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October 19, 1994

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1700 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115

Re. [redacted]
File: [redacted]

Dear Mr. Roche:

[redacted] was examined on October 18, 1994 regarding an accident which occurred on August 15, 1992. Before [redacted] agreed to provide a complete history, she spoke to Attorney Henrietta.

This 38 year old female informed me that she was injured in August of 1992 when she was driving an automobile which was moving when it was involved in an accident with another automobile. The front end of her vehicle was damaged. She was restrained at the time of the accident and "pushed myself back into the seat with both hands". Following the accident, she was "shook-up".

The following day, she phoned Dr. Coleman, her family physician. Within a week of the accident, she was examined by him. By that time she had pain in the superior aspect of her right shoulder - "kinda like down through your neck", as well as pain in her upper back and lower back. Her left thigh was "kinda going numb". Dr. Coleman referred her to physical therapy. She received therapy three times a week "over a long extended period of time, more than one year".

Sometime after the initial examination, she was re-examined by Dr. Coleman. He then referred her to Dr. Kennedy at the Orthopedic Clinic at Barberton Hospital. Dr. Kennedy advised her to continue with physical therapy. He also injected her right shoulder with "cortisone shots" on approximately four occasions. He did not order any specialized diagnostic test of the right shoulder.

In February of 1993, [redacted] was admitted to Barberton Hospital for three days. She underwent surgery, at which time Dr. Kennedy repaired the "rotor cuff and fixed a torn tendon". She recalled at that time she was unable to lift her right arm and had continual pain.

Following her surgery, she continued under Dr. Kennedy's care. She wore a sling for approximately two weeks and then went to physical therapy. She remained under Dr. Kennedy's care until approximately July 1993.

In June or July of 1993, Dr. Kennedy referred her for "pain management" at Barberton Hospital. At that time, she had symptoms referable to her right shoulder, upper back and neck. She recalled that the surgery "didn't completely solve the problem". She went for therapy two times a week for two months. She received "nerve blocks - after the first one, it made the pain worse". She indicated that she received these "blocks" around her entire shoulder girdle.

Dr. Lew then referred her back to Dr. Kennedy. He indicated that there was "nothing else he could do". Dr. Kennedy referred her to Dr. Wilcox who also indicated that there was "nothing else he could do".

In November of 1993, she came under the care of Chiropractor Leone at the recommendation of a friend. She received treatment three times a week for approximately one month. She recalled that the treatment "wasn't helping. It wasn't curing the pain.". She last received chiropractic treatment in March of 1994.

In approximately February of 1994, she underwent a CT scan. She recalled "They did my back instead of my shoulder. There was nothing wrong."

At the time of this examination, [redacted] complained "It's still may arm." She was referring to her right arm and indicated that "it depends on use. It will go numb." She indicated that her entire arm became numb and that she also experienced numbness in her right thumb and index finger. She experienced pain in the anterior and posterior aspect of the right shoulder as well as "down my arm to my hand". The pain occurred "quite often". Her symptoms were increased by "anything I try to do." They were decreased by taking Tylenol, although "nothing makes it feel better".

She had no other symptoms referable to the accident of August 15, 1992.

Her past history indicated that she had no symptoms referable to her neck, right shoulder or right arm prior to the accident. She had not been involved in any prior vehicular accidents. She had sustained an injury to her right knee at work. She had not been involved in any subsequent accidents.

Her past medical history indicated that she had no long term medical problems. She was taking Premarin. Her past surgical history indicated that she had undergone six operations for a cleft palate and several gynecological procedures.

At the time of the accident, she was working as a waitress. Following the accident, she missed two days from work and then worked until the time of her surgery. She indicated that Dr. Kennedy informed her that "work was agitating my arm".

Physical examination revealed a female of approximately her stated age who was of short stature and somewhat over weight. 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 were no areas of localized tenderness with palpation of the spinous processes, paracervical muscles or trapezii. There was a full range of cervical flexion, extension, lateral rotation and lateral bending.

Examination of her thoracic spine revealed increase in the upper thoracic kyphosis. There was no evidence of spasm or localized tenderness. The peripheral pulses were palpable in all three positions.

Examination of the right shoulder revealed no evidence of atrophy or deformity. There was a well healed scar extending from the coracoid over the lateral aspect of the acromion. [redacted] indicated that she was "uncomfortable" with the lightest of palpation of the area above and below the scar. The active range of motion, in degrees, of the right shoulder was abduction - 184, forward flexion - 180, external rotation - 45, internal rotation - to T12, horizontal flexion - complete. She complained of pain with abduction beyond 180 degrees and forward flexion beyond 180 degrees. The apprehension and the impingement sign were each negative. There was no evidence of glenohumeral laxity. (Internal rotation could be accomplished to T8 on the left.)

Neurological examination of the upper extremities revealed symmetrical deep tendon reflexes, normal motor power and normal sensory perception. Phalen's sign was negative bilaterally. Tinel's sign was positive over the right cubital tunnel and the right carpal tunnel. (When I noted these findings, I asked whether she had undergone EMG and nerve conduction studies. [redacted] indicated that Chiropractor Leone had "nerve tests" performed in his office by another individual. These demonstrated "carpal tunnel in my wrist". She wore a brace for a period of time.)

Radiographs of the cervical spine revealed no evidence of fracture or dislocation. There was congenital fusion of the C2-3 vertebral elements.

Radiographs of the right shoulder revealed no evidence of fracture, dislocation or degenerative change.

I have reviewed the material which you forwarded, and note that Dr. Coleman's office records cover the period between May 30, 1991 and September 22, 1992. On August 25, 1992, ten days after the accident, he noted, among other things, the following:

> Exam - Tender L low back. Tender R trapezius muscle. Normal reflexes. No neural signs or symptoms. Cervical OK. [?] pain when standing on L leg. IMP - Neck strain, L/S strain.

Dr. Coleman re-examined [redacted] on September 22, 1992, at which time she had "occas pain R arm - tender R trapezius muscle". There is nothing to indicate that Mrs. Brooks had actual right shoulder pain or limitation of right shoulder motion.

On August 31, 1992, Physical Therapist Richardson performed an evaluation. He noted, among other things, the following:

> she has continued working as a waitress since the accident and when she's carrying her work trays the pain is increased. She experiences pain primarily in the {R} cervical and dorsal area and in the {L} lumbosacral region...tender in the {R} and the {L} trapezius with the {R} more involved than the {L}.

There is nothing to indicate that [redacted] had symptoms or physical findings referable to her right shoulder.

I have reviewed the radiographs of the cervical spine and of the right shoulder obtained on September 23, 1992 and compared them with those obtained at the time of this examination. There has been no change.

Dr. Kennedy's records describe his treatment of [redacted] between October 7, 1992 and February 14, 1994. Between October 7, 1992 and January 25, 1993, he examined her at Barberton Citizens Hospital. Between February 19, 1993 and February 14, 1994, he examined her in his office. At the time of the initial examination, approximately two months after the accident, Dr. Kennedy noted, among other things, the following:

> C/O'ing of rt. shoulder and lt. hip pain...Localized the shoulder pain to the trapezius and the deltoid. States that the whole arm goes numb, particularly when she is getting ultrasound. Describes this in a stocking-glove type fashion. Difficulty with overhead activity...Pain on palpation of trapezius and lateral acromion. Mild biceps and CA ligament tenderness...can maintain overhead elevation...Full motor strength...A: Lumbar strain, rotator cuff tendonitis, can not completely rule-out brachial plexus lesion.

Thereafter, Dr. Kennedy re-examined [redacted] on varying intervals. On November 11, 1992, he noted "Full ROM of the shoulder, full elevation. Positive impingement sign, pos. reinforcement impingement sign." On January 25, 1993, he noted that "there is no sign of a cuff tear clinically". He discussed surgery with the patient.

The records from Barberton Citizens Hospital indicate that [redacted] underwent "Decompression, right shoulder, with acromioplasty and repair of right rotator cuff" on February 11, 1993. At the time of surgery, Dr. Kennedy "discovered...a 3cm linear tear between the rotator interval".

Following surgery, Dr. Kennedy re-examined [redacted] at varying intervals. On February 19, 1993, eight days after surgery, the patient had "good passive ROM, able to abduct to 90°. On March 9, 1993, the patient was "essentially asymptomatic and she had an exacerbation turning over in the bed and has had a recurrence of her pain". [redacted] continued to have right shoulder symptoms and on May 24, 1993, Dr. Kennedy's impression was "S/P acromial decompression rotator cuff repair, chronic pain, reflex sympathetic dystrophy." He referred her for "acupuncture or injections". On July 1, 1993, he referred her to Dr. Wilcox "for a second opinion". On February 14, 1994, seven months after the last examination, Dr. Kennedy referred [redacted] to Dr. Lippitt.

In his letter of December 2, 1993, Dr. Kennedy summarizes his treatment of [redacted] He indicates that the patient "underwent a decompressive acromioplasty for a longstanding impingement syndrome".

In his letter of March 2, 1994, Dr. Kennedy explains why he "cannot be more specific regarding [redacted] specifically in reference to 'longstanding' ".

Further records from Barberton Citizens Hospital indicate that Dr. Lew examined [redacted] on June 1, 1993. I am unable to decipher his handwritten notes.

Dr. Reich's office records cover the period between December 27, 1993 and February 1, 1994. I am unable to decipher his handwritten entries, but do note that he ordered a CT scan of the lumbar spine. This was performed on February 3, 1994 and was interpreted as "Essentially unremarkable appearing study."

Chiropractor Leone's records indicate that he treated [redacted] between August 26, 1993 and October 26, 1993. However, in his letter of October 26, 1993, he indicates that he first treated the patient on September 26, 1993. Chiropractor Leone's records contain the results of studies performed by Dr. Saltis. On November 24, 1993, he performed nerve conduction studies which revealed "No indicators of significant ulnar neuropathy...the patient has evidence of mild bilateral carpal tunnel syndrome." He also performed dermatomal somatosensory evoked responses which revealed "no signs of root lesion".

Based on this information, I believe that [redacted] was involved in a vehicular accident on August 15, 1992 and that she sustained a mild cervical and lumbosacral strain. The magnitude of her injury is evidenced by the fact that she was first examined by Dr. Coleman on August 25, 1992, ten days after the accident.

I do not believe that [redacted] sustained any injury to her right shoulder. In particular, I believe that she did not sustain the tear of the rotator cuff interval identified by Dr. Kennedy at the time of surgery six months after the accident. Had [redacted] sustained a right shoulder injury with a concomitant rotator cuff tear, her symptoms and physical findings in the immediate post-accident period would have been different than those found in the records which I have reviewed.

At the time of this examination, more than two years after the accident and 20 months after her surgery, [redacted] complains of symptoms referable to her right shoulder and right arm. There are no objective findings on physical or radiographic examination to substantiate her complaints.

I believe that [redacted] has recovered from the mild cervical and lumbosacral strain which she sustained on August 15, 1992. I believe that she has no permanent disability directly attributable to this accident.

My opinions are stated with a reasonable degree of medical certainty.

Very Truly Yours,

Dennis B. Brooks, M.D.

DBB/blf