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ORTHOPAEDIC SURGERY

October 23, 1983

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RTA LEGAL DEPT

Mr. Douglas A. Gonda
Chief Litigation Officer
The Greater Cleveland
Regional Transit Authority
615 Superior Avenue, N.W.
Cleveland, Ohio 44113

Dear Mr. Gonda:

The above named claimant was examined by me on September 30, 1983 regarding an accident which occurred on November 24, 1980. This 63-year-old female informed me that she was injured in November of 1980 when she was sitting on an RTA bus which was struck from behind by a second bus. She recalled that she was sitting on the front seat, which rung parallel with the aisle, and was thrown up against another seat striking the left side of her neck. She then fell backwards. She was aware of pain in her neck, left shoulder and low back. She was taken to St. Vincent Charity Hospital where she was examined, treated and released.

Approximately two days after the accident, she came under the care of Dr. Gabelman and was treated by him with medication. She was referred to physical therapy and received "electrical" treatments every other day for approximately one year. She was examined by Dr. Gabelman approximately every two weeks, and she was also treated by Dr. Mars for her headaches.

During 1981, she was admitted to Suburban Community Hospital by Dr. Gabelman and received treatment with "weights" for her neck and back. She was in the hospital for approximately two weeks. During August of 1982, Dr. Gabelman "throwed me back in" Suburban Community Hospital. She was again treated with "weights" and therapy. At that time, she was using a cane. Later in 1982, she began ambulating with a walker. She also came under the care of Dr. Morrison for heart difficulties.

In 1983, she continued under the care of her physicians and was last examined by Dr. Gabelman and Dr. Mars in September of 1983. She has not again been hospitalized.

At the time of this examination, the claimant stated that she had pain in the lumbosacral area which radiated into the buttock and down the anterior and posterior aspect of each thigh. Her symptoms were more pronounced on the left and were increased when she sat for longer than 20 minutes or walked. In fact, she stated that without her walker, she was unable to walk "too far", because she would stumble. She would also use a cane. In addition, she had pain in the left side of her neck as well as the anterior and posterior aspects of her left shoulder. There was no associated arm radiation. When she attempted to turn her

head, she would have to turn her entire body. She was presently taking Oarvocet every four hours and had taken one on the morning of the examination. In addition, she was taking a multitude of heart medications.

Her past medical history indicated that she had "never had in my whole life" any symptoms referable to her neck, low back or left shoulder? She had sustained no new injuries. She had worked in a commercial laundry prior to her accident and had been unable to return to work.

Physical examination revealed a female of approximately her stated age who was of short stature and moderately overweight. She stated that she was 5 feet 2 inches tall and weighed 165 pounds. She had been able to change from her street clothes into an examining gown without assistance She brought her walker into the examining room but was able to walk slowly without it. She 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 the liahtest of palpation in the posterior aspect of the cervical spine as well as in the left trapezius, There was approximately 10 degrees of cervical flexion, extension, lateral rotation and lateral bending. All maneuvers were performed in a rigid fashion and accompanied by turning of her body.

Examination of her left shoulder revealed no evidence of deformity or atrophy. There was tenderness to palpation throughout the shoulder, The range of motion of each shoulder, in degrees, was: abduction - 90, forward flexion - 60, external rotation - 45, internal rotation - 45, horizontal flexion - complete. There was pain with all motion. Neurologic examination of the upper extremities revealed symmetrically increased deep tendon reflexes with normal motor power. There was decreased perception of pinprick in the lett arm in a non-anatomic position.

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There was tenderness to the liahtest of palpation in the lumbosacral ?s a and each buttock. Forward flexion was accomplished such that the fingertips reached the knees and there was approximately 25 percent of lateral bending and extension. The claimant stated that she was unable to walk on either her heels or toes.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally. Paradoxically, supine straight leg raising was restricted to 10 degrees bilaterally and accompanied by low back pain. Lasegue's maneuver decreased this pain bi laterally. The crossed extensor response was positive bi laterally. Further neurologic examination of the lower extremities revealed symmetrically hyperactive deep tendon reflexes with two-beat clonus on the right. Babinski signs were negative. There was decreased sensation in the left leg in a non-anatomic pattern. Strength was normal.

Radiographs of the cervical spine revealed no evidence of fracture or dislocation. There was advanced cervical spondylosis as demonstrated by considerable disc space narrowing at the C5-6 interspace with a lesser degree of narrowing at the C4-5 interspace. Prominent spurring was present at these levels and, to a lesser degree, at C6-7.

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

Radiographs of the lumbosacral spine and pelvis revealed no evidence of fracture or dislocation. There was mild disc space narrowing at the L3-4 interspace with a questionable vacuum phenomenon.

The material forwarded to me has been reviewed and the emergency room records of St. Vincent Charity Hospital indicate that the claimant was in that facility on November 24, 1980. I have reviewed the radiographs obtained on that date and compared them with those taken at the time of this examination. There has been no change in the degree of spondylosis in either the cervical or lumbosacral spine in the three years since the accident. The impression of the examining physician was "Neck sprain, left shoulder sprain, lumbar sprain".

In his report of February 25, 1982, Dr. Gabelman describes his treatment of the claimant between November 28, 1980 and January 30, 1982. At the time *of* the initial examination, four days after the accident, the claimant had symptoms and physical findings consistent with Dr. Gabelman's. impression "Sprain of the cervical, thoracic and lumbosacral spine". During subsequent examinations, the claimant continued to be symptomatic but had no symptoms of leg radiation. A CT-scan on December 13, 1981, a year after the accident, "did not reveal any definite evidence of a herniated disc". The claimant was later admitted to Suburhan Community Hospital between January 18, 1982 and January 30, 1982.

Dr. Gabelman's hill indicates his treatment between November 28, 1980 and January 30, 1982. The claimant was not examined every two weeks during that period of time. The bill from Suburban Rehabilitation Center indicates the extensive physical therapy which the claimant received between December 3, 1980 and December 8, 1981.

Records from Suburban Community Hospital indicate the claimant was in that facility between January 18, 1982 and January 30, 1982. Dr. Gabelman's admission note indicated "Her physical exam revealed tenderness over the cervical, lumbosacral area. There is some restriction of motion in each region but no definite spasm, There are no localizing neurological findings".

Additional recrods from Suburban Community Hospital indicate that the claimant was in that facility between August 11, 1982 and August 15, 1982. The admission note indicates "She complained of pain going to both lower extremities as well as numbness in the left lower extremity", although it does not indicate when this symptom began. A myelogram was performed on August 12, 1982 and interpreted as showing a "Transitional first sacral segment. .. Findings are thought to be compatible with a disc herniation at L4-5 on the right". A CT-scan was performed on August 13, 1982 and was "...thought to represent a l-ate-ral bulge at the L4-5 intervertebral disc". (If it were to become an issue, I would be pleased to review these films. The defect noted on both the myelogram and CT-scan corresponds with the area *of* degenerative disc disease on the plane films. Considering the transitional first sacral segment, that area becomes the L4-5 space.) The discharge summary indicates the claimant was seen in consultation by Dr. Mars but his consultation *of* August 12, 1982 is difficult to interpret.

October 23, 1983

Page four.

Based on the information available to me, I believe the claimant was involved in an accident on November 24, 1980 and that she sustained a cervical and lumbosacral strain as well as a left shoulder sprain. These injuries necessitated some treatment in the immediate post accident period. However, I do not believe that they necessitated the hospitalizations at Suburban Community Hospital. Had this been the case, the claimant would have been hospitalized soon after the accident rather than approximately a year later. In addition, although a myelogram and a CT-scan obtained approximately two years after the accident were suggestive of a "Herniated disc", I do not believe that these findings are related to the accident. Had this been the case, the claimant would have developed radicular symptoms much sooner than she did.

t the time of this examination, approximately three years after the accident, the claimant has symptoms referable to her cervical and lumbosacral spine as well as her left shoulder. Although she may have the symptoms which she describes, the multitude of unusual physical findings described above clearly indicates that she is attempting to exaggerate her apparent disability. As noted above, there has been no change in the cervical and lumbosacral spondylosis which was present at the time of the accident. In summary, I believe the claimant has no present disability which is directly attributable to the accident of November 24, 1980.

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/anm

Mars report says pain radiated prior to Oct 7, 1981