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ORTHOPAEDIC SURGERY

May 18, 1985

Mr. Terrence J. Kenneally
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2121 The Superior Building
815 Superior Avenue, N.E.
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Re: Thomas Leroy Wonder
File No. 1700-5102

Dear Mr. Kenneally:

Thomas Wonder was examined on May 8, 1985 regarding an accident which occurred on July 6, 1983. This 31-year-old male informed me, in the presence of his counsel, that he had been injured on July 6, 1983 when he was driving an automobile which was moving when it was struck on the right front fender by a second car. He was wearing seat belts at the time of the accident and struck the windshield and mirror with his forehead and the driver's door with his left shoulder and arm. He did not become unconscious, although he was "dazed" for approximately one-minute, He noted a "lump" on his forehead and "a little soreness" in his shoulder and left arm.

The following day, he awoke with a headache and went to Elyria Memorial Hospital where he was examined, treated and released. By that time, his nose was also "sore". He recalled that he received no specific treatment for his injuries.

Within a week of the accident, he came under the care of Dr. Perng. He had symptoms with respect to his neck and superior aspect of his left shoulder, Medication was prescribed, Approximately a month after the accident, he came under the care of Dr. Seltzer, His symptoms were "the same as before". He was treated with physical therapy which included "massage and cream", He was also referred to a "therapy building" and received treatment approximately two times a week for two to three weeks and then once a week for four to five weeks. He was re-examined by Dr. Seltzer during that period of time, He recalled that that was-"the end of the treatment for awhile - It still bothered me - I was trying to live with it".

In approximately May of 1984, he came under the care of Dr. Evans for "things got bad again". His left arm had become "weaker" and he had pain in his neck and superior aspect of his left shoulder. He was treated with massage and muscle relaxants. He was also evaluated by Dr. Fernando

and, apparently, electrodiagnostic studies were performed. He did not know the results of these. tests. He returned to Dr. Evans for further treatment and continued>under his care until July or August of 1984. At that time, it was suggested that he receive treatment at The Cleveland Clinic, but he "couldn't afford it".

He has not been treated by other physicians nor has he been hospitalized,

At the time of this examination, Mr. Wonder stated that he was "getting worse". His neck was "a lot stiffer" and he was. "sore" on the left side of his neck, In addition, the superior aspect of his left shoulder was "tight and aches". Activities such as mopping a floor and attempting to work with his hands above his head increased his symptoms- There was no associated arm radiation.

In addition, he had pain in the- thoracic area, on the left side.. This symptom began approximately two months ago and was most pronounced while driving. When he was asked if he had injured his thoracic spine in the accident, he indicated "I could have and just now it began to show"..

His past medical history indicated that he had "pulled a muscle" in the superior aspect of his left shoulder in 1979 or 1980. He was treated by Dr. Perng for this. He received acupuncture and, after a period of treatment, had "no more problem". He had sustained no new injuries.

Prior to the accident, he had worked as a security guard and returned to work the day following the accident. He continued working until January of 1985 when he was "discharged",

Physical examination revealed a male of approximately his stated age who was of average height and thin proportions. He indicated that he was 5 feet 11 inches tall and weighed 125 pounds. He sat with his left shoulder depressed and his head tipped to the right. He 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 his cervical spine revealed decrease in his cervical lordosis without evidence of spasm, There appeared to be webbing on the left side of his neck extending to a prominent left trapezius. There was tenderness to palpation in the paracervical and trapezius muscles- There was normal cervical flexion and extension with approximately 50 percent limitation of lateral bending and lateral rotation bilaterally- .He complained of pain at the extremes of motion,

Examination of his shoulders revealed no areas of localized tenderness. There was a full range of shoulder motion bilaterally with complaints of pain on abduction of the left shoulder.

Examination of the thoracic spine revealed an apparent left thoracic scoliosis.. However, in the forward flexed position, there- was only minimal prominence of the left ribcage. There was no increase in the thoracic kyphosis nor any evidence of spasm, There were no areas of localized tenderness to palpation. Neurological examination of the upper extremites revealed normal deep tendon reflexes, motor power and sensory perception.

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

Radiographs of the thoracic spine revealed no evidence of .fracture, dislocation, disc space narrowing or scoliosis-

I have reviewed the material forwarded to me and note that the Emergency Room records of Elyria Memorial Hospital indicate. that Mr. Wonder was treated in that- facility on July 7, 1983, a day after the accident, The impression of the examining physician was "Acute cervical strain", There is nothing to indicate that there were symptoms or physical findings referable to the thoracic spine.

In his report of October 10, 1983, Dr. Perng describes his treatment between July 11, 1983 and August 3, 1983. His diagnosis was "Acute. cervical strain".

In his letter of October 20, 1983, Dr. Seltzer describes his treatment between August 16, 1983 and September 15, 1983, At the time of the initial examination, approximately five weeks after the accident, there were symptoms and physical findings referable to the cervical spine. Dr. Seltzer does not describe the physical findings which map have- been present on subsequent examinations prior to September 15, 1983. At that time, there was "clearing of the spasm and tenderness...range of motion had now returned to normal..." Dr. Seltzer's office records do not describe any physical findings other than on the first and last examinations.

In his letter of July 3, 1984, Dr. Evans describes his treatment between March 2, 1984 and July 2, 1984. At the time of the initial examination, eight months after the first examination and six months after Dr. Seltzer's last treatment, Mr. Wonder had symptoms referable to his neck and left shoulder. Dr. Evans does not describe the physical findings which may have been present initially or on subsequent examinations- He. makes a diagnosis of "Cervical and thoracic myofascitis", but the basis for this diagnosis is unclear.

In his letter of March 30, 1984, Dr. Fernando describes his examination of that date. He indicates a history "of numbness in the fingers since

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an auto accident in July of 1983". (This history is not contained in the records. of the other treating physicians.) He observed "kyphoscoliosis, which is apparently..secondary to the auto accident according to. the patient, as he says he was never crooked like this before...There was also some decreased sensation in the glove and stocking distribution, again not consistently". Electrodiagnostic studies were performed and these were normal- Dr. Fernando's final impression on March 30t 1984 was not confirmed by the electrodiagnostic studies.

Based on the information available to me, I believe that Mr. Wonder was involved' in a vehicular accident on July 6, 1983 and that he sustained a cervical strain. These injuries probably required some treatment in the immediate post: accident period for, as noted above, by September 15, 1983 he was discharged from Dr. Seltzer's care.

At the time of this examination8 Mr. Wonder had symptoms referable to his cervical and thoracic spine,. As noted above, 'there is nothing to indicate that he sustained an injury to his thoracic spine in the accident- His posturing and limitation of cervical motion appears to be voluntary in nature, for there is nothing on radiographic examination tu indicate any traumatic or congenital abnormality of the cervical spine. Moreover8 electrodiagnostic studies performed almost a *year* after the accident were normal. Thus, I believe that Mr. Wonder has no permanent disability directly attributable to the accident of July 6, 1983.

Very truly yours,

DBBrooksMD

Dennis B. Brooks, M.D.

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