EXHIBIT 9

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DIPLOMATE OF THE AMERICAN BOARD OF ORTHOPAEDIC SURGEONS
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ADDENDUM

January 15, 2018

Law Offices of
Omrani & Taub, PC
909 Third Avenue – 28th Floor
New York, New York 10022

Re: **RUIZ, HERME**

Dear Counselor:

This is in response to your request for a medical narrative on the above-captioned patient.

History: The patient was seen initially at my office at 360 Mamaroneck Avenue, White Plains, New York 360 Mamaroneck Avenue, White Plains, New York 10605 on 4/1/2015. At the time he was a 52 year old male who presented with complaint of injuries sustained as a result of a motor vehicle accident that occurred on 2/3/2015. The patient reported that he struck both knees against the steering column and had ongoing bilateral knee pain since that time. He was under the care of Dr. Sutera, a chiropractor, and presented on this day with continued complaint of bilateral knee pain, right greater than left. The patient complained of episodes of buckling and nighttime pain.

Past Medical/Surgical History: Significant for hypercholesterolemia; status post bilateral eye surgery.

Allergies: Denied any drug allergies

Medications: Patient was taking Prednisolone Drops, Combigan Drops, Simbrinza Eye Drops and Travatan Eye Drops as well as Acetazolamide ER.

Review of Systems: Unremarkable to respiratory, cardiac, GI, GU or endocrine system symptoms.

PHYSICAL EXAMINATION: Examination revealed a well-developed, 5'8", 220 pound, left-hand dominant male.

Examination of the patient's bilateral knees revealed him to be ambulating with a slightly antalgic gait favoring the right lower extremity without any assistive device. Range of motion of the right knee was from 0 to 125 degrees where 0 to 135 degrees is considered normal. Tenderness to palpation was noted about the medial joint line and patellar tendon insertion. He

had a positive McMurray sign appreciated in the medial compartment of the knee. The left knee lacked 5 degrees of terminal extension with flexion to 125 degrees. There was tenderness along the lateral joint line and along the patellar tendon insertion at the tibial tubercle. A positive McMurray test was appreciated at the lateral joint line.

IMPRESSION: Internal derangement of the bilateral knees with probable medial meniscal tear to the right knee and possible lateral meniscal tear to the left knee.

PLAN:

The plan was for MRI evaluation to evaluate for underlying meniscal pathology. The patient was to avoid those activities that might exacerbate his symptoms or cause further injury. He would follow up after his MRI evaluation.

MRI evaluation of the cervical spine, report dated 3/25/2015, revealed early disk degeneration with minimal midline ventral canal encroachment at C3-C4; no disk herniation, fracture or canal stenosis noted.

MRI evaluation of the patient's left knee dated 4/18/2015 revealed increased signal at the junction of the posterior horn and body of the medial meniscus which intersects the inferior articular surface compatible with a meniscal tear; diffuse thinning of the articular cartilage overlying the posterior weightbearing aspect of the medial femoral condyle; a 7 x 10 mm osteochondral impaction injury within the medial patellar ridge with denuding of the overlying articular cartilage; proximal patellar tendinosis without tear; trace suprapatellar joint effusion.

MRI of the right knee performed 4/18/2015 revealed a SLAP tear of the posterior horn and body of the medial meniscus with displaced SLAP component within the intrameniscal recess; (2) diffuse thinning of the articular cartilage overlying the posterior weightbearing aspect of the medial femoral condyle associated with subchondral bone marrow edema; (3) focal osteochondral impaction injuries within the lateral patellar facet and medial patellar ridge with associated subchondral edema and denuding of the overlying articular cartilage and (4) small suprapatellar joint effusion which commutes with a 1 cm popliteal cyst.

MRI evaluation of the right knee, report dated 4/23/2016, revealed a complex tear of the posterior horn and body of the medial meniscus with both horizontal and radial components; diffuse thinning of the articular cartilage overlying the central posterior weightbearing aspect of the medial femoral condyle with associated subchondral edema; diffuse thinning of the articular cartilage overlying the medial and lateral patellar ridges with associated subchondral cystic change; small suprapatellar joint effusion which communicates with a 1.5 cm popliteal cyst.

The patient underwent surgical intervention, report dated 6/30/2016: Surgeon Louis C. Rose, M.D. Preoperative Diagnosis: internal derangement of right knee, tear medial meniscus. Postoperative Diagnosis: medial and lateral meniscal tears, synovitis, tenosynovitis,

chondromalacia of the right knee. Operative Procedure: arthroscopic medial and lateral meniscectomy, synovectomy, chondroplasty of the medial femoral condyle.
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Operative Note dated 12/21/2017: Surgeon Louis C. Rose, M.D. Preoperative Diagnosis: internal derangement of left knee, tear medial meniscus. Postoperative Diagnosis: left knee tear medial and lateral meniscal, synovitis, tenosynovitis, sprain of the anterior cruciate ligament, chondromalacia patella and chondromalacia. Operative Procedure: left knee arthroscopy for partial medial and lateral meniscectomy, synovectomy, ACL thermal shrinkage, chondroplasty of the patella, chondroplasty of medial femoral condyle.

The patient was followed on a regular monthly basis and seen most recently on 12/27/2017 with continued complaint of bilateral knee pain. The patient reported taking the medication as prescribed and using an ice machine as well as a cane for ambulation. He continued to complain of nocturnal awakening.

Examination of the patient's left knee revealed him to be ambulating with a slight antalgic gait favoring the left lower extremity with the use of a cane in the right hand. Moderate swelling obliterating the normal patellar fossa was noted. The arthroscopic portals were healing. Sutures were present with no ecchymosis, erythema or drainage. Range of motion was limited from 0 to 85 degrees with mild tenderness diffusely about the knee. Strength was -5/5 with resisted knee extension.

Examination of the right knee on 11/29/2017 revealed well-healed surgical wound sites. Range of motion was limited from 0 to 120 degrees actively and passively. Mild VMO atrophy with moderate tenderness at the medial compartment was noted. Strength was 4/5 with resisted knee extension.

IMPRESSION: S/P bilateral knee arthroscopies with residual limited range of motion and weakness

PLAN:

The plan was for continued physical therapy and use of over the counter anti-inflammatory and analgesic medications. The patient would follow up in a period of four weeks.

SUMMATION:

In summation, we have a 55 year old male who sustained a permanent partial disability to his bilateral knees that is causally related to the history as stated and the direct result of being involved in a motor vehicle accident that occurred on 2/3/2015, approximately three years prior to this final visit.

The patient sustained the aforementioned injuries and has been symptomatic since the time of the accident despite undergoing surgical intervention and extensive physical therapy. It is my opinion that he will be symptomatic on a permanent basis having continued pain, swelling and limited range of motion of the bilateral knees.

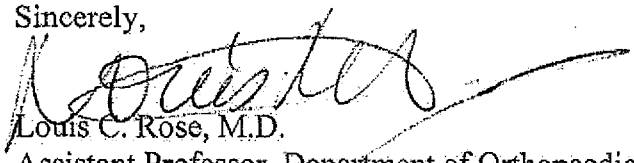
This patient will have difficulty with long periods of standing, walking, lifting, carrying, pushing and pulling of even light objects. He will have difficulty ambulating stairs, crouching, kneeling as well as participating in any type of sporting activities such as running, jogging or cycling. This patient will require continued physical therapy and use of anti-inflammatory and analgesic medications on a permanent basis.

Overall this patient is moderately disabled on a permanent basis. It should be noted that patients with injuries such as this will usually go on to develop post traumatic arthritis requiring total joint replacement at some point in the future. It should be noted that total joint replacement is not curative and that these patients have improvement in their symptoms rather than function.

Should you have any further questions regarding this matter, please feel free to contact me at my office.

I, Louis C. Rose, M.D., certify and affirm that the foregoing report is true to the best of my knowledge. I am a duly licensed physician in the State of New York and I hereby affirm, under the penalty of perjury, the contents of this report to be true.

Sincerely,



Louis C. Rose, M.D.
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At New York Medical College

LCRI:er

Review of Dr. Martin Barschi IME examination dated the 10th of April 2017, is incorrect on many assumptions. On presentation the patient's weight was 220 lbs. and is height was 5 foot 8 inches with a BMI of 24.2 which is within normal limits. As such the claim of obesity as a factor is incorrect. Furthermore, the intraoperative photos do not show diffuse articular cartilage damage consistent with osteoarthritis, solely traumatic induced localized injury to his knees consistent with the history of striking his knees and the time of the accident. In addition regarding the patient waiting four days for treatment. It is not unusual for patients with other injuries to initially concentrate on other injured areas until they begin to walk significant distances when symptomatology then presents itself.