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**MULTNOMAH COUNTY BOARD OF COMMISSIONERS
PUBLIC TESTIMONY SIGN-UP**

Please complete this form and return to the Board Clerk

This form is a public record

MEETING DATE:

12/22/11

SUBJECT:

LAW SUIT CONTINUED
12/15/11 TO 1/27/11 #21 TIMES

AGENDA NUMBER OR TOPIC:

FOR: — AGAINST: — THE ABOVE AGENDA ITEM

NAME:

PAUL ADOLPH PHILLIPS

ADDRESS:

1212 SW CLAY APT #217

CITY/STATE/ZIP:

PORTLAND, OREGON 97201

PHONE:

DAYS:

503-224-9454

ES:

EMAIL:

FAX:

WRITTEN TESTIMONY:

PAGE #1 FROM
O.H.S.U. ENCOUNTER DATE -
-11/15/2010

AUTHOR - STAFF SURGEON

AMER. J. MIRZA M.D

ASSISTANCE PROFESSOR

ADULT TRAUMA / RECONSTRUCTION

IF YOU WISH TO ADDRESS THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Address the County Commissioners from the presenter table microphones. Please limit your comments to **3 minutes**.
3. State your name for the official record.
4. If written documentation is presented, please furnish one copy to the Board Clerk.

IF YOU WISH TO SUBMIT WRITTEN COMMENTS TO THE BOARD:

1. Please complete this form and return to the Board Clerk.
2. Written testimony will be entered into the official record.

Patient Information

Patient Name	Sex	DOB
Phillips, Paul Adolph	Male	3/10/1954

Procedures signed by Amer J Mirza, MD at 11/16/10 1429

Author: Amer J Mirza, MD	Service: Orthopedic Surgery	Author Type: Physician
Filed: 11/16/10 1429	Note Time: 11/16/10 1421	

ORTHOPAEDIC OPERATIVE NOTE

Date: 11/16/2010
MR: Paul Adolph Phillips 00225289

PREOPERATIVE DIAGNOSIS(S):

1. Left intracapsular displaced femoral neck fracture
2. Blindness
3. Hypertension

POSTOPERATIVE DIAGNOSIS(S): Same

PROCEDURE: Left hip bipolar hemiarthroplasty

IMPLANTS: Zimmer Size 13 TM stem, +10.5 neck length, 28 mm inner head, 53 mm outer shell.

STAFF SURGEON: Amer Mirza, MD

ASSISTANT SURGEONS: 1. Mathew Harrison, MD PGY5

Anesthesia: General

Estimated Blood Loss: 450 ml

Fluids: 1 liter Hespan, 2 liters crystalloid

Urine Output: 700 ml

Complications: None appreciated

Specimens: None

Drains: Medium hemovac drain



**DEPARTMENT OF
ORTHOPAEDICS AND
REHABILITATION**

Cornell West
1500 NW Bethany Blvd., Suite 195
Beaverton, OR 97006
TEL: 503-494-6400
FAX: 503-346-6844

Amer Mirza, M.D.
Assistant Professor
Adult Trauma / Reconstruction

11-14-12 9:35am

Indications:

Mr. Paul Adolph Phillips is a very pleasant unfortunate 56 year-old male who sustained a left hip fracture in a ground-level fall. He had immediate pain in the left hip and was unable to weight bear on the injured. The patient was brought to the OHSU emergency room and x-rays were obtained of the pelvis and the left hip revealing a displaced intracapsular femoral neck fracture. I discussed treatment options with the patient. We discussed both nonoperative and operative treatment options. Nonoperative treatment would entail a period of protected weightbearing on the left lower extremity. I did not recommend nonoperative treatment given the significant associated morbidity and mortality. We also discussed additional risks of non-operative treatment of the patient's hip fracture including, nonunion, malunion, avascular necrosis of the femoral head, leg length discrepancy and potential for chronic pain in the hip. Given the patient's age, I recommended operative treatment of her hip fracture with a cemented hip hemiarthroplasty. Risks of surgery including but not limited to bleeding, infection, nerve injury, hip instability, hip dislocation, groin pain, need for repeat surgery including conversion to total hip arthroplasty, leg length discrepancy, deep venous thrombosis, stroke, and death. Questions were elicited and answered. Knowing the risks and alternatives, the patient elected to proceed with operative treatment of his hip fracture with a hip hemiarthroplasty

Procedure in Detail:

The patient was identified preoperatively in the preoperative holding area. He was brought to the operating room and laid supine on the operating room table. After starting general endotracheal anesthesia, the patient was positioned in a the lateral decubitus position with the operative side up on a bean bag. An axillary roll was placed in the axilla of the down arm. The bean bag was inflated to secure body, torso, and pelvis as well. The patient was given 2 grams of intravenous antibiotics preoperatively (Ancef). The left lower extremity was then prepped and draped in the usual sterile manner using Chloraprep and DuraPrep. A formal surgical timeout was performed to verify the patient's name, surgical site marking, surgical consent, patient position, surgical sponge counts, surgical equipment/ implant present in the operating room, and preoperative



Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People. Saving Money through Prevention.



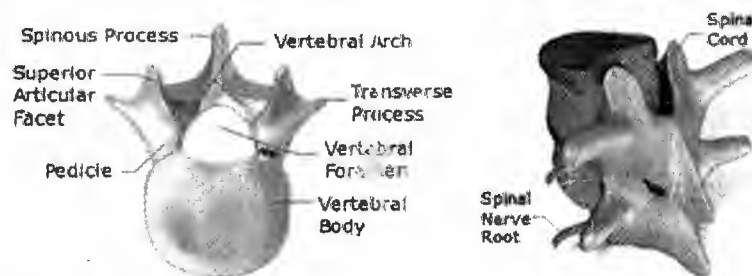
Spinal Cord Injury (SCI): Fact Sheet

Spinal cord injury (SCI) is an important contributing factor to morbidity and mortality in the United States.

Overview

Spinal cord injury may occur following damage to the spinal column. The spinal column comprises 31 bones called *vertebrae*: 7 cervical vertebrae (neck), 12 thoracic vertebrae (upper and middle back), 5 lumbar vertebrae (lower back), 5 sacral vertebrae (sacrum), and 2 fused coccygeal vertebrae (coccyx).

Each vertebra comprises a vertebral body and a vertebral arch, which form an enclosed opening (or vertebral foramen). The vertebrae are stacked on top of each other, aligning the vertebral foramen and forming the spinal column.



The spinal cord, the central bundle of nerves extending from the brain and branching peripherally, is responsible for transmitting signals between the brain and the rest of the body. The spinal cord is located within the spinal column. Any damage to the spinal column could affect the spinal cord and result in temporary or permanent neurologic impairments.

Occurrence

- About 200,000 people are currently living with SCI in the United States.^{2,14}

60:160 PEOPLE

- Annually, 15 to 40 new cases per million people—or 12,000 to 20,000 new patients—are estimated to occur.^{2,3,9,11}
- Alcohol has been found to play a major factor in 25% of spinal cord injuries.¹

Long-term Complications

Traumatic injury to the spinal cord can result in neurologic impairments in any body system controlled by the affected nerves, including musculoskeletal (resulting in incomplete or complete paraplegia or tetraplegia⁹), respiratory,^{11,13} urinary,^{7,10,11,13} or gastrointestinal^{7,10,11,13}. Long-term complications from SCI also include any psychological side effects, such as depression and anxiety^{5,7}.



1 out of 30,000 people
15,000
TO
25,000


Cost

- Average annual medical cost: \$15,000–\$30,000 per year⁶
- Estimated lifetime cost: \$500,000–more than \$3 million, depending on injury severity^{9,11}

Causes

- Motor vehicle accidents: 46%^{1,2,3,8,9,11}
 - Use of a seatbelt can reduce the odds of a spinal cord injury by 60%^{4,16}
 - Use of a seatbelt and airbag combined can reduce the odds of injury by 80%⁴
- Falls: 22%^{1,2,3,8,9,11}
- Violence: 16%^{1,2,8,9,11}
- Sports: 12%^{1,2,9,11}

Estimated SCI Racial/
Ethnic Distribution



White	65%
African American	25%
Hispanic	8%
Other	2%

Demographics

- Males account for 80% of spinal cord injury patients.^{1,2,8,9,11,14,15}
 - Most new SCI cases occur in persons younger than 30 years old;^{2,3} an estimated 50%–70% occur in those aged 15–35 years.²
- Estimated racial/ethnic distribution⁹
 - White: 65%^{9,14}
 - African American: 25%^{9,14}
 - Hispanic: 8%⁹
 - Other: 2%^{9,14}

References

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