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ORTHOPAEDIC SURGERY

had neck [illegible] asked Brooks what would you do if I came to you.

December 3, 1983

Mr. Martin J. Murphy
Attorney at Law
[illegible] Engineers Building
Cleveland, Ohio 441[illegible]

Dear Mr. Murphy:

The above named claimant was examined by me on November 17, 1983 regarding an accident which occurred on December 13, 1980. This 32-year-old male informed me that he was injured in approximately 1980, when he was driving an automobile which was stopped and was involved in a collision. He recalled that two cars struck each other and one of the cars careened off the right front end of his car. He was wearing a combination seat belt and shoulder harness and was turned to the right at the time of the accident. Immediately thereafter, he "hurt all over". Later that day, he walked to Kaiser Permanente Hospital, where he was examined, treated and released. He was aware of pain in his neck by that time.

The following day, he was aware of pain in his neck and low back as well as a headache. He thouyht his symptoms would "go away". Approximately one to two months after the accident, he came under the care of Dr. Charles Shin and was referred for physical therapy. He received cervical and pelvic traction as well as hot packs, massage and "the electrical device". He received therapy for approximately two months, three times a week. He continued under Dr. Shin's care and was given medication. He also had a second course of physical tnerapy.

In approximately Harch of 1982, he noted the onset of pain radiating down his right leg to his heel. He also developed "burning" in the middle three toes with associated tingling. In Hay of 1982, he was admitted to Southwest General Hospital where a "battery of tests" were performed. These demonstrated that "something was putting pressure on the disc". Dr. Shin apparently suggested surgery but the patient declined. He was also evaluated by a urologist for kidney stones. He remained in the hospital for approximately three weeks and received physical tnerapy as well as traction in bed.

During 1983, he continued under Dr. Shin's care and was last examined by him on November 10, 1983.

At tne time of this examination, the claimant stated that his neck pain had "returned" approximately two to three months ago. He described a burning sensation as well as pain which radiated from the superior aspect of his right shoulder into his neck. This symptom was increased by turning his head to the right. He had pain "all the time". His low back

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symptoms were described as a "tight burning knot" which radiated into "both cheeks". He also had "burning" in the posterior aspect of the right thigh and calf as well as the heel. Ha continued to have "tingles" In the three middle toes as well as the dorsum of his foot. Changing from the sitting to the standing position as wall as bending and sitting for longer than an hour and a half increased his symptoms. A Valsalva maneuver produced only back pain. He was presently taking Nalfon, Vallum end Tylenol No. 3 and had taken each of these medications on the dey of the examination.

His past medical history Indicated no symptoms referable to his neck or low back prior to the accident. He had sustained no new injuries. He was not working at the time of the accident but, subsequently, missed time from work because of *his* hospitalization and physical therapy.

When it was noticed that he had extensive burn scars on each hand as well as his right thigh, ne was asked about this. He stated that he had been injured in 1973 and had sustained no back injury,

Physical examination revealed a male of approximately his stated age who was of average proportions. He stated that he was 6 feet 1 inch tall and weighed 200 pounds. He arose from the sitting position without difficulty, ambulated in a rather stiff fashion. He ascended and descended 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 tenderness to palpation in the right trapezius. There was a normal ranga of cervical flexion and extension with approximately SO percent of right lateral rotation and 75 percent of left lateral rotation and lateral bending bilaterally. Thasa maneuvers were performed In a cogwheel-like fashion.

Neurological examination of the upper extremities revealed symmetrically depressed deep tendon reflexes. Motor power was normal. Sensation was decreased in the area of the scars.

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There was tenderness to the lightest of palpation in the lumbosacral area. There was approximately 10 degrees of flexion and extension with approximately 2b degrees of lateral bending bilaterally. He stared that he was unable to perform heel walking or toe walking. Burns' test was considerably positive and the claimant stated that his back was "locking up" as he was asked to sit back onto his heels.

Further examination revealed that sitting straight leg raising could be accomplished *to* the horizontal bilaterally. Supine straight leg raising was restricted to I0 degrees bilaterally and accompanied by low back pain. Lasegue's maneuver was negative. Further neurological examination revealed symmetrical deep tendon reflexes with normal motor power....There was slight decreased perception of light touch In the SI dermatome on the right.

Radiographs of the cervical spine revealed no evidence of fracture, dislocation or degenerative change.

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Radiographs of the lumbosacral spine and pelvis revealed no evidence of fracture or dislocation. There was considerable disc space narrowing at the L5-S1 interspace.

The material forwarded to me has been reviewed and the records of Kaiser Permanente Hospital indicate the claimant was in the emergency room on December 13, 1980. The record is somewhat difficult to interpret but the impression of the examining physician was "Muscle sprain". I haw, reviewed radiographs of the cervical and lumbosacral spina which were obtained on the day of the accident and compared them with those obtained at the time of tnis examination. There has been no change in the configuration of either the cervical or lumbosacral spine.

In his report of May 20, 1982, Dr. Shin describes his treatment of the claimant between January 8, 1981 and February 3, 1981. At the time of the initial examination, approximately four weeks after the accident, the claimant had symptoms referable to hls cervical, thoracic and lumbosacral spine. "The radiating pain and distal neurovascular status and radiculitis conditions were not seriously remarkable". On January 15, 1981, "Distal neurovascular status was not changed". Dr. Shin's diagnoses of "Traumatic cervical myofascitis. Traumatic lumbar myofascitis" appear consistent with the symptoms and physical findings he describes. His diagnosis of "To be ruled out cervical and lumbar disc herniation" is not consistent with his report.

Records from Southwest General Hospital indicate the claimant was in that facility between June 13, 1982 and June 30, 1962. The history and physical examination, dictated by Dr. Shin on "10/17/82", indicates "The patient sustained this back injury from an automobile accident recently and he has had recurrent relapsing severe low back pein which was greatly associated with distal radiculitis". On June 25, 1982, a myelogram was performed and this was interpreted by the radiologist as showing "There is Increased distance between the anterior margin of Metrizamide column and posterior aspect of the lumbar vertebral bodies at L4-5 intervertebral disc region. This represents most likely a bulgin-annulus. There is no definite evidence of an extradural defect to suggest herniated intervertebral disc". On June 18, 1982, electrodiagnostic studies were performed which were interpreted as demonstrating "The above findings ara compatible with minimal radiculopathy at low lumbosacral root involving mostly right S-1 root". The discharge summary, dictated by Dr. Shin on "10-18", lists as a final diagnosis "Herniated lumbar disc with nerve root compression on the right side". This diagnosis does not appear consistent with the records.

Based on the information available to me, I believe that the claimant was involved in a vehicular accident on December 13, 1980 and that he may have sustained a cervical and lumbosacral strain. That these injuries were of minor magnitude is evidenced by the fact that he received no medical treatment in the four weeks between the accident and his first examination by Dr. Shin. Although he was hospitalized approximately 18 months after the accident, I do not believe this hospitalization was necessitated by the accident. As noted above, there is nothing to indicate that the claimant had radicular symptoms in the immediate post accident period.

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At the time of this examination, three years after tho accident, *the* claimant has symptoms referable to his cervical and lumbosacral spine. Although he may have the symptoms which he describes, the multitude of unusual physical findings clearly indicates that he is attempting to exaggerate his apparent disabilities. In summary, I believe *the* claimant has no permanent disability directly attributable to the accident of December 13, 1980.

Very truly yours,

Dennis E. Brooks, M.D.

DBB/anm