$250,000 Settlement for Motor Vehicle Accident

In January 2018, Plaintiff was operating a motor vehicle, stopped in traffic, waiting to make a left turn when the Defendant negligently, carelessly and recklessly failed to make proper observations, take evasive actions and otherwise failed to maintain proper following distance, causing him to violently strike the rear of Plaintiff's vehicle.

Initially Plaintiff did not present to the hospital because he was under the mistaken impression he was merely suffering from some soreness that would resolve on its own. When his pain began to increase in terms of frequency and intensity, he immediately sought medical attention. In February 2018, he presented to his primary care physician where he complained of pain, especially on his neck and lower back. He was immediately recommended for physical therapy. He presented to a chiropractor and commenced a course of conservative management consisting of chiropractic care, physical therapy and acupuncture. During the course of his treatment, he was referred for diagnostic testing in order to determine the nature and extent of his injuries. In April 2018 he underwent a lumbar and cervical MRI which revealed central disc herniation at L4-5 with impression upon the ventral margin of the dural sleeve as well as upon the anteromedial aspects of the traversing L5 nerve root sleeves, with slight superior and inferior extrusion of herniated disc material and a right central disc herniation at C3-4, flattening the adjacent cervical cord; and a right central and lateral disc herniation at C6-7 narrowing the proximal portion of the intervertebral foramen. In May 2018, he underwent an MRI to his thoracic spine which indicated a right paracentral protruding disc herniation at T8-9 which abuts the cord. During this time and following his diagnostic testing, he was also referred to a pain management specialist who recommended a thoracic epidural steroid injection. Additionally, he underwent an EMG/NCV study which revealed right S1 radiculopathy. His chiropractic treatment and physical therapy concluded in June 2018.

Given the severity of the Plaintiff's injuries and the failure to respond to the conservative course of treatment, he consulted with a pain management doctor and was recommended injection therapy. Plaintiff therefore underwent an interlaminar cervical epidural steroid injection at C7-T1 under

fluoroscopic guidance. He thereafter underwent a total of two (2) bilateral thoracic transforaminal epidural steroid injections at T8-T9 and T9-T10 under fluoroscopy in mid-July and early August. In mid-August 2018, he returned to the pain management doctor with increasing pain. At that time, he was recommended medial branch blocks at T6-T7, T7-T8, T8-T9 and T9-T10.

In September 2018, he underwent the recommended medial branch block and in October he underwent right thoracic radiofrequency ablations at T7-T8, T8-T9. T9-T10 and T10-T11 under fluoroscopic guidance. During this time, Plaintiff consulted a surgeon to better ascertain his surgical options.

When Plaintiff's injection therapy failed to resolve his pain, in December 2018, he ultimately underwent anterior cervical complete discectomy with spinal cord and nerve root decompression at C6-C7; total disc arthroplasty using anterior approach at the C6-C7 level and use of intraoperative fluoroscopy.

At the present time his is being examined post-operatively. No further treatment has been recommended.

The case settled for $250,000 prior to the scheduling of a trial.