[redacted]

Dear Mr. [redacted]:

At your request, I have reviewed the medical records of [redacted], a 26 old man as of [redacted]. I understand that complete medical records are not yet in my possession. The available records include apparently adequate excerpts from:

[redacted]

As you are aware, I am a physician licensed to practice medicine in all of its branches, specializing in Emergency Medicine. I have training in Internal Medicine, Emergency Medicine and Public Health. I am Board Certified by the American Board of Emergency Medicine. I engage in the active and current practice of medicine. Please refer to my attached CV. I have knowledge and expertise based on my education, training and experience to render opinions on subjects that are at issue in the care of [redacted].

Factual Summary of Care

On June 15, [redacted], a physician at an Urgent Care clinic [redacted] of [redacted] Health System examined [redacted] for leg pain rated 8 on a scale of 1 to 10. Mr. [redacted] had recently stopped his Coumadin, an anticoagulant, which was prescribed for a previous pulmonary embolism. The patient was described as slightly pale with pain in his foot and calf and a 0.5 cm increase in the girth of his right calf compared to his left. Mr. [redacted] had a history of Asperger's Syndrome and Ulcerative Colitis. Dr. [redacted] and the staff of the Urgent Care Clinic advised the patient and family to go the emergency department for evaluation of leg pain rated 8 on a scale of 1-10 in intensity. He was driven immediately to the emergency department at [redacted] Hospital. Dr. [redacted] clinical impression was "Calf swelling".

Mr. [redacted] reported to the emergency department staff and was examined by the attending emergency physician, [redacted] MD for pain of his right foot, ankle and calf for the last 3 days. ER nurse, [redacted] RN, reports "pulses present" in her note but does not indicate which pulses or how they compared to pulses in the contralateral extremity. Dr. [redacted] also reports that the patient had "no N/V [neurovascular] compromise distally". According to the history obtained by Dr. [redacted], the patient's pain is "worsened with movement and with walking, better with rest". This pain pattern is consistent with and typical for intermittent claudication, a syndrome of limb ischemic due to inadequate blood flow to the muscles occurring upon exercise. As the tissue oxygen demands increase with exertion, the perfusion to the muscles does not; this results in in pain while walking. A differential diagnosis to include arterial insufficiency or intermittent claudication was not entered in the emergency department records and likely not considered by Dr. [redacted]. Only a venous Doppler was ordered, in order to rule out a deep vein thrombosis. This test was negative according to [redacted], MD, the radiologist. The study report indicates that "the visualized portions of the posterior tibial and peroneal veins were compressible and normal in appearance." There was no mention of an arterial thrombosis or any comment regarding the quality of the arterial circulation found in the report of Mr. [redacted]'s ultrasound. Mr. [redacted]'s diagnosis entered by the emergency physician was "RLE pain, ETBD" [etiology to be determined]. The patient was referred to his doctor for a recheck in 2 days with a recommendation for a repeat venous Doppler in 5-7 days. Mr. [redacted] was discharged from the emergency department on the same day. No ankle brachial index test was performed or a blood pressure taken in the right leg to help evaluate the possibility of peripheral vascular disease. No arterial Doppler exam was obtained. No referral to a vascular surgery was made.

The following day, Mr. [redacted] went to a family physician, Dr. [redacted] office complaining of continuing pain in his right foot and ankle. Dr. [redacted] was aware of the patient's history of a negative venous Doppler and no prior history of trauma. Dr. [redacted] ordered an X-Ray which was negative for traumatic injury. On June 19, [redacted] again visited Dr. [redacted] in her office with worsening right foot and ankle pain. He was using crutches to assist his ambulation. Dr. [redacted] note documents "good peripheral pulses" but does not mention which pulses she checked and how they compared to those of the contralateral extremity. Despite the need for crutches, the family physician does not document a neurological examination of the affected limb. Dr. [redacted] recommended that Mr. [redacted] see a podiatrist or an orthopedic surgeon. An appointment was made for Mr. [redacted] to see Dr. [redacted] an orthopedic surgeon on June 20, [redacted].

Dr. [redacted] evaluated Mr. [redacted] and found him visibly in pain. He was tender over the dorsum of his foot where erythema was noted. According to Dr. [redacted]'s correspondence, Mr. [redacted] "neurovascular status of the right foot" was intact. There is no specific documentation of the presence or character of the dorsalis pedis or posterior tibia pulses of the patient's right foot or how they compared to the contralateral side. No apparent ankle branchial index was performed or blood pressure readings of the lower leg obtained in the orthopedic office. Mr. [redacted] was sent to [redacted] Hospital for admission for "Cellulitis, right foot".

On June 20, [redacted] was admitted to [redacted] Hospital in the early afternoon under the care of a hospitalist, [redacted], MD. Dr. [redacted] documented in his history and physical exam at 13:51, "erythema on dorsum of right foot" and "normal strength, no focal deficit appreciated". There is no written comment found regarding Mr. [redacted]'s vascular

examination or the status of his circulation of his lower leg by this hospitalist. The patient was diagnosed with right foot pain, right foot cellulitis, leukocytosis, ulcerative colitis and Asperger's. A venous Doppler of the patient's right leg was repeated. According to the radiologist's interpretation, "there is thrombus within the peroneal vein, not evident on the prior exam". "Impression conveyed to [redacted] RN, at 408 PM on 6/20/[redacted]." According to an addendum to his original history and physical documented at 19:30, Dr. [redacted] writes "later called with pain/decreased temperature to right foot; discussed with vascular and will anticoagulated and perform arterial study". I find no acknowledgement by Dr. [redacted] of the peroneal vein thrombosis reported by the radiologist to Nurse [redacted] at 16:08. Dr. [redacted] ordered an arterial Doppler which was performed about 18:30 on June 20, [redacted]. At 20:39, [redacted], MD, the radiologist indicates the findings revealed a "nonocclusive" blood clot within the right popliteal artery with the dorsalis pedis artery not identified and diminished flow to the peroneal and posterior tibial arteries. Dr. [redacted], a vascular surgeon was consulted by Dr. [redacted]. He saw Mr. [redacted] and documented his note at 21:49. He indicated Mr [redacted] was "Admitted today to hospital and hospitalist noted decrease pulse in foot". Dr. [redacted] physical examination of Mr. [redacted] right leg revealed "palpable femoral and pop pulse, 1+ on right compared to left". A neurological examination is not noted. A CT angiogram was ordered and resulted at 01:01 on June 21, [redacted] by Dr. [redacted] as "intraluminal filling defect within the right popliteal artery and single vessel runoff right lower extremity via the anterior tibial artery to the midcalf consider distal embolism." I have not yet found evidence of a stat call to a nurse or a physician with these findings in Mr. [redacted] available records. An operative report by [redacted] MD is timed at 07:19 on June 21, [redacted] An aortogram revealed thrombus in the popliteal artery above the knee with reconstitution below the knee but no flow in either tibial artery beyond the proximal third of Mr [redacted] leg. According to a history dictated by Dr. [redacted] at 07:28, on June 21, [redacted] "has already been having neurological changes for at least 5 days and has been using crutches to walk around for 4 days now." Mr. [redacted] underwent an open thrombectomy of the popliteal, anterior, posterior artery and peroneal artery. These procedures were repeated for intraoperative thrombus with saphenous vein patch. A four compartment fasciotomy was performed. A repeat thrombectomy was performed with suspected inflow problem from behind the knee in the popliteal artery. An intra-arterial administration of TPA was given. Finally, an above the knee popliteal artery to posterior tibial artery bypass was done using a reverse saphenous vein graft. Mr. [redacted] was thought to have a prothrombotic state associated with his Ulcerative Colitis. He was discharged after prolonged hospitalization on July 9, [redacted]. Mr. [redacted] remained on anticoagulants and platelet inhibitors. The patient's discharge diagnoses included right "foot drop and reperfusion injury".

In July of [redacted], [redacted] was found to have gangrene circumferentially almost to his right ankle. Consequently, he underwent a below the knee amputation at the [redacted] Medical Center.

Although the currently available records are not complete and additional information is expected upon on further discovery, it is my opinion, based upon a reasonable degree of medical certainty that there is a reasonable and meritorious basis for bringing a cause of action against certain providers of medical care to [redacted] as described above.

In my opinion, Dr. [redacted] deviated from the standard of care in his treatment of Mr [redacted] in the one or more of following respects within reasonable medical certainty:

1. Failure to perform and document an adequate physical examination of [redacted] under the circumstances of his presentation, one which suggested the reasonable probability of arterial insufficiency of his right lower leg;
2. Failure to formulate or consider an adequate differential diagnosis for the patient, one that included intermittent claudication which was medically consistent with his given history;
3. Failure to properly regard the possibility of a hypercoagulable state or disorder of coagulation in a patient who despite his young age had already experienced pulmonary embolism and had Ulcerative Colitis, a disorder which may be associated with such;
4. Failure to order an arterial Doppler examination of the patient, check ankle brachial indexes (ABIs), lower leg blood pressures and consult or at a minimum refer [redacted] to a vascular surgeon for evaluation;
5. Failure to order arterial studies were required on an urgent basis based on proper medical decision making and understanding of the patient's unexplained and moderately severe and persistent non-traumatic leg pain, his risk factors for a hypercoagulable state, the results of a proper physical examination, held-held Doppler exam and/or ABIs which more likely than not, if performed, would have been significantly abnormal;
6. Failure to consult a vascular surgeon on a timely basis;
7. Failure to timely diagnose or properly consider the likely diagnosis of arterial insufficiency of the patient's right leg;

It is my opinion that within reasonable medical certainty, one or more of the aforementioned deviations from the standard of care by Dr. [redacted] was a proximate or substantial contributory cause of [redacted] outcome and injuries.