PLAINTIFF'S EXHIBIT

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Re: [redacted]
File Number: V-2498

Dear Mr. Eklund

[redacted] was examined on May 28, 1992 regarding an accident which occurred on March 24, 1989. The history was obtained and the physical examination was performed in the presence of Mr. Willis.

"his 45-year-old male informed me that he was injured on approximately March 23, 1989 when he was lying on a bed in a van which was moving when the van was involved in an accident with a car. The front end and both sides of the van were damaged. Mr. [redacted] indicated "they totalled it." Although he did not remember his movements following the impact, he did recall that when he awoke the left side of his body was shaking. He was unable to find his dentures. He had pain in his head and left shoulder! for he had struck the back of the bench seat in the van.

The accident occurred in Charleston, West Virginia and he went to Charleston Women and Children's Hospital soon after the accident. There, he was examined, treated, and released with a "cervical collar and a sling." He was also given prescriptions. He recalled that by that time, he had pain in his neck, superior aspect of his left shoulder, jaw, and "knee." He could not recall which knee had been painful.

He and his family then proceeded to Crystal River, Florida. Approximately four days after the accident, they returned back to Akron, Ohio. His son did the majority of the driving on the way home.

Within a week of the accident, he came under the care of Chiropractor Shimmel. We performed "spinal manipulation" and treated Mr. [redacted] with "hot and cold packs and so forth." Mr. [redacted] indicated that the majority of treatment was to the "cervical area." He received treatment for approximately six to seven months. Initially, he received treatment .very other day and eventually received treatment every two weeks. He recalled that the treatments "did relieve the pain temporarily."

Approximately six months after the accident, he was examined by Dr. Sveda. A bone-scan was performed and this revealed that "there were no bone chips." Dr. Sveda referred Mr. [redacted] to physical therapy. He received treatments for approximately three to six months, approximately two times a week. He recalled that the therapist "did craniosacral readjustment." He also received rubs "with a machine on my back." He was re-examined by Dr. Sveda on two or three occasions.

Approximately a year after the accident, he came under the care of Dr. Lefkovitz, at Akron General Medical Center. Mr. [redacted] received "pain management" and this included the use of a "TENS unit *and* drugs." He was re-examined by Dr. Lefkovitz approximately every month.

During 1991 as well as during 1992, he was re-examined by Dr. Lefkovitz approximately once a month. He was last examined on April 20, 1990.

At this point in the history, Mr. Willis indicated that Mr. [redacted] had come under the care of Dr. Lefkovitz in August of 1989 and the care of Dr. Sveda in May of 1989.

During 1990, Mr. [redacted] also received treatment from Chiropractor Fakhoury in Crystal River, Florida.

Mr. [redacted] indicated that he had been examined by five physicians for "the Railroad Retirement Board." He indicated that at the time of the accident, he had been working as an engineer on the railroad. He had not returned to work.

He also indicated that an MRI had been ordered, but he "couldn't fit into the tube. Cinefluoroscopy was done. It showed stretched or torn ligaments by the movement on my spine." The cinefluoroscopy had been performed by Chiropractor Fakhoury. He had also undergone "two nerve conductance tests." These studies revealed "some problem with C3-C4-C5 and the brain stem." After these tests had been performed, his physicians gave him "some suggestions for relief of pain."

At the time of this examination, Mr. [redacted] indicated that "if I touch any part of my cervical spine, it's still sore to touch and it's swollen." He experienced "headaches" which began in the posterior aspect of his cervical spine and radiated into his head. His headaches were "directly related to *my* activity." His left jaw was more symptomatic than his right jaw. He would have jaw symptoms "if I lift something heavier than I should lift." He also had jaw symptoms with "motion of my left, arm. I can't open my mouth all the way."

When he performed activities above shoulder level, he would develop arm pain. He indicated that the pain in the lateral aspect of his right arm *ras* "not near as severe" as the pain in his left arm. On occasion, it radiated into his little finger. He had pain at the lateral aspect of the left acromion which radiated down the posterior arm as far as his elbow. From there it "goes straight down." He had numbness in the hypothenar, area.

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He was symptomatic with respect to his mid back which was "tired." He experienced a "burning" in his mid back. During the year preceding this examination, he developed low back pain. He indicated that "I have mobility problems." When asked if he had sustained a specific injury to his low back, he indicated "everything that happens I blame on that [the accident]." His low back symptoms were increased if he sat or stood "too long." He had pain which radiated into his legs, moreso on the left than the right. The radiation was down the posterior aspect of the thigh to the knee. Coughing, sneezing, and bowel movements produced no leg radiation.

He was presently taking Midrin, Stelazine, and Klonopin. He had not taken any of these medications on the day of this examination. He was not taking any other medication.

His past medical history indicated that he had sustained an injury to his "upper back" in approximately 1987. This occurred at work. He was treated by Chiropractor Shimmel for approximately one month. He had no symptoms referable to his low back after that treatment. He had had no neck or low back symptoms prior to the accident of March 24, 1989. When he was asked if he had sustained any injuries or had been involved in any ccidents after March 24, 1989, Mr. [redacted] indicated "I'm going to have .o say no."

I then left the examining room while Mr. [redacted] removed his clothing and put on an examining gown, When I returned, he indicated that on the way to this examination, his van had been struck from behind by a car. He was not injured.

Physical examination revealed a male of approximately his stated age who was considerably overweight. He indicated that his height was 6 feet and his weight, approximately 280 pounds. 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 normal cervical lordosis without evidence of paracervical or trapezius spasm. There was normal cervical flexion and extension with complaints of pain at the extreme of extension. There was approximately 75 percent of normal lateral rotation bilaterally and approximately 80 percent of normal lateral bending bilaterally. He complained of pain from the mid range of these motions to the extremes. Lateral rotation and lateral bending were performed in a ratchet like fashion.

Examination of his shoulders revealed no evidence of atrophy, deformity, or localized tenderness. There was a full range of shoulder motion ilaterally. He complained of pain with external rotation of the right shoulder. Impingement signs were negative.

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Examination of the thoracic spine revealed increase in the thoracic kyphosis. There was no evidence of paraspinous spasm or of localized tenderness. Neurologic examination of the upper extremities revealed symmetrically depressed deep tendon reflexes. Muscle strength was normal. There was decreased perception of pinprick in the left upper extremity in a non-anatomic pattern. In fact, the decreased perception of pinprick extended from the midline of the chest into the left: upper extremity. Perception of pinprick over the right and left sides of the forehead was "close;" whereas on the chest, there was a "definite difference."

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There were no areas of localized tenderness with palpation of the lumbosacral spine, sacroiliac joints, or sciatic notches. Forward flexion could be accomplished such that the fingertips reached the ankles. He extended from the flexed position by placing his hands on his thighs. Extension and lateral bending were performed normally. Heel walking and toe walking were performed without evidence of weakness or of pain.

Further examination revealed that sitting straight leg raising could be [illegible]mplished to the horizontal bilaterally. The tripod sign was negative. Supine straight leg raising could be accomplished to 70 degrees on the right and to 60 degrees on the left. It was accompanied by buttock pain on each side. Lasegue's maneuver was negative. Simultaneous hip and knee flexion decreased the buttock pain. Further neurological examination of the lower extremities revealed symmetrically decreased deep tendon reflexes and normal muscle strength. There was decreased perception of pinprick in the left lower extremity in a non-anatomic pattern.

Mr. [redacted] indicated that he wished that no additional radiographs be obtained.

I have reviewed the voluminous records which you forwarded and note that Mr. [redacted] was treated in the Emergency Room of Women and Children's Hospital shortly after midnight on March 24, 1989. The examining physician noted findings referable to the cervical spine, thoracic spine, right elbow, and left shoulder. His diagnosis was "Contusion, Cx Strain."

I have reviewed the radiographs obtained on March 24, 1989 and note that those of the cervical spine reveal no evidence of fracture, dislocation, or disc space narrowing, There is a small spur at C5.

In a letter of March 3, 1990, Chiropractor Shimmel summarizes his treatment of Mr. [redacted] between April 5,. 1989 and February 20, 1990. A the time of the initial examination, approximately two weeks after the [illegible]ident, the patient had complaints referable to the neck, left shoulder, [illegible]d mid back. Physical examination revealed findings referable to the cervical ,and thoracic spine and left shoulder. Chiropractor Shimmel

obtained radiographs and made the diagnosis "chronic cero-thoracic sprain/strain [sic] with Thoracic, left shoulder and neck muscle spasms." He does not present the symptoms and physical findings which may have been present on subsequent examinations and which may have necessitated additional treatment. There is nothing to indicate that Mr. [redacted] had symptoms or physical findings referable to his low back while he was under Chiropractor Shimmel's care.

Dr. Sveda's records indicate that he evaluated Mr. [redacted] on May 18, 1989 and May 25, 1989. He made the diagnosis of "Cervical-dorsal strain" at the time of the initial examination. However, the symptoms and physical findings upon which this diagnosis was made are not included with his records.

In his letter of August 14, 1989, Dr. Lefkovitz describes his examination which apparently occurred on that date. At that time, approximately five months after the accident, there were some findings referable to the cervical spine. There were "no focal neurological deficits," nor were there any symptoms or physical findings referable to the low back. Dr. Lefkovitz' diagnosis was "post-traumatic cervical myofascial pain syndrome."

In his letter of June 13, 1990, Dr. Lefkovitz indicates that "on April 5, 1990, the patient underwent a cinefluoroscopy study which demonstrated listhesis of C3 on C4 and C4 on C5." He does not indicate whether he actually reviewed that study. He does indicate a diagnosis of "post-traumatic cervical upper back region myofascial pain syndrome, as well as cervical spine ligamentous laxity."

I cannot decipher Dr. Lefkovitz' handwritten records.

I am also unable to decipher Chiropractor Fakhoury's handwritten records. I do note his interpretation of radiographs obtained on April 3, 1990. After describing the findings noted on these radiographs, Chiropractor Fakhoury made the following diagnoses: "Cervical myofascitis with associated myospasm and radiculitis resulting cervicalgia and cephalgia. Post traumatic tempro-mandibular joint pain and disfunction." I have reviewed the lateral extension and flexion views of the cervical spine obtained on April 3, 1990. There is no evidence of ligamentous laxity. The "mild retrolisthesis of C4 onto C5" is often seen on flexion and extension radiographs and is not indicative of laxity. In addition, I do not believe that a practitioner is able to diagnose "cervical myofascitis..." from plane radiographs.

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In his letter of August 30, 1990, Dr. Smith describes his examination of August 29, 1990. At that time, Dr. Smith noted, among other things, the following:

> The patient's complaint at this time is primarily of occiput and posterior neck pain in the paraspinal musculature and also notes a difference in the entire right side of his body with a decrease in sensation and occasional numbness, both in his arm and in his leg, in a non-dermatomal pattern. This is not present during this examination. [Emphasis added.]

Following a physical examination, Dr. Smith made several diagnoses, The basis for these diagnoses is not clear.

In his letter of August 31, 1990, Dr. Berke describes his examination of Mr. [redacted] apparently on that date. Physical examination revealed, among other things, "a non-anatomic right hemisensory deficit to pin prick which splits the midline including the sternum and the back." Dr. Berke noted that "[t]he sensory deficits...are unfortunately not of the variety seen with organic disease of the central or peripheral nervous system."

In his letter of March 16, 1992, Dr. Mann describes his examination of that date. Dr. Mann concluded "there is no physical process present, certainly not one that can account for his many symptoms and apparent total disability."

I have reviewed an AP and lateral of the cervical spine obtained on January 8, 1992. I note that the appearance of the cervical spine is no different approximately three years after the accident than it was on the date of the accident.

Based on this information, I believe that Mr. [redacted] was involved in a vehicular accident on March 24, 1989 and that he sustained a cervical strain and various contusions. At the time of this examination! more than three years after the accident, he is symptomatic with respect to his entire spine, both arms, and both legs. I do not believe that he sustained any injury to his low back in the accident of March 24, 1989, for there is nothing in the records of the practitioners who treated him in the immediate post-accident period to indicate such an injury.

At the time of this examination, there is nothing on physical or radiographic examination to substantiate Mr. [redacted] complaints. I believe that he has recovered from the injuries he sustained on March 24, 1989 and that he will have no permanent disability directly attributable to that accident.

Very truly yours,

Dennis B. Brooks, M.D.

DBB/anm