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

ORTHOPAEDIC SURGERY

26900 CEDAR ROAD
BEACHWOOD, OHIO 44122
TELEPHONE 216/464-4414

August 10, 1981

Mr. Thomas L. Brunn
Attorney at Law
2121 The Superior Building
815 Superior Avenue, N.E.
Cleveland, Ohio 44114

RE: Margherita Spina
Your File No: 1700-3465

Dear Mr. Brunn:

The above named claimant was examined by me on August 10, 1981, regarding alleged disability as a result of an accident which occurred on September 4, 1978. This 42 year old female informed me, in the presence of her counsel, that she was injured on September 4, 1978, when she was sitting as a front passenger in an automobile which was stopped when it was struck from behind by a second car. The claimant was not wearing seatbelts at the time of the accident and recalled that she went forward and then backward in her seat striking her head on the head rest. A second impact occurred and she again went forward in her seat. Immediately following the accident, she was aware of headache and a sensation of "fire" in her neck, posterior aspect of her shoulders and low back. She was taken via ambulance to Geauga Community Hospital where she was examined, x-rayed and received two injections for vomiting and dizziness. She was then released to her home.

The following day, she contacted Dr. Ippolito and was referred by him to Dr. Stephen Weiss. She was examined soon thereafter and admitted to Shaker Medical Center the day after her examination. She remained in the hospital for approximately 13 days and received physical therapy and cervical traction. In addition, a CT scan of her head was performed at Mt. Sinai Hospital because of her headaches. At the time of her discharge, she noted "not too much change".

She then continued with out-patient physical therapy at St. Luke's Hospital and this included pelvic traction, ultrasound and hot packs approximately twice a week for approximate two months. This treatment also produced "not too much change".

She was then advised by the physical therapist at St. Luke's Hospital to continue her treatment with Dr. Nowacek. She initially was examined by him in February of 1979. Medication and therapy was prescribed. In addition, she received injections in her low back and neck and Dr. Nowacek "cracked the joints and stretched the legs". She also received manipulative therapy at St. Luke's Hospital. After a period of time, she "felt a little better" and so, the injections were discontinued.

She continued her care with Dr. Nowacek during 1980 and recalled that he wanted to hospitali her. She preferred to "wait to see if I got better". During that period of time, she was "working on and off". She was admitted to St. Luke's Hospital on June 14, 1981, and remaine in the hospital for approximately 14 days. She stated that at that time, her low back

continued to be painful and that her legs continued to be "stiff". During her hospitalization, she apparently had manipulation under general anesthesia on two occasions. The first manipulation was of her low back and the second of her "upper back". In addition, she received traction, hot packs and exercises. At the time of her discharge, she "felt a little better".

She then continued her care with Dr. Nowacek and received physical therapy twice a week ar exercises three times a day. She has not been treated by other physicians nor has she aga been hospitalized.

At the time of this examination, the claimant stated that she was still symptomatic. She had constant low back pain which increased when she "did more". Activities such as bendin lifting and "a little housework" increased her pain in the middle of the lumbosacral area. She continued to have a "pull" in her legs with the right leg being more symptomatic than left. She described this sensation as being in the posterior aspect of the thigh, into th calf and the foot. Her "nerves" would become stiff and her legs would become stiff such t she was unable to move "freely". There was no associated leg numbness.

In addition, she continued to have stiffness of her neck and pain about each scapula when she moved her shoulders. Her right arm would "go to sleep" and this sensation was felt do the entire right arm and all of the fingers. The numbness was most pronounced in the morning upon awakening but was not present every day. Humidity and rain increased this symptom. In addition, she stated that she had difficulty with turning and extending her head and would have to support her head while so doing.

The claimant was presently taking Inderal, Erythromycin, Darvon Compound, Valium and Decadron. The latter medication was prescribed for five days a week. The claimant had taken her medication on the day of the examination.

The past medical history indicated a vehicular accident in either 1976 or 1977 at which time she sustained a "neck lash". She was treated by Dr. Cydulka and was "okay" after a period of treatment. In addition, she had a "small accident" sometime before 1976 and had a "very mild" injury to her neck. She had no prior symptoms referable to her low back and specifically stated that she was asymptomatic prior to the accident under discussion. She was being treated by Dr. Ippolito for a "torn cartilage" in her right knee. She had sustained no new injuries.

Prior to the accident under discussion, the claimant worked in the "environmental services' at St. Luke's Hospital. She missed "quite a bit" of work and ceased her employment on June 1, 1981.

Physical examination revealed a female who appeared older than her stated age and was of short stature. She stated she was five feet, one inch tall and weighed 148 pounds. 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 said to be tenderness to the slight of palpation in the posterior aspect of the cervical spine as well as in each trapezius. Cervical flexion and extension could be accomplished normally and there was approximately 50 percent of lateral rotation and right lateral bending with 75 percent of left lateral bending. These maneuvers were performed in a slow, cogwheel-like fashion. There was also said to be pain with the slightest of cervical compression.

Examination of the shoulders revealed no tenderness to palpation and a full range of shoulder motion bilaterally. There was pain at the extremes of all motion. Tests for thoracic outlet syndrome were negative. Neurologic examination of the upper extremities revealed normal deep tendon reflexes, although the left biceps reflex could not be elicited because of the claimant's apparent inability to relax. There was normal motor power in the upper extremities with decreased sensation to pin-prick in a non-dermatomal pattern in each upper extremity. Incidentally noted were areas of ecchymosis in the right hand and left forearm.

Examination of the thoracic spine revealed no evidence of deformity or spasm. There was tenderness to the lightest of palpation. Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of spasm. Again, there was tenderness to palpation of the slightest degree in the entire lumbosacral area and each buttock. Forward flexion could be accomplished such that the fingertips reached the dorsum of the feet and extension and lateral bending were performed normally. There was pain with each of these maneuvers as well as with toe walking. Both heel walking and toe walking were performed without evidence of weakness.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally and was accompanied by hamstring tightness on the right. Paradoxically, supine straight leg raising was restricted to 45 degrees on the right and to 30 degrees on the left. Each maneuver was accompanied by low back and posterior thigh pain. Lasegue's maneuver was negative. Further neurologic examination of the lower extremities revealed normal deep tendon reflexes and motor power. There was decreased perception of pin-prick in the left leg in a non-dermatomal pattern. Incidentally noted were several areas of ecchymosis about each tibia.

Radiographs of the cervical, thoracic and lumbosacral spine as well as the pelvis revealed no evidence of fracture, dislocation or disc space narrowing.

The material forwarded to me has been reviewed and the emergency room records of Geauga Community Hospital indicate that the claimant was treated in that facility on September 4, 1978. The record is generally illegible but the diagnosis of the examining physician appears to be "Anxiety, M. spasm".

The records of Shaker Medical Center indicate that the claimant was treated at that facility between September 9, 1978 and September 22, 1978. The initial history and physical examination indicates the claimant's symptoms referable to her head, neck and low back as well as "several episodes of vomiting". Physical examination revealed "Tenderness all the neck, low back... LRS is sl. positive, r. side". On September 16, 1978, the claimant was examined by Dr. Colombi whose impression was "Cervical and LS myofascitis with HA secondary to cervical

myofascitis". The claimant was discharged with the diagnosis of "Cervical myofascitis. Lumbar myofascitis".

In his report of November 27, 1978, Dr. Weiss describes his treatment of the claimant between September 7, 1978 and November 1, 1978. At the time of the initial examination, the claimant had symptoms referable to her head and entire spine. "She has no leg pain, no numbness or paresthesias". The symptoms and physical findings described by Dr. Weiss appea consistent with his "Initial Impression: Cervical, thoracic and lumbosacral myofascitis, severe in nature". On October 27, 1978, seven weeks after the accident, the claimant had "...pain in her low back radiating into both legs... There was a peculiar sensory deficit at L4-5 and S1 dermatomes bilaterally".

In his report of January 9, 1981, Dr. Nowacek refers to a prior report of August 29, 1980. He does not describe the symptoms or physical findings upon which his diagnosis is based.

Based on the information available to me, I believe that the claimant was involved in a vehicular accident on September 4, 1978, and probably sustained a cervical, thoracic and lumbosacral strain. These injuries necessitated her hospitalization at Shaker Medical Center and the follow-up care provided by Dr. Weiss. I am unable to comment on the St. Luke's hospitalization or the treatment provided by Dr. Nowacek.

At the time of this examination, almost three years after the accident, the claimant continues to be symptomatic with respect to her entire spine, right arm and both lower extremities. Although she may well have the symptoms which she describes, there is little, if anything, on physical examination to substantiate her complaints. In fact, the manner in which the cervical range of motion is performed, the decreased pin-prick perception in a non-anatomical pattern, and the discrepancy between sitting and supine straight leg raising indicates that the claimant is exaggerating her apparent disability. In addition, radiographs of the entire spine demonstrate no evidence of disc space narrowing. Therefore, I believe that the claimant will have no permanent orthopaedic disability directly attributable to her accident of September 4, 1978.

Very truly yours,

DBBrooks MD.
Dennis B. Brooks, M.D.

DBB/gr

DRS. HILL & THOMAS

DRS. JOHN D. OSMOND, JR., HUGH A. O'NEILL, GEORGE L. SACKETT, JR., KEITH R. IRISH, JAMES P. FARMER, BEN F. JACKSON, CARL J. FERBER, JAMES J. RODA, RICHARD L. KING, S. BRUCE DeVILLE, BELA F. BALLO, VICTOR J. DeMARCO, CHARLES J. DOYLE, ROBERT L. LAZARONY, HOWARD J. KLEIN, GLENN F. SYKORA, JOHN N. HOLYLAND, ROBERT P. JACOBSON, EUGENE A. WHITE, FRANCIS A. GREICIUS, JR., JAMES E. LALAK, AND RIAZ TARAR

PARMATOWN MEDICAL BLDG.
7441 Ridgewood Drive
Parma, Ohio 44129
Phone: 888-4752

UNIVERSITY SUBURBAN MEDICAL BLDG.
1611 South Green Road
South Euclid, Ohio 44121
Phone: 382-2853

LAKELAND MEDICAL BLDG.
25701 N. Lakeland Blvd.
Euclid, Ohio 44132
Phone: 261-6500

CENTER-CHAGRIN MEDICAL BLDG.
3461 Warrensville Center Road
Shaker Hts., Ohio 44122
Phone: 283-6308

DEACONESS MEDICAL BLDG.
4255 Pearl Road
Cleveland, Ohio 44109
Phone: 661-0161

Patient: Mrs. Margaret Spina

Address: 11893 Clearview Road, Chesterland, Ohio 44026

Referred by: C. J. Nowacek, M.D.

X-Ray Examination of: Cervical spine

Date: 2-7-79

Case No. L 53096

AP, lateral, oblique and pillar views of the cervical spine show normal alignment of th vertebrae with a normal range of motion seen in the lateral flexion and extension views The disc spaces are maintained. The neural arches are intact. There is no evidence of fracture or bone destruction.

Conclusion: Normal cervical spine.

CJF:mh

Carl J. Ferber, M.D.