremity
Orthopaedic Surgery
Surgery of Peripheral Nerves

August 18, 1998

Dean A. Goetz, Esq.
603 North Coast Highway
Suite 101
Solana Beach, California 92075

Ms. Diana Cumpian
Argonaut Insurance
120 South State College, Suite 100
Brea, California 92621

RE: HOLLIFIELD, Rick
CLM: 62X103499

Dear Mr. Goetz:

I am in receipt of your letter of August 3, 1998 regarding Rick Hollifield.

The patient's diagnosis involves a fracture of the distal left forearm and injury to the left wrist which the patient sustained while at work on August 28, 1996.

The patient's prognosis has improved with surgical treatment. On his last visit, Mr. Hollifield appeared to have healed the distal radius fracture which has given us great difficulty in management during the last year. The appropriate bone plating and grafting appears to have solved the problem of bone union in this area. In addition, because of articular damage to the distal radial surface, it was necessary to fuse the distal radius to the proximal carpal row. This is a more difficult and time consuming procedure than a total wrist fusion, but will allow the patient movement in the second carpal row. This mid carpal row motion will give the patient improved function in his hand. Mr. Hollifield has never required a total wrist fusion. A total wrist fusion would carry extra morbidity and increased disability for Mr. Hollifield. For this reason, I have worked diligently toward avoiding this procedure and have fused the proximal carpal row to the distal radius with some difficulty. This will allow Mr. Hollifield about 30° of motion in his wrist which will be helpful to him in grasping and holding objects. The prognosis for the success of this plan is good at this time because of the recent radiographs which show healing in both of these areas.

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The patient's injury occurred when he fell at work and sustained a high velocity, high impact injury to his distal left forearm. His recovery period has been complicated by many factors. He underwent a carpal tunnel release because of compression injury to the median nerve in the wrist. He had difficulty in healing the distal radial fracture because of malalignment problems and the difficulty in securing a bone graft. He had further difficulty in incorporating bone graft into the fusion of the distal radius-proximal carpal row. All of these problems appear to be behind Mr. Hollifield at this time. He has healed his fracture of the distal radius. He has healed the radius to proximal carpal row fusion. His wrist is straight and well aligned. His fingers move well. His sensation and median nerve function is normal. The recovery period which has been prolonged, has been justified because of the need to treat all of these areas simultaneously with the goal of providing this patient the best possible use of his hand in a longterm prognosis. The simplicity of a wrist fusion may sound appealing, but the patient's problem has involved more than his wrist joint and has been difficult to deal with because of the fracture in the distal radius as well as the injury to the wrist joint itself. Furthermore, fusion of the middle carpal row which would cost the patient loss of all motion in the wrist, has never been necessary and is presently a functional joint allowing the patient some motion in the wrist.

Future medical expenses will involve another surgical procedure which is considered a minor consequence. A pin must be removed from the wrist joint. In addition, some bone debridement of bone grafted areas would be reasonable. These procedures can be performed in about one hour in an outpatient surgical setting. The cost of these operations would probably be about $1,000-$1,200 for the surgical and assistant fee if an assistant is used for the case. If there is an anesthesiologist required, then his fee would probably be about $400. The cost of a surgical center would be about $1,200 for this procedure. Following this, therapy would be necessary as Mr. Hollifield must build strength into his hand and forearm. Fortunately, his forearm and wrist are painfree at this time and he is able to use his fingers for strengthening the forearm musculature. Cost of therapy is hard to determine, but may involve 12-14 weeks of therapy treatments given three times weekly. Each therapy treatment bills at about $75.

The length of future disability involves both temporary and permanent disability factors. I would predict that the patient's temporary disability status and a permanent and stationary report will be completed before the end of the year. Thus, I feel that the length of his future temporary disability would be about 3-4 months. A permanent and stationary report

should be generated before the end of 1998. This will involve review of the patient's history, physical findings, disability, loss of pre-injury capacity, and recommendations for further work restriction. I believe that Mr. Hollifield will probably not return to his job in the construction industry. For this reason, I would anticipate that a qualified injured worker status with vocational rehabilitation would be reasonable to anticipate in this case.

The permanent and stationary report on Mr. Hollifield will contain all of the necessary requirements for appropriate disability evaluation. I understand that all parties in this case have become somewhat anxious to see this matter brought to a permanent and stationary status and I can assure you that I feel the same way. Mr. Hollifield has done well, but has required a very complex treatment program. At present, it should be noted that his forearm is straight, symptomatically improved to the point where he has very little pain in his wrist or forearm, and will allow him to return to work using his left hand for grasping and holding activities. His eventual disability will obviously be presented in the permanent and stationary report and should not be prematurely evaluated at this time.

I am very grateful to case manager, Doris Harrah, RN, for her assistance in managing this difficult situation for a long time. I believe that she has kept this case moving forward although we have required multiple operations to bring this situation to what I believe will be a satisfactory result for Mr. Hollifield and one of reasonable disability while still allowing this patient to re-enter the open labor market.

DISCLOSURE

"I declare under a penalty of perjury that the information contained in this report and its attachment, if any, is true and correct to the best of my knowledge and belief, except as to the information that I have indicated I received from others. As to that information, I declare under a penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true".

Signed this 27 day of August, 1998, at San Diego, California

Richard M. Braun, M.D.

RMB:dlh 08/21
cc: Doris Harrah, RN