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MEDNET

Euclid Clinic
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October 7, 1985

Mr. Cyril J. McIlhargie
Attorny at Law
100 Erieview Plaza
Fourteenth Floor
Cleveland, **OH 44114**

RE: [redacted]

Dear Mr. McIlhargie:

Today I had the opportunity of evaluating [redacted]. The patient is a **41** year old right handed woman who stated that she had a nerve injured in her left arm. She stated that this injury occurred on November 10, **1983.** She said that she was in the doctor's office getting a tetracycline shot to combat a cold that was hanging on. She said as soon as the material was injected into her arm, she felt a tingling feeling like a crazy bone sensation go down the arm into the back of the hand. This carried on for quite some time. The patient had sought further medical opinion with regard to this sensation that occurred after the time of the injection. The patient indicated the injection was in the left upper arm on the outside. She said that after this painful sensation, she has some problems trying to lift up the fingers and the wrist.

Patient went to a neurosurgeon, David Lehtinen. She was given pain medications. The evaluation there indicates that the weakness was confined to the radial nerve area.

Further, the patient went to the Cleveland Clinic. She saw Dr. Furlan and Dr. Wilbourn. The patient nad a series of EMGs roughly **6** months apart which showed the involvement of the radial nerve predominately axonal pattern. By the last **EMG,** the patient had returned to essentially normal function. This also parallels the improvement clinically as noted in the doctors reports and examinations.

The patient's chief complaints today are a numbish feeling in the back of the wrist and the back of the hand on the left. Sometimes if the patient has to work deburring or cleaning metal

October 7, 1985
Arlene McIlhargie

parts, the wrist may ache. Patient had been off work as a waitress until a few months ago when she took a temporary job in a factory working on castings. She then left that job and achieved permanent employment at her current factory about three months ago.

The past medical history, family history, and review **of** systems are noncontributory.

The neurologic examination reveals an alert, oriented, pleasant patient. Exam of the head and neck unremarkable. Cranials are normal. The motor exam shows normal power throughout. No fasciculations or atrophy. Girth of the arms are also normal. The sensory examination showed some inconsistencies in that the pin-prick showed diminished appreciation of the pin point not only over the dorsum of the hand but also the dorsum of the fingertips including the skin part way up the arm to approximately 40 mm below the antecubital fossa. Vibration sensation was diminished at the first, second and third MIP joint. The reflexes are intact throughout. Range of motion of the joints is full; there is no winging of the scapula.

The patient appears to have made a functionally complete recovery from **a** radial mononeuropathy. **EMGs** that were done at Cleveland Clinic verify this and the patient's fine hand movements are also consistent with this.

From the normal neurologic examination today and the clinical courses delineated, this patient is functioning normally. If there are any further questions regarding this matter, please let me know.

Very truly yours,

A. C. J. Brickel, M. D.
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ACJB:sk

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November 21, 1988

Doc 77

Tobias J. Hirshman, Attorney at Law
JACOBSON, MAYNARD, TUSCHMAN & KALUR
1301 East 9th Street
Suite 1400
Cleveland, Ohio 44114-1824

RE: Discenza, Antonino

Dear Mr. Hirshman:

This is in reply to your request for information regarding Antonino Discenza.

I first had the opportunity of seeing the patient on August 31, 1988. Basically, he is a 54-year-old right-handed construction worker who has problems with his legs and right groin area. The patient mentioned being injured on the job, suffering a hernia. This hernia was producing pain and dysfunction and subsequently he underwent a resection of the hernia. This was done at University Hospitals by Dr. Kent H. Johnston. The date of the surgery was October 14, 1985. From what the patient tells me and from what I am able to gather in the records of University Hospitals, he complained after the surgery of pain right around the groin area extending into the genitals, most specifically into the scrotal area. There were also additional complaints of pain aching down the leg with a dead-like feeling extending down the right leg, thigh, behind the knee into the calf and into the heel cord area. The patient stated it was his understanding that the ilioinguinal nerve was entrapped during surgery. There was subsequent wound swelling which was treated with antibiotic coverage with resolution of the swelling. Because the pain continued in the leg and groin area, surgical lysis of the adhesions was performed February 13, 1986. The patient says that for awhile after this he felt good but that the pain in the groin area recurred, stayed the same as before the lysis, and there was also the pain extending down the right leg and to an extent, down the left leg. Further records since the surgery indicate diagnosis and treatment of essential hypertension. The patient also takes an array of medications for a heart condition and medication to block the nerve pain.

RE: Discenza, Antonino
November 21, 1988
MEDNET/Euclid Clinic Foundation

The neurologic examination shows the patient was alert, oriented, and able to answer questions without difficulty although his primary language is Italian rather than English, Cranial nerve examination was essentially unremarkable. Motor examination

showed some atrophy of the lower quadriceps on the right, about 25% difference as compared to the left but without fasciculations, There is some vasculating weakness in thigh flexion and other muscles in the proximal and distal right leg on primary testing, but indirect testing with gait shows that these muscles retain their functional and antigravity power. There is diminished light touch and pinprick over the top of the thigh on the right which then extends back over the calf and down to the Achilles tendon area on the right. There is some guarding to palpation of the scar. There is reported tenderness over the abductor muscles. Reflexes are symmetric and 1+ throughout. Skin tone and nutrition appears normal throughout. Cremasteric reflex is normal. The genitalia are normal uncircumcised male. There is some diminished light touch, lateral aspect anterior scrotum on the right,

Subsequent to this analysis I had the patient undergo MRI of the abdomen which was listed as normal as was the MRI of the lumbar spine. Ultrasound of the abdomen and vascular analysis of the arteries and veins of the lower extremity also were within normal limits. Records indicate a paralumbar mass at one time and also the exam showed diminished pulses in the feet. These two tests were to look for the mass and/or demonstrate the condition of the arterial venous supply of the lower extremities.

I also had the patient undergo a study called an EMG. EMG study showed evidence of L5 radicular dysfunction or nerve root malfunction on the right,

Subsequent to the examination and review of the EMG study the patient has dysfunction of the ilioinginal nerve which is a purely sensory nerve that innervates the scrotum anteriorly and a small patch of skin on the inner thigh just below the groin, The rest of the findings in the leg relate to other causes for which I had requested from your office additional medical information. This was supplied in the form of various evaluations relating to injuries to the right knee, fracture in the right knee area and back injury.

RE: Discenza, Antonino
November 21, **1988**

These findings are primarily documented in files from the Bureau of Workers' Compensation of the State of Ohio, Specifically, I was looking for findings that might appear on the medical records to correlate with the L5 nerve root injury on the right. These records do substantiate a pre-existing L5 nerve root injury, Also noted on my exam is the absence of trophic changes in the extremities related to autonomic nerve dysfunction which further verifies that the symptoms in the right leg relate to the L5 nerve root injury.

If there are further questions regarding this matter, please let me know,

Very truly yours,

Arthur C. J. Brickel, Jr., M.D.
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ACJB:pat