Orthopaedics

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CONFIDENTIAL

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James J. Turek, Esquire
Reminger & Reminger
113 Saint Clair Avenue, N.E.
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RE: Walter Holland
DOI: April 16, 1998
R&R File No. 5100-01-43959-00

Dear Attorney Turek:

Today I am having the opportunity of evaluating the above named fifty-six-year-old man for the problem of chronic low back pain. At your request, I have performed a musculoskeletal examination, radiographic and imaging review, medical records review and have attempted to formulate a reasonable assessment of the case.

SUBJECTIVE

CHIEF COMPLAINTS

At the present time, this man is reporting long standing aching and stiffness of his lower back. The pain intermittently radiates into both legs, left more than right, and is associated with numbness and tingling of his feet. If he dips his toes into water, he is unable to differentiate hot from cold. At times, his low back discomfort radiates up his spine and down his arms. This is accompanied by numbness and tingling of his hands.

Constipation alternating with diarrhea is a long term problem. He also describes urinary "dribbling." His family physician placed him on medication for this without benefit. There may have been some discussion about seeing a urologist.

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HISTORY OF PRESENT ILLNESS

The patient relates virtually all of his low back trouble to a highway accident that occurred on April 6, 1998. As the belted driver of an 18 wheeler tractor-trailer traveling approximately 40 MPH along I-76, he was struck from behind by another semi truck. His legs "flew up" striking the steering column, but he managed to get his truck stopped. Subsequently, he drove to the nearest exit, and another truck driver picked him up. Once he arrived home in Philadelphia, Pennsylvania, he began experiencing increasing difficulty walking because of severe back spasms. An initial clinical evaluation was provided in the emergency department of Albert Einstein Medical Center were there was concern over lower extremity edema. A doppler ultrasound evaluation was negative.

Later in the day, 4/10/98, the patient was evaluated by a chiropractor, C. Boucher, D.C., for the problem of headaches, mid and low back pain, as well as a left thigh contusion and pain, swelling and stiffness of the legs. Dr. Boucher made the diagnoses *CERVICAL, THORACIC, LUMBOSACRAL SPRAIN/STRAIN WITH SUBLUXATION, CONTUSION-SPRAIN/STRAIN KNEE/LEG* based on the presence of swelling, edema and spasm at the involved sites. Treatments (massage, trigger point therapy, muscle stimulation, traction, spinal manipulation and exercise) were provided for one month leading to consultations with associate W. Mangino, II, M.D., an anesthesiologist who deals in pain management, and a physiatrist B. Varada, M.D.

Noting patient complaints of severe mid to low back pain, left thigh pain, radicular pain into the legs with swelling but no parasthesias on 5/2/98, Dr. Varada performed an examination leading to the diagnoses *ACUTE, SEVERE THORACIC AND LUMBOSACRAL STRAIN/SPRAIN WITH ASSOCIATED MYOFASCITIS, RIGHT THIGH CONTUSION WITH STRAIN.* Deep tendon reflexes were noted to be normal, and sensation was grossly intact. Continued physical modalities and chiropractic manipulation were recommended. As pain subsided, exercises were to be started.

On 5/8/98, Dr. Mangino evaluated the patient for persistent low back pain, as well as radicular left leg pain and right thigh pain. Pitting edema was noted involving the left foot and lower leg. Patellar tendon reflexes were normal, but the Achilles reflexes were normal. Some weakness was present involving the extensors of the ankles and left great toe. Dr. Mangino made the diagnoses *LUMBAR STRAIN AND CONTUSION, LUMBAR MYOFASCIAL PAIN SYNDROME, LEFT EXTENSOR FOOT TENDONITIS, SEVERE CONTUSION TO THE LEFT ANTERIOR THIGH, MILD CONTUSION TO THE RIGHT ANTERIOR THIGH.* Imaging of the lower back was recommended as well as continued out-patient therapy. The patient was interested in returning to work. Dr. Mangino was somewhat concerned that the patient's underlying diabetes might cause problems with healing and causalgia.

An MRI of the lower back performed by Callo Hill on 5/18/98 was interpreted by L. F. Gordon, M.D., as showing "disk degeneration and bulging L1-L2 and L5-S1...question left-sided disk herniation at L5-S1." Degenerative joint disease with foraminal stenosis was visualized at L4-L5. An orthopaedic surgeon in Philadelphia may have evaluated the situation. On 6/24/98, now noting dorsiflexion weakness of the left ankle and foot as well as a diminished left ankle reflex, Dr. Mangino

discussed the possibility of providing an epidural steroid injection. There was some concern regarding technical difficulty in doing the block because of the patient's size. Again, diabetes was felt to be a complicating factor leading to a poor prognosis. The same day, Dr. Boucher discharged the patient because the insurance company, Liberty Mutual, assumed direct clinical management. The authorized treating physician was Dr. David Clements.

On 6/30/98, electrical studies of the legs performed by a "Dr. Shah" showed a bilateral L4-L5 radiculopathy. Right and left peroneal nerve entrapment was also opined. By October of 1998, the patient had successfully returned to work.

The following year, April 1999, the patient was again evaluated by Drs. Boucher and Mangino. Noting a diminished left knee and ankle reflex, positive left-sided straight leg raise and left quadriceps weakness, Dr. Mangino felt there was continued trouble with the L5-S1 disk herniation as well as "Stage I RSD - Complex Regional Pain Syndrome." An oral narcotic analgesic was prescribed, and the epidural injections were still felt to be a viable option. A neurosurgical consultation was considered. The patient's prognosis was felt to be "grave." Two months later, 6/23/99, Naproxen was prescribed, and continued chiropractic treatment was recommended. Discontinuing work was recommended in an effort to get various "issues resolved." Some of the problem was the heavy manual labor involved on a day to day basis. Also, electrical studies and repeat MR imaging of the lower back were recommended.

On 11/4/99, electrical studies performed and interpreted by S. Sacks, D.O., showed an L5-S1 radiculopathy greater on the left than right. Continued pain management was recommended. Later that day, Dr. Mangino opined the diagnoses *SEVERE LEFT-SIDED LUMBAR RADICULOPATHY AND COMPLEX REGIONAL PAIN SYNDROME, BILATERAL MYOFASCIAL PAIN SYNDROME.* NSAIDs were recommended, and there was some consideration of placing the patient on an anti-depressant medication. A change in chiropractors was promoted leading to treatment with D. Paolini, D.C. Other options considered included trigger point injections, epidural injections, and intradiscal electrothermal annuloplasty. The patient was clearly placed off work at this time.

Six months later, 4/5/00, Liberty Mutual wrote to Dr. Mangino again (after a telephone conversation as well) documenting that they would not be financially responsible for care at his facility. Two months earlier, the only authorized treating physician, Dr. Clements, opined that the patient had healed a low back strain superimposed on degenerative disk and joint disease. A small left-sided disk herniation was felt to be pre-existing. Arthritis was also noted in both knees. This then led to an orthopaedic surgical evaluation by G. D. Hayken, M.D., on 6/15/00.

Dr. Hayken noted a normal gait but the use of a cane to protect his left knee. Lower extremity reflexes were symmetrical with no motor weakness. Straight leg raising was negative. The diagnosis *LUMBOSACRAL STRAIN SUPERIMPOSED ON DISK DEGENERATION AND FACET JOINT ARTHRITIS* was made, and Dr. Hayken felt the patient could return to work with lifting restrictions. The left knee was felt to be more of a problem than the lower back. As it related to the remote back injury, no additional orthopaedic or chiropractic care was felt to be necessary.

The following month, 7/6/00, a repeat MRI was performed by Rittenhouse Square Imaging at the request of Dr. Mangino. Disk dessication was noted at L1-L2, L3-L4 and L5-S1. An L5-S1 left-sided disk herniation was visualized impinging on the left S1 nerve root by R. S. Scheer, M.D. In a somewhat confusing statement, Dr. Scheer implies there was no sign of a disk herniation on the previous MRI, but then says he would like to see the previous study "to compare the images."

Noting that the patient was continuing to treat with Chiropractor Paolini without benefit, Dr. Mangino opined on 8/29 & 12/5/00 that the patient would benefit from a consultation with a neurosurgeon. The patient told me today that he feels he needs to "discuss a surgical option."

PAST MEDICAL HISTORY

There was never a problem with low back pain prior to the 4/6/98 accident.

Diabetes mellitus is controlled with the oral medication Glucophage. Hypertension is also managed with an oral agent. Allergies: None. Surgery: Tonsillectomy, age 14. The patient does not smoke, and there is no history of substance abuse.

OBJECTIVE

PHYSICAL EXAMINATION

This man is six feet tall and weighs 303 pounds. He is friendly and cooperative. His attorney from Philadelphia was present in the room, also a friendly, helpful chap. The patient walks slowly with the help of a cane.

The low back area is normal appearing. Mild diffuse tenderness is present, but no spasm. ROM is restricted in all planes because of complaints of pain. The hips move through an even and symmetrical range-of-motion without pain.

In the sitting position, straight leg raising is negative. Reflexes at the knees and ankles are symmetrically hypoactive at 1+. Sensation is diffusely decreased across the toes, but all motor groups are working at 5/5 muscle power. Pulses cannot be palpated in his feet or ankles. No visible lower extremity atrophy.

IMAGING

AP and lateral radiographs of the lumbosacral spine performed in the office today show slight disk space narrowing at L5-S1. Osteophytes are present at the anterior corners of the L4 and L5 vertebrae. Best seen on the oblique views, the posterior elements are narrowed and sclerotic. Best seen on the AP view, lateral syndesmotic bridging is visualized between L4-L5.

First hand, I have reviewed the MR images of this man's lower back dated 5/18/98. The resolution is relatively poor, but there is evidence of diffuse disk bulging at L5-S1. I cannot say for sure that there is a herniation. The quality of the 7/6/00 MRI is better, and there is a probable disk herniation at L5-S1. Disk bulging is also visualized at L4-L5. Disk Dessication is noted at several other levels.

DIAGNOSTIC IMPRESSION:

(1) LUMBOSACRAL SPONDYLOSIS
(DEGENERATIVE DISK AND JOINT DISEASE)

(2) OBESITY

(3) DIABETES MELLITUS AND HYPERTENSION

This is an interesting case in which we have a patient who apparently has been participating in two distinct tracks of medical care: One insurance-sanctioned group of physicians, who visualize very limited impairment, a degenerative, arthritic basis for long-term symptoms, no evidence of an accident-related permanent injury, and thus no reasonable indication for future diagnostic studies or treatment. The other free-standing group of doctors, spearheaded by Dr. Mangino, who believe the patient herniated his L5-S1 disk in the truck accident on 4/6/98 giving rise to a profoundly disabling myofascial pain syndrome, radiculopathy and causalgia. Countless modality-based treatments have been provided without benefit giving rise to the opinion of a permanent injury-related problem with a very poor prognosis. Additional treatment would involve invasive measures including injections and surgery.

Further complicating the situation is underlying litigation of which there appears to be both a Workers' Compensation and personal injury component. Today, the patient's attorney sincerely told me his primary concern was to get his client "the medical care he deserves and needs."

As I talk with this man today, and then review the medical records, his symptoms have been all over the place. Low back pain has been consistent, but lower extremity pain and neurological symptoms have been variable. Pain traveling up the spine and down the arms causing numbness and tingling of the hands is a non-anatomical symptom complex. The difficulty distinguishing hot and cold water by dipping his toes into water sounds like diabetic neuropathy.

Similarly, this patient's neurological examination has not been consistent with S1 left-sided nerve root compression consistent with an L5-S1 herniated disk. Drs. Varada and Mangino noted no Achilles tendon reflex abnormality during early clinical evaluations. It wasn't until after the first MRI that Dr. Mangino began to document a left decreased ankle reflex. The dorsiflexion weakness of the left ankle and great toe would be more of an L5 nerve root problem. Earlier this year, Dr. Hayken noted no asymmetry to this patient's leg reflexes. My exam today shows hypoactive but symmetrical

reflexes with no demonstrable weakness. There is no sign of reflex sympathetic dystrophy.

Electrical studies are notoriously unreliable in establishing proximal nerve root compression. In this case, one neurologist documented electrical evidence of a bilateral L4-L5 radiculopathy. Over a year later, the electromyographer opines a left L5-S1 radiculopathy.

Magnetic resonance imaging does little to clarify the situation in this case. Both MRIs (5/18/98 & 7/6/00) show multilevel degenerative disk and joint disease. L5-S1 disk bulging is seen in 1998. This has probably progressed to herniation on this year's imaging study. As we get older, our disk spaces between the vertebrae tend to lose water content (dessication or dehydration). The surrounding disk covering (annulus fibrosis) loses its tensile strength. Thus, MR evidence of disk bulging, protrusion and herniation is a ubiquitous finding in the presence of arthritis (degenerative disk and joint disease). Some patients have pain. Other patients are completely asymptomatic.

In summary, then, what we have in this case are variable patient complaints (subjective feature) in which there have been no consistent symptoms, physical findings, electrical studies or imaging that can be utilized to objectively verify or substantiate what he says. Additionally, the patient is obese, deconditioned and diabetic. In this type of obscure clinical situation, giving the same modality-based treatments (massage, manipulation, ultrasound, electrical stimulation) over and over again, week after week, month after month, year after year, is an ineffective, inefficient method of managing a musculoskeletal symptom complex. Rather than fostering a feeling of well-being, it makes the patient dependent on the doctor.

In the motor vehicle accident of 4/6/98, this man bruised his thighs and sprained his lower back. There is no evidence presented of a post-traumatic, anatomical lesion. Overall, his symptoms, physical findings and imaging are much more consistent with spondylosis, referred pain and diabetic neuropathy than chronic sciatica from lumbar root compression (herniated nucleus palposis). As it relates to the 4/6/98 incident, there is no reasonable indication for future diagnostic studies and/or treatment.

If I can provide any additional information with respect to the evaluation and/or management of this patient, please don't hesitate to give me a call.

Sincerely yours,

James David Brodell, M.D.
JAMES DAVID BRODELL, M.D., INC.

JDB/apb