Fellow of the Royal College of Surgeons of Canada

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**Mordechai Kamel, MD**

[redacted]

Diplomate, American Board of Orthopaedic Surgeons

Diplomate and Senior Disability Analyst, American Board of Disability Analysts

[redacted]

[redacted]

Re: [redacted]
DOB:
SSN:
DOA:

Dear Attorney [redacted]:

The above named patient was referred for assessment of chronic discomfort in the front of his right leg. He stated that on [redacted] he was an unrestrained rear passenger in a vehicle that struck the car in front of it while traveling at about 30 mph. His right foot was under the front seat and he went forward over the seat. He had immediate pain but no bruising. He was taken to [redacted], his leg was x-rayed, he was told that he had no fracture and no treatment was rendered. He limped for several days and then the acute pain got better. He continued to complain of discomfort and a "numb" feeling in the leg when he ran, participated in sports or walked fast. He described a localized bump on the lower leg. He had an ultrasound of the leg and the report was reviewed and was normal. He had had an MRI of the leg and the report was normal. Review of systems was negative. History of past health was non contributory. Family history was non contributory. Physical examination that day demonstrated that the knees were normal. Examination of the legs demonstrated that on the right there was a visible mass lateral to the tibia at the junction of the middle and lower thirds of the leg over the anterior compartment musculature. There was a palpable defect in the anterior compartment fascia measuring about 2 cm by 1.5 cm. On the left there was no visible mass in the anterior compartment musculature. There

was no palpable defect in the anterior compartment fascia. The ankle, foot and neurovascular exams were normal.

The patient was felt to be suffering from Anterior Compartment Syndrome. I had a long and detailed discussion with the patient and mother about the nature of the diagnosis and the mechanism for the pain and numbness being caused by the muscles of the anterior compartment herniating through the defect with activity and becoming anoxic as the muscle swelled due to activity. I explained that the only available treatment was surgical compartment decompression. I discussed the nature and recovery of compartment decompression.

The patient was reviewed again on [redacted]. At that time he continued to complain of discomfort and a "numb" feeling in the leg when he ran, did sports or walked fast. About a week previously, while he was very active playing football, he noted that he was unable to dorsiflex the right ankle and great toe. Objective examination that day was essentially unchanged. I had a long and detailed discussion with the patient and mother about the nature of the diagnosis and the mechanism for the pain being caused by the muscles of the anterior compartment herniating through the defect with activity and becoming anoxic as the muscle swelled due to activity. I explained the recent episode of inability to dorsiflex in the context of the muscle trapping and explained that if there was anything more, the neurological exam would not as yet have recovered. I explained that the only available treatment was surgical compartment decompression. I discussed the nature and recovery of compartment decompression.

Patient returned for review on [redacted] and stated that he was ready to have his right anterior compartment decompressed when school ends. Objective examination was unchanged. I began by answering his questions and discussing briefly the benefits of anterior compartment decompression. I discussed in detail the risks of anterior compartment decompression including but not limited to the anaesthetic morbidity and mortality including cardiac and pulmonary causes, stroke and stress ulcers. I discussed the general risks of surgical intervention including but not limited to sepsis, its incidence in anterior compartment decompression and its treatment. I then discussed the risks of phlebitis, its diagnosis and treatment. I then discussed with him the risks specific to anterior compartment decompression including but not limited to the risk of continued pain

postoperatively, the risk of postoperative bleeding and haematoma, the risk of damage to structures including nerves and vessels in the leg. I explained that because of my own post surgical disability I would be unable to perform his surgery and I would be referring him to Dr. [redacted] to have it done.

Based on a reasonable degree of medical certainty, this young man's diagnosis is chronic right anterior compartment syndrome.

Based on a reasonable degree of medical certainty this diagnosis is directly causally connected to the motor vehicle accident of [redacted].

As of the date of his last visit, the patient had not reached maximal medical improvement as he still required surgical decompression of the anterior compartment with all of the risks attendant on surgery as explained to the patient. Assessment of permanent partial disability will have to await the final outcome of surgery. Prognosis, however, is for full recovery.

Hoping this information meets your needs. Do not hesitate to contact me if I can assist you further.

Sworn and subscribed to this [redacted] day of [redacted], [redacted], under pains and penalties of perjury.

Sincerely