ROBERT D. ZAAS, M.D.
DENNIS B. BROOKS, M.D.
INC.

ORTHOPAEDIC SURGERY

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TELEPHONE 216/464-4414

April 16, 1983

Mr. James J. Dyson
Attorney at Law
Brainard Place
29001 Cedar Road
Cleveland, Ohio 44124

Re: James Stakich

Dear Mr, Dyson:

The above named claimant was examined by me on April 12, 1983 regarding injuries which he received on January 19, 1982. This 44-year-old male informed me, in the presence of a representative of his counsel, that he was injured in January of 1982 when he was sitting as a front seat passenger in an automobile which was moving when the automobile struck a tree. (The claimant was instructed by the representative not to answer a question regarding the wearing of seatbelts.) He recalled that, at the time of the accident, he went forward striking his head on the windshield and his chest on the dashboard. His left hip struck the floor mounted gearshift level. Immediately Following the accident, he was "in a state of shock" and was aware of blood on his face, pain in his left hip and, in general, "a lot of pain". He was "afraid I really did something". He was taken to Fairview General Hospital and admitted for approximately 10 days. He was under the care of Drs. Konanahalli and Radkowski. Approximately 21 sutures were required to repair his facial lacerations. He was also placed in traction for several days for treatment of a "straight through solid fracture" of his left hip. In addition, he sustained a right rib fracture. At the time of his discharge, he was ambulating with a walker.

Following his discharge, he continued under the care of Dr. Konanahalli for several months and was examined by Dr. Radkowski on one occasion. On approximately April 20, 1982, he returned to his occupation as a laborer.

He initially stated that he had received no medical treatment for the last nine months and then recalled that he had been examined by Dr. Konanahalli approximately two weeks ago.

At the time of this examination, the claimant stated "Things are good considering what I went through". He stated that he was unable to jog or play golf because of symptoms in his left hip, "Everything else came along". He described "discomfort under the hip bone" and indicated an area posterolateral to the greater trochanter. When he had these symptoms, he would become "worked up inside - nervous". This symptom was present constantly and was increased by activities such as lifting, shoveling and performing any exertion. When

he attempted *to* play golf, his left side would "collapse" and he had pain performing a "frog kick" in swimming. He took Percodan approximately once a night. He had no other symptoms referable to the accident under discussion.

His past medical history indicated no symptoms referable to his hip prior to the accident. He had sustained no new injuries. He had worked as a laborer prior to the accident and was away from his employment for approximately three months. He was presently working steadily although he was not performing his previous job as a "finish raker" because he "can't handle the job". Whenever he is on his feet for a prolonged period of time, his pain "gets more than I want to bear".

Physical examination revealed a male of approximately his stated age who was of average proportions. He stated that he was 5 feet 8 inches tall and weighed 138 pounds. He arose from the sitting position without difficulty and ambulated without limp. The Trendelenburg test was negative bilaterally. He was able to ascend and descend the examining table in a normal fashion.

Examination of the left hip revealed no areas of swelling or deformity. There was tenderness to palpation over the posterolateral aspect of the greater trochanter but no tenderness in other areas. The range of hip motion, in degrees, was: fixed flexion contracture - 0, further flexion - 120, external rotation/internal rotation in flexion - 45/30, external rotation/internal rotation in extension - 30/15, abduction - 45, adduction - 30. These motions were comparable to the uninvolved right hip. The strength of the hip and thigh musculature was normal, in particular, there was neither pain nor weakness with resisted abduction in both the supine and side lying positions.

The material forwarded to me has been reviewed and the records of Fairview General Hospital indicate that the claimant was in that facility between January 19, 1982 and February 1, 1982. His facial lacerations were repaired in the emergency room and he was admitted to the hospital I have reviewed the radiographs of the left hip obtained during the hospitalization and compared them with those obtained at the time of this examination. There has been no change. A fracture of the right 1st rib and 2nd left rib was identified.

In his report of June 7, 1982, Dr. Radkowski summarizes his treatment of the claimant, including the initial hospitalization. Following his discharge, the claimant was examined by Dr. Radkowski, approximately three months after the accident, although he apparently had been requested to return sooner. There were no abnormal physical findings at the time of that examination. Although the claimant requested pain medication, Dr. Radkowski noted "I did not feel that his symptoms of pain were of sufficient magnitude to require a narcotic".

Based on the information available *to* me, I believe that the claimant was involved in a vehicular accident on January 19, 1982 and that he sustained multiple facial lacerations, two rib fractures and a fracture of the superior aspect of the left greater trochanter. These injuries obviously necessitated his hospitalization and the follow-up care provided by his physicians for approximately three months,

April 16, 1983

Mr, James J. Dyson
Re: James Stakich

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At the time of this examination, approximately 15 months after the accident, the claimant continues to be symptomatic. Although he may have the symptom which he describes, there is nothing on physical examination to substantiate his complaints. Although radiographs demonstrate a nonunion of the fracture of the superior aspect of the greater trochanter, this should not be the source of considerable symptoms. In summary, I believe that the claimant will have little, if any, permanent disability directly attributable to his accident.

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/anm

ROBERT D. **ZAAS,** M.D.
DENNIS **B.** BROOKS, M D.
INC.

ORTHOPAEDIC SURGERY

11811 SHAKER BOULEVARD
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TELEPHONE 216/791-3600

October **13,** 1978

Mr. George W. Stuhldreher
Attorney at Law
630 Bulkley Building
Cleveland, Ohio 44115

RE: Louis Davis
Your File No. 990-45

Dear Mr. Stuhldreher:

The above named claimant was examined by me on October 10, 1978, regarding alieged disability as a result of an accident which occurred on July 18, 1975. This 40 year old electrical foreman informed me, in the presence of his counsel, that on July 18, 1975, he was driving an automobile which was stopped when it was struck from behind by a second vehicle.. The claimant was not wearing seatbelts at the time of the accident and informed me that he was thrown forward hitting his head and becoming unconscious. He stated that his next memory was that of awakening in St. Alexis Hospital. He remained in that facility for approximately 17 days, receiving treatment for injuries to his head, neck, low back and right hip. He was cared for by Dr. Bruck during that period of time, and following his discharge from the hospital, continued under Dr. Bruck's care. The claimant stated that he was certain that following his hospitalization, he had had right leg pain and thought that this leg pain may have been present while he was in the hospital. He continued his treatment with Dr. Bruck, receiving physical therapy for approximately one year. He was referred to Dr. Poolos, the neurosurgeon, and the claimant informed me that Dr. Poolos suggested surgery. He, however, declined this, for he was afraid of "poor results". He had also been seen by Dr. Nicholas Demmy, the psychiatrist, for treatment of recurring nightmares, He had not again been hospitalized for his complaints, although five days prior to the present examination, had had surgery as an out-patient. This consisted of removing a "tumor" from his breast, as well as "growths" from his eyelids and neck.

At the time of this examination, the claimant stated that his head was "okay", He continued to have occasional nightmares. His neck was "stiff and sore", and he noted restriction of head movement. He described pain in the posterior aspect of his cervical spine which radiated into the upper aspect of his thoracic spine. There was no associated arm radiation. His low back was "very painful" and he described pain in the center of the lumbosacral area with radiation into the right buttock and outer aspect of the right thigh. He noted numbness in the same area. He stated that after sitting for a prolonged period of time, he would note numbness in his entire right leg when he stood up. Activities such as stair climbing or walking for more than 20 houses would increase his symptoms.

His past medical history indicated no symptoms referable to his head or neck prior to the accident under discussion. He informed me that in approximately 1965, he fell down stairs while walking at Value City. He actually "bounced" down several of these stairs and required several sessions of treatment from Dr. Ippolito. There was no leg radiation following this first accident, and the claimant stated that he was "in good shape" prior to the accident of July 18, 1975. He had not sustained any new injuries.

Physical examination revealed a male of approximately his stated age who was of large proportions. He stated that he was six feet, two inches tall and weighed 228 pounds. He arose from the sitting position slowly and ambulated with a bizarre gait maintaining his right hip in abduction and his right knee in extension. He stated that he was unable to walk on either the heel or toesofhis right foot.

Examination of hi5 cervical spine and neck revealed multiple small recently sutured areas which were the residuals of his surgery. These were located primarily in the right and left lateral aspects of the neck. These were the only areas which were tender to palpation. There was normal cervical lordosis without evidence of paracervical or trapezius spasm. Although normal cervical flexion and extension were present, there was approximately 50 percent decrease in lateral bending and lateral rotation bilatera11y.

Neurologic examination of the upper extremities, including testing of the deep tendon reflexes, motor power and sensory perception, was within normal 1imits.

Examination of the lumbosacral spine revealed a list to the right without evidence of paraspinous spasm. Forward flexion was restricted such that the fingertips reached the proximal tibias. Extension and lateral bending could be accomplished to approximately 75 percent of normal. Burns test was positive.

Further examination revealed that sitting straight leg raising could be accomplished to 5 degrees on the right and was accompanied by low back pain while it would be accornplished to the horizontal on the left. Paradoxically, supine straight leg raising was limited to 10 degrees bilaterally and said to be accompanied by low back pain. Flexion of the chin on the chest increased the back pain but did not produce leg pain. Lasegue's maneuver was negative. The crossed extensor test was positive.

Neurologic examination of the lower extremities revealed normal deep tendon reflexes, motor power and sensory perception. The right calf was 1.5cm larger than the left calf.

X-rays of the cervical spine revealed moderate narrowing of the C5-6 interspace with associated osteophytosis. There was osteophytosis at the C4-5 interspace as well. There was no evidence of fracture or dislocation.

X-rays of the lumbosacral spine and pelvis revealed no evidence of fracture or dislocation. There was considerable disc space narrowing at the L5-S1 interspace with minimal narrowing of the L4-5 interspace and associated osteophytosis. There was an

apparent unilateral spondylolysis of L5 without spondylolisthesis.

No information has been forwarded to me for review, and it would be important to compare the actual x-rays taken at the time of the accident with those obtained at the time of this examination, as well as to review the hospital records of St. Alexis Hospital and the medical reports of Dr. Bruck, Dr. Poolos, Dr. Demmy and Dr. Kovach.

At the time of this examination, the claimant may have symptoms as he describes them, but the multitude of paradoxical physical findings suggest that he is magnifying what symptoms he may have. Although there is x-ray evidence of rather advanced cervical and lumbar spondylosis, this is not necessarily traumatic in nature, In fact, the degree of spondylosis which is demonstrated at the time of this examination is rather unusual for a patient of 40 years of age. It is possible that the claimant may have myofascial symptoms secondary to his underlying spondylosis, but there is nothing on this examination to indicate nerve root compression. Thus, I believe that although the claimant might have some difficulty in an occupation which required repetitive bending, very heavy lifting or prolonged standing, I do not feel that he is totally disabled from obtaining gainful employment.

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/gr

August 11, 1979

Mr. James G. Gowan
Attorney at Law
630 Bulkley Building
Cleveland, Ohio 44115

RE: Mabel L. Cochran
Your File No: 865-12

Dear Hr. Gowan:

The above named claimant was examined by me on August 6, 1979, regarding alleged disability as a result of en accident which occurred on October 30, 1976. This 68 year old female informed me, in the presence of a representative of her counsel, thst she was injured on October 30, 1976, when she was sitting in the front passenger seat of an automobile which was stopping. The car in which she was riding was struck from the passenger's side, and the claimant, who was not wearing seatbelts, was "crammed under the dash compartment". She stated that she was aware of pain in her left foot and lateral aspect of her left calf and thigh. She was "very upset" following the accident and did not want to proceed to the hospital. Instead, she went home. She apparantly contactcd Dr. Wells, her Internist, but stated that she did not see him immediately because she was "dying of pain". Several days later, she was evaluated by Dr. Wells at Euclid General Clinic and was referred to Or. Lee for her symptoms referable to her left hip and entire left leg. She stated that following an examination and x-rays, Dr. Lee sent her home, and she remained on bed rest for "two and a half months". She further stated she was unable to "sit up", and she felt the muscles and ligaments wouldn't Real in her leg unless she rested. She stated that she stayed in bed for a total of six and a half months until she was able to sit in a wheelchair,

During that period, she apparently saw Dr. Lee who referred her to Dr. Wells, and the latter referred her to Dr. Nemunaitis. She recalled that on March 3, 1377, she was admitted to Euclid General Hospital for approximately 17 days and was treated wfth heat and "sand bags" to her left hip and buttock. She was also placed in pelvic traction. She stated that although she attempted to walk, she was unable to do so because of "spurs in the rlght knee". She denied any injury to her right knee as a result of the accident.

Following her discharge, she continued with Dr. Nemunaitis and continued to be symptomatic with left leg pain. Approximately October of 1977, she moved to West Virginia because she was unable to care for herself in Cleveland. She has had no medical treatment for her leg since moving to West Virginia.

At the time of this examination, the claimant stated that she was still symptomatic. She slept in a "hospital bed" because she noted that whenever she slept supine, she would have paln in her left leg. She had not had a "good night's sleep" since the accident. She described her pain as "dull" and this pain was localized In the posterior aspect of the left buttock and radiated into tho left posterior thigh and lateral calf, as well as into the lateral toes. She described a burning sensation In the same distribution. Activitiws such as twisting or sweeping increased her symptoms. She stated that she had "poor circulation" in the leg, and there was associated numbness end paln. She further stated that Dr. McGee thinks that she has "phlebitis" and that she has bean *on* "blood thinners" In the past.

The claimant had no other symptoms and was asked specifically about this.

The past medical history indicated that In approximately 1968 or 1969, the claimant had "arthritis of the spine". She stated that this condition affected the lower four vertebrae and that she received Injections. The vertebrae then "fused together", and she was without symptoms referable to her low beck prior to the accident. In addition, In 1971, she underwent left knee surgery, and following approximately two years of convalescence, she had "no trouble with it". She had sustalned no new injurles.

Physical examination revealed a female of approximately her stated age who was of short stature and moderately over nourished. She stated that she was four feet, ten inches tall and weighed 168 pounds. She used a cane In her right hand for ambulation and wore a slipper on her left foot rather than a regular shoe. She arose from the sitting position slowly, ambulated with a left antalgic limp end ascended and descendéd the examining table in a laborious fashion.

Examination of her lumbosacral spine revealed increase in her lumbar lordosis without evidence of paraspinous spasm. There was tenderness to palpation in the entire left side of the lumbosacral area end in the entire left buttock. Forward flexion could be accomplished such that the fingertips reached the ankles, end extension could be performed fully. On the latter maneuver, there was a hitch as she extended from the flexed position. Lateral bending was somewhat diminished. Heel walking and too walking could not be performed.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally, and on the left was accompanied by left anterior knee paln, Supine straight leg raising could be accomplished to 90 degrees bilaterally end Lasegue's maneuver was negative. Neurologic examination of the lower extremities revealed symmetrically depressed deep tendon reflexes, a giving way type weakness of the extensor hallucis longus bilaterally and normal sensation. The left calf was approximately 3cm. smaller in circumference than the right in It's proximal portion end less thsn 1cm. smaller than the right in it's distal portion. The claimant complained of paln In the entire left leg *on* the slightest pressure and even stated that she had pain with testing of the deep tendon reflexes.

Examination of the hips revealed no areas of localized tenderness. There was a full range of hip flexion with no rotation in flexion, approximately 30 degrees of internal and external rotation in extension end approximately 20 degrees of abduction and adduction.

X-rays of the lumbosacral spine and pelvis revealed no evidence of fracture, or dislocation. Far advanced degenerative disc disease was noted at the lumbosacral interspace with almost complete obliteration of that space. Degenerative spondylolisthesis was noted at the L4-5 interspace. The right and left hips were comparable.

The material forwarded to me has been reviewed, and in his report of January 19, 1978, Dr. Lee describes his examination of the claimant on November 4, 1976, five days after the accident. At the time of the initial examination, the patient's symptoms and physical findings were related to her left knee. The patient was examined again approximately three weeks later, at which time she was "much improved". It is of note that during the period of time that she was under Dr. Lee's care, she apparently had no symptoms or physical findings referable to her lumbosacral spine.

In his report of January 19, 1977, Dr. Nemunaitis describes his treatment of the claimant which began on January 7, 1977, more than two months after the accident. Although the claimant had symptoms referable to her lumbosacral spine, she demonstrated only "mild paraspinous spasm with rather significant pain with attempted lumbosacral stress maneuvers".

In his report of June 20, 1977, Dr. Nemunaitis describes his continuing care of the patient. He mentions his prior treatment of the claimant, and it would be of interest to review Dr. Nemunaitis' office notes to determine the claimant's symptoms in the immediate pre-accident period.

In his report of January 11, 1978, Dr. Nemunaitis describes his treatment of the claimant from duns 1977 through October 1977. Her symptoms at that time were referable to her right knee. It is of note that Dr. Nemunaitis makes no mention of the claimant's symptoms referable to her back or her left leg.

The various records from Euclid General Hospital have also been reviewed, and a short stay admission note of August 28, 1973 indicates "Long hx. of intermittent legs and arthritis of the back". The claimant was admitted to Euclid General Hospital on May 12, 1977 and discharged on May 29, 1977, approximately four and a half months after her accident. The discharge summary indicates "The patient's hospital course was that of progratsive improvement and response to conservative therapy, hence, it was felt thst neurosurgical intervantion was not necessary at this point". The initial physical examination revealed no neurological findings and, thus, it is not clear why the initial impression included "L paraparesis".

Mr. Jams G. Gowan
RE: Mabel L. Cochran

August 11, 1979

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I haw reviewed the x-rays of the lumbosacral spine obtained on May 15, 1977, and these demonstrate considerable narrowing of the lumbosacral Interspace, as well as degenerative spondylolisthesis at the L4-5 Interspace. These x-rays have been compared with those obtained at the time of the present examination, end there is no change In either the degree? of spondylolisthesis or the degree of degenerative disc disease.

It would be Important to review the office records of the physiclaas who have treated the claimant since she has moved to West Virginia to determine her status over the past several years.

Based on the information available to me, I believe that the claimant was Involved in a vehicular accident on October 30, 1976, urd probably sustained some Injury to her left knee and possibly some Injury to her lumbosacral spine. It Is of nota that she was symptomatic with respect to her left. knee In the Immediate post-accident period but apparently had no symptoms referable to her back, for these are not described during the perlod that she was under active orthopaedic treatment. She then became symptomatic with respect to her low back and left leg and was ultimaaely admitted to the hospital for further treatment. Although this hospitalization was Indicated by her symptoms, it does not appear to haee been necessitated by the accident, for it appears that the clalmant's symptoms referable to her low back and left leg began several months after the acctdent.

The claimant continues to be symptomatic at the present time, and there is nothing on physical examination to Indicate that she has nerve root compression, either on the basis of a herniated disc or spinal stenosis. She probably does have some symptoms, although not to the degree that she complains, and these symptoms are on the basis of her far advanced degenerative disc disease and degenerative spondylolisthesis. However, as noted above, there has been no progression of her lumber spondylosis in the almost three years since the accident, and, thus, it appears that what disability she may have at the present time Is not directly attributable to her accident of October 30, 1976.

Very truly yours,

Dennis B. Brooks, M.D.

DBB/gr

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DENNIS B. BROOKS, M.D.
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ORTHOPAEDIC SURGERY

July 7, 1979

Mr. Richard C. Talbert
Attorney at Law
2121 The Superior Building
815 Superior Avenue, N.E.
Cleveland, Ohio 44114

RE: Gitl Feuerwerger
Your File No: 200-785

Dear Mr. Talbert:

The above named claimant was examined by me on July 2, 1979, regarding alleged disability as a result of an accident which occurred on September 8, 1976. This 50 year old female informed me, in the presence of a representative of her attorney, that she was injured on September 8, 1976, while she was driving an automobile which was stopped when it was struck from behind. The claimant stated that she was not wearing seatbelts, and at the time of the impact, was thrown forward against the steering wheel, chipping four teeth. In addition, she noted pain in her neck and arms, as well as numbness in her hands. She was taken to Mt. Sinai Hospital, where she was examined, treated and released. She contacted her family physician, Dr. Miller, and was seen by him sometime thereafter. She was referred to physical therapy, which she attended for approximately two to three weeks. She was also treated with Darvocet and Valium. She stated that during this period of time, she was "getting worse" and was experiencing pain in her neck and, in general, was a "mess all-in-all". She also developed low back pain but was unable to recall when these symptoms began.

Sometime thereafter, she came under the care of Dr. Gerald Yosowitz, and she informed me that he wanted to hospitalize her. She preferred to continue with physical therapy, but in approximately December of 1976, she was admitted to Mt. Sinai Hospital. She remained in the hospital for approximately three weeks and was placed in cervical traction. She was unable to recall whether she was also given physical therapy for her low back symptoms. Following her discharge, she was "about the same" and continued under Dr. Yosowitz' care for approximately one month.

She then came under the care of Dr. Howard Tucker, and in approximately July 1978, was readmitted to Mt. Sinai Hospital. She again was treated with physical therapy modalities during her three week hospital stay. She continued with physical therapy as an out-patient. She was placed on Elavil by Dr. Tucker and also continued treatment with Dr. Yosowitz. Her low back symptoms subsided.

At the time of this examination, the claimant stated that she was "not too good". She slept in her cervical collar and described aching in her neck which radiated into her hands, with the left side being more symptomatic than the right. She also noted a

"funny feeling" in her hands, as well as pain in the mid thoracic area. She was unable to describe those activities which increased her symptoms. She also described pain in the low back which radiated into the posterior aspect of each leg and into her calf. She was more symptomatic on the left than on the right, but there was no associated numbness. Vacuuming increased her low back and leg symptoms.

Her past medical history indicated that in approximately 1971, she was involved in a vehicular accident and sustained an injury to her low back which she described as a fractured vertebra. She was admitted to Hillcrest Hospital by Dr. Leeb and was treated by him for a period of time. She stated that her low back "bothered me once in awhile" prior to her more recent accident. She could not recall whether she previously had had leg pain. In approximately 1974, she came under the care of Dr. Howard Tucker for her "neuritis". She stated that she saw Dr. Tucker occasionally and had symptoms primarily in her right hand. Since the accident under discussion, the hand symptoms which she was experiencing were different. She had sustained no new injuries.

Physical examination revealed a female of approximately her stated age who was of average contour. Her speech was slightly slurred and flattening of the left naso-labial fold was apparent. She arose from the sitting position without difficulty, ambulated without limp and was able to ascend and descend the examining table in a normal fashion.

Examination of her cervical spine revealed normal cervical lordosis without evidence of paracervical or trapezius spasm. There was tenderness to palpation in the left trapezius. Cervical flexion, extension and lateral rotation could be accomplished normally. There was approximately 25 percent decrease in lateral bending bilaterally. Cervical compression produced pain at the cervicothoracic junction.

Examination of the thoracic spine revealed no evidence of deformity or localized tenderness. Neurologic examination of the upper extremities revealed normal deep tendon reflexes, motor power and sensory perception. Hoffmann's test was negative.

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There was no tenderness to palpation in the lumbosacral area, sacroiliac joints or sciatic notches. Forward flexion could be accomplished such that the fingertips reached the distal tibias, and extension was mildly limited. Lateral bending could be performed in a normal fashion. Toe walking could be performed without evidence of weakness or of pain. Slight weakness was noted on left heel walking,

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally. Supine straight leg raising could be accomplished to 90 degrees bilaterally, and Lasegue's maneuver was negative. Neurologic examination

revealed symmetrically increased deep tendon reflexes with sustained right ankle clonus. Motor power and sensory perception in the lower extremities was within normal limits. The Babinski test was negative bilaterally.

X-rays of the cervical spine revealed no evidence of fracture, dislocation or disc space narrowing.

X-rays of the thoracic spine revealed the residuals of an old compression fracture of L1 with anterior brudging between T12 and L1.

X-rays of the lumbosacral spine and pelvis also demonstrated the old fracture of Ll. There was no evidence of disc space narrowing or degenerative change.

The material forwarded to me has been reviewed and includes a "Comprehensive Medical Report" signed by Dr. Weinberg. It is of note that he makes no diagnosis and states that it is "difficult to prove" whether the condition was aggravated by the accident.

Records of Mt. Sinai Hospital indicate that the claimant was seen in the emergency room of that facility on September 8, 1976, and was discharged with the diagnosis of "Lac. L. eyelid. Compression fx. L1 ? acute". It is of note that the radiologist indicates that the fracture of Ll had been present previously and that he did not consider it an acute fracture. In addition, the records do not indicate that the claimant had any symptoms referable to her spine nor that she was experiencing any numbness.

The patient was admitted to Mt. Sinai Hospital on December 1, 1976 and discharged on December 17, 1976, with the final diagnoses of "Cervical radiculitis-left, Multiple Sclerosis". (The claimant is apparently unaware of her diagnosis of Multiple Sclerosis in that she made no mention of this to me during the taking of her history and I was specifically requested not to mention this condition by her attorney). The discharge summary indicates that the claimant experienced symptoms referable to her neck and shoulders, as well as her left upper extremity from the time of the accident. There is no mention that she had symptoms referable to her thoracic or lumbosacral spine during that hospitalization, some three months after the accident. Although the discharge summary indicates that the claimant was seen by Dr. Tucker in consultation, I have not had the opportunity of reviewing that consultation.

The patient was again admitted to Mt. Sinai Hospital on June 30, 1978 and discharged on July 21, 1978, and was under the care of Dr. Howard Tucker during that period of time. It is of note that Dr. Tucker does not include the diagnosis of Multiple Sclerosis in his final diagnoses of "1. Cervical myofascitis. 2. Post-traumatic headaches. 3. Cervical disc suspected". I have not had the opportunity of reviewing the actual physical examination which was performed during that hospitalization and would be pleased to do so if it were to become an issue.

Mr. Richard C. Talbert
RE: Gitl Feuerwerger

July 7, 1979

In his letter of February 25, 1977, Mr. Hotz, the therapist, describes his treatment of the claimant, There is no mention that she had symptoms or physical findings referable to her lumbosacral spine during that period of time.

In his report of March 2, 1977, Dr. Yosowitz describes his treatment of the claimant between October 7, 1976 and February 10, 1977. He indicates that the claimant had neck and upper back pain immediately following the accident but, apparently, had no arm radiation. The initial history and physical examination is consistent with his diagnosis of "Acute cervical myofascitis". On an office, some six weeks after the accident, October 21, 1976, there is the first mention that the claimant was having symptoms referable to her low back. Some two months after the accident, on November 18, 1976, there is the first mention of left upper extremity symptoms. Although Dr. Yosowitz states that the "discharge diagnosis was cervical and lumbosacral myofascitis", for the hospitalization which began on December 1, 1976; as noted above, the discharge diagnosis was "Cervical radiculitis-left, Multiple Sclerosis". It is difficult to understand how Dr. Yosowitz concluded "She sustained injuries to her neck and lower back, resulting in a cervical and lumbosacral myofascitis of a moderate to severe degree", 'when he indicates that the claimant's first symptoms referable to her low back appeared approximately six weeks after the accident.

In his report of March 26, 1979, Dr. Yosowitz describes his continuing care of the claimant. In neither this report nor his earlier report does he mention the Multiple Sclerosis, and one wonders if he was aware of that condition.

Based on the information available to me, I believe that the claimant was involved in a vehicular accident on September 8, 1976, and sustained a laceration of her left eyelid and a cervical sprain. The care which she received in the immediate post-accident period, and possibly the hospitalization of December 1, 1976, was necessitated by the accident. Although the claimant continues to be symptomatic, and may well have symptoms as she describes them, almost three years after her accident, there is nothing on this examination to indicate that she will have any permanent disability as a result of her accident. Had she sustained significant injuries, then associated changes in the cervical, thoracic and lumbosacral spine would be evident by this time. In fact, it is possible that the continuing symptoms which the claimant is experiencing are on the basis of her pre-existent Multiple Sclerosis.

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/gr

GFORGE R KRAUSE M.D
MORTIMER LUBERT, M D
NORMAN E BERMAN, M D.
ALBERT R BENNETT, M D
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AVRAM E PEARLSTEIN, M D.
SUHAS G PARULEKAR, M.D.
HARVEY J. WEST, M D

DRS. KRAUSE, LUBERT, BERMAN, BENNETT, SHAPIRO, WIENER, GOODMAN, GOLD AND LERNER, INC.

DIAGNOSTIC RADIOLOGY RADIOTHERAPY • NUCLEAR MEDICINE

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207 SEVERANCE MEDICAL ARTS BLDQ. I 5 SEVERANCE CIRCLE I CLEVELAND, OHIO 44118
220 HEIGHTS MEDICAL CENTER BLDO. I FAIRMOUNT AT CEDAR / CLEVELAND HEIGHTS, OHIO 44108
311 SEVERANCE MEDICAL ARTS BLDQ. / 5 SEVERANCE CIRCLE I CLEVELAND, OHIO 44118

RADIOGRAPHIC REPORT

Patient | Date | Referred by | No.

FEUERWERGER, GITL 7-2-79 Dr. Brooks 79-39818

Examination Performed at: YOUNG MEDICAL BUILDING

Report:

CERVICAL SPIRE: AP, oblique and lateral views In flexion and extension wfth a coned down view of the atlanto-axial junction show normal cervical lordosis with good range of motion. There is no loss of height of the vertebral bodies or narrowing of the intervertebral disc spaces. The reiationship et the atlanto-axial junction is normal.

DORSAL SPINE: AP and lateral views show no evidence of a compression fracture of the dorsal vertebrae. One does see an old compression fracture of L1 with loss of perhaps 1/4 of the vertebral height of this vertebral body. This appears to be an old injury as there is bony bridging between Ti2 and L1 both anteriorly and laterally.

LUMBOSACRAL SPINE: AP, lateral and oblique views with a coned down view of the lumbosacral junction and an angled view of the pelvis show no loss of height of the lumbar vertebrae aside from the old fracture of L1 described above. The other lumbar vertebrae are intact and there Is no narrowing of the intervertebral disc spaces. The sacroiliac and hip joints are normal.

Harry E. Goodman, M.D.

HEG:jw

NORMAN J. ROSENBERG, M.D.
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ORTHOPAEDIC SURGERY

November 11, 1978

Ms. Karen Janscn
American States Insurance
5851 Pearl Road
Parma Heights, Ohio 44130

RE: Nicole Fosdick

Dear Ms. Jansen:

The above named claimant was evaluated by me on Novembor 6, 1978, for disability as a result of an accident which occurred on August 27, 1977. I learned from *this* 4 1/2 year old female, as well as her mother who was accompanied by her counsel, that in August of 1977, the child was sitting on a riding lawnmower. Shes apparently fell off the lawnmower and sustained injuries to her left heel. She was taken to Marymount Hospital, where she was admitted and came under the care of Dr. Thomas Shaw. Dr. Shaw "Did something *to* a nerve in the back" and then performed a skin graft *to* the left heel. The patient was placed in a *soft* dressing for approximately two and a half weeks and following her discharge from the hospital, has continued under Dr. Shaw's care.

The claimant's mother informd me that she was told that at approximately five years of age, the claimant would be evaluated for further surgery. She was required to wear "special shoes" to avoid injury to her heel. The only complaints that were elicited were those of *pain* when the heel was actually struck.

The past medical history indicated no symptoms referable to the above described areas prior *to* the accfdent under discussion and no new injuries.

Physical examination revealed a pleasant child of approximately her stated age. She ambulated without limp. Her general standing alignment was within normal limits, and she was able *to* walk on her heels and toes without difficulty. She was able to stand on one leg with minimal assistance for purposes of balance.

Further examination of the left foot and heel revealed that the length of the foot was equal to that of the right. There was a well healed skin graft extending from the medial malleolus to the plantar aspect of the foot and measuring 3.5cm. by 6cm. in largest dimension. There was some loss of subcutaneous tissue below *the* graft, *but* there was no tenderness *to* palpation. There was an additional 2cm. scar posterior to the area of the graft.

There was a full range of ankle, forefoot and subtalar motion. The circulatory status was normal and sensation appeared intact. There was no palpable defect in the Achilles tendon, and the motor power in the lower extremity was within normal limits.

X-rays of *the* left foot and heel reveal the residuals of a healed fracture of the left calcaneus with irregularity of the soft tissue contours *about the* heel.

The material forwarded to me has been reviewed, and the records of Marymount Hospital indicate that the claimant was initially examined in the emergency room of that facility on August 27, 1977, and then was admitted to the hospital and was later discharged on September 10, 1977. On August 30, 1977, the claimant underwent "Rotation of flapp medial ankle and foot and split thickness skin graft to donor site and posterior ankle" for her injury which wars described as "Avulsion of heel with compound fracture of the calcaneus; partial disruption of *the* Achilles tendon; defect, 6.0 X 7.0cms." It is of note that the defect was In the skin and not the Achilles tendon. At the time of surgery, a fracture apparently of the posterior aspect of the calcaneus was also identified and was approximated with sutures.

On September 3, 1977, the patient was returned to the operating room for a dressing change.

Based on the information available to me, I believe that the claimant was involved In an accident on August 27, 1977, and sustained an injury to her left heel resulting in loss of soft tissue about the medial aspect of the heel *as* well as sustaining a fracture of the left calcaneus. These injuries were treated in an excellent fashion by her physician. The fractured calcaneus has healed with minor irregularity of the contour which should not cause functional .disability. There Is adequate soft tissue covering over the plantar aspect of the heel,. There Is no functional disability referable *to* the Achilles tendon. The loss of subcutaneous tissue over the medial aspect of the calcaneus is permanent, although this loss might be restored by further surgery. However, at tha time of this examination, additional surgery does not appear *to* be indicated, for tho graft has heated well and there Is no evidence of graft breakdown. The "special shoes" which the child is said ta be required to wear are merely standard shoes with a high heel counter. The residual scars cause no Functional disability and may even become less prominent with time.

Very truly yours,

Dennis B. Brooks, M.D.

DBB/gr

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ORTHOPAEDIC SURGERY

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December 28, 1981

Mr. Frank L. Gallucci
Attorney at Law
She illuminating Bldg., Suite 2222
55 Public Square
Cleveland, Ohio 44113

Re: Michael Edmonds

1st saw 8 months post DcA

Dear Mr. Gallucci:

Michael Edmonds is a 28-year-old male who first consulted me on October 15, 1981, because of injuries which he sustained on February 7, 1981. He informed me that on the latter date he was working under the hood of a stopped car when it was struck from behind by a second vehicle. Immediately following the accident, he "blacked out" and when he awoke was aware of blood over his entire face. He was taken to Deaconess Hospital where apparently a scalp laceration was repaired with "48 stitches". Hospitalization was suggested, but he declined this.

Soon thereafter, he came under the care of Dr. Pawlyszyn because of continuing head and neck symptoms. He was treated by him for a period of time and then came under the care of Dr. Ksnkoly. He was off from work for approximately six months.

He was then able to return to work, but after so doing for two days he noted recurrent neck pain. He returned to Dr. Konkoly and received further manipulative treatment. When he continued to be symptomatic, he was referred to me.

At the time of my initial examination, the patient stated that his neck symptoms were intermittent. He would usually notice stiffness in the posterior aspect of his cervical spine and shoulders, and then his symptoms would become "unbearable". In addition, his arms would become "heavy". Activities such as rapid turning of his head would increase his neck symptoms. There was no associated arm radiation. His past medical history indicated no symptoms referable to his neck prior to his accident and no new injuries.

Physical examination revealed a male of approximately his stated age who was of average proportions. He arose from the sitting position without difficulty and ambulated without limp.

Examination of his cervical spine revealed normal cervical lordosis without evidence of paracervical or trapezius spasm. There were no areas of localized tenderness to palpation. Cervical flexion, extension and rotation could be accomplished normally. There was approximately 25 percent decrease in right lateral bending.

Examination of the shoulders revealed no areas of localized tenderness to palpation. There was a full range of shoulder motion bilaterally. Neurological examination of the upper extremities revealed normal deep tendon reflexes, motor power and sensory perception.

DEC 31 1981

Radiographs of the cervical spine revealed no evidence of fracture, dislocation or disc space narrowing.

At the time of my initial examination, based on the history which I received and that examination, I felt that Mr. Edmonds had sustained an extensive scalp laceration as well as a cervical sprain as a result of his accident of February 7, 1981. I instructed him in appropriate cervical rehabilitative exercises and prescribed Darvocet for analgesia I asked him to return again as necessary.

As of this date, I have not had the opportunity of re-examining Mr. Edmonds, and thus, am unaware of his present condition. Because he was still symptomatic at the time of my only examination, I am unable to make a statement about his eventual recovery.

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/sld

DEC 31 1981