Highland
Musculo-Skeletal
Associates, Inc.

January 20, 1997

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RE: Vasile Minzat
Case No. 302845
File Nc. 1112/13895-SF

Dear Mr. Ritzler:

I evaluated the above plaintiff in my office on January 20, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on May 22, 1994. The plaintiff, as you know, is of Romanian extraction. He has been working in the United States for the past eight years.

He was the driver and solo occupant of a 1989 Nissan pickup truck in the vicinity of West 143rd and Elsetta. He was traveling in a north bound direction on West 143rd when the right side of his vehicle was struck in the passenger side by a Buick Century vehicle. According to the police and accident report, his vehicle was functional, the damage was moderate, and it was, in fact, driven away.

He was taken later that day to the Fairview General Hospital Emergency Room by his son. A series of x-rays and examinations were performed. He complained primarily of abdominal pain at that time. He was essentially treated and released.

He subsequently returned to the Wassler Clinic where he was evaluated on May 25, 1994, approximately three days later. The impression of those physicians was that he had neck pain, right hand paresthesia and no fractures. He had a back contusion. An abdominal CT scan was reviewed which was performed on the day of injury. This was somewhat difficult to interpret as there was absolutely no abnormalities noted in the liver, pancreas, or spleen. Both kidneys appeared to be normal and there was no free air. Despite this, the conclusion was "there is definite evidence of intra-abdominal trauma". There, however, does not appear to be any abnormality noted. My interpretation of these results would be that this is, in fact, a **negative** study.

He subsequently came under the care of Dr. Dorian Vidu who saw him initially on May 27, 1994. He treated the patient for a period of time with conservative physical therapy. No precise neurological deficits were noted, only neck, back and extremity **pain,** initially in the left lower extremity. **A** CT scan of the brain was ordered, as well as an ultrasound of the billiary tree, and this was normal. He was treated with a series of medications including Flexeril and Motrin, an anti-inflammatory and a muscle relaxant. He was referred to other physicians for follow up.

Approximately three months after the accident he was evaluated by Dr. Arthur Brickle at University MedNet in the Parma area. **A** thorough neurological examination at that time revealed a "probable ligament injury". EMG and nerve conduction studies were performed which did not show any radicular injury. It was felt that he may have an early carpal tunnel type syndrome. The EMG studies were consistent with a diagnosis of C5-6 radiculitis. No further evaluations were performed by this physician.

Although the patient did not recall, he saw one additional neurologist in October of 1995, Dr. Peter Bambakidis. The complaints at that time were chronic neck and right *arm* **pain,** as well as low back **pain.** The neurological examination was essentially normal other than a positive Tinel sign at the wrist. He reviewed the studies done, as well as reviewed the EMG studies done by Dr. Brickle. He did note there was no MRI scan performed. The symptoms were that of right carpal tunnel syndrome. This

Board Certified neurologist did not feel that his **pain** was neurologic in origin, and felt that most of his symptoms were from a musculoskeletal origin.

It was difficult to assess who this gentleman's treating physician is currently. He states he is still under the care of Dr. Vidu, although there are no recent records from this physician to review.

EMPLOYMENT HISTORE': The plaintiff used to work as a railroad mechanic and operator in Romania for many years. He has been employed as a dishwasher at a local restaurant. He stated that he was out of work for about seven months because of this injury.

CURRENT SYMPTOMS: At the time of this evaluation he complained of ongoing symptoms in the neck, primarily in the midline, and low back pain.

In reference to his neck, he claimed to have a constant aching type of **pain** which seems to be fairly well localized in the cervical paraspinals. He still complains of what is probably numbness radiating into his right upper extremity. This was not consistent nor could he explain to me the precise neurological pattern. He claims that the hand sometimes goes numb and this wakes him up at night. His symptoms seem to be more on the thumb side of the hand and, as will be discussed below, is probably related to a right carpal tunnel syndrome. He has no left arm complaints. He claims to have no weakness in his right upper extremity. He is right handed.

In reference to his low back, he complains of a midline pain that seems to be worse when sitting and standing for long periods of time. Activity seems to *make* it worse, especially bending and lifting. The bulk of the pain seems to be in the midline lumbosacral region with some radiation into the right iliac crest. He did complain of some right leg pain but it was difficult to establish if this is still present.

PHYSICAL EXAMINATION revealed a pleasant 55 year old male who appeared somewhat older than his stated age. He was observed walking in and out of the exam

room, and walked with a normal gait pattern. He was able to arise on his heels and toes without difficulty. Ascending and descending the examining table was performed normally. He was able to easily get up out of a chair when asked during the evaluation.

Examination of his cervical spine revealed no objective sips of injury. There was no spasm, dysmetria or muscular guarding or increased muscle tone. He claimed to have discomfort in the neck paraspinal muscle area above the C7 vertebral process. There was also some tenderness noted in the medial trapezius area. There was; however, no objective sips of problems. There was good flexibility of his cervical spine in forward flexion, extension, side bending and rotation. Over 90 percent of his predicted motion was noted. Protraction, retraction, and elevation of the scapulae were performed normally. There was good muscle tone and development noted in the neck, upper back, and periscapular musculature.

Examination of both shoulders revealed a full range of motion in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. There was proportional visible muscle development and on circumferential measurements at the axillary, midarm, forearm and wrist level, no atrophy was detected. A detailed neurological evaluation including sensory, motor, and reflex testing failed to reveal any precise abnormality. There may have been a positive Phalen sign on the right at approximately 30 seconds. The balance of the neurologic examination, objectively, was normal.

Examination of his lumbar spine revealed minimal decreased range of motion in forward flexion being able to bend forward to just above his ankle level. There was good reversal of his lumbar lordosis with this maneuver. Hyperextension,. side bending, and rotation were minimally restricted. No spasm, dysmetria, or muscular guarding, or increased muscle tone was noted with any of these maneuvers. His straight leg raising in both the sitting and supine positions was performed to 90 degrees bilaterally. A negative Lesague's sign was noted bilaterally. A detailed neurologic exam of both lower extremities was normal. Circumferential measurements of the

upper and Iower thigh, and upper and lower calf level, were equal and symmetrical bilaterally.

IMPRESSION: Subjective residuals of a neck and back strain. Possible right carpal tunnel syndrome. No evidence of treatable orthopaedic or neurological abnormality.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included the records from the Fairview General Hospital including the diagnostic scans, Dr. Hassler's Clinic, Dr. Dorian Vidu, University MedNet, as well as Dr. Peter Bambakidis.

After careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning his ongoing level of physical impairment.

On the basis of this evaluation, at worst, in my opinion, he sustained a strain or sprain of the neck and low back. He has complained of continuing ann pain. This does not follow any particular dermatomal pattern. The only abnormality was a slightly abnormal EMG. This was not felt to be clinically significant by the subsequent evaluating neurologist, Dr. Bambakidis. There were no other neurological testing performed in the form of a CT or MRI scan of the neck or low back. All other diagnostic studies were interpreted as normal, even though there was some discrepancy in the CT scan of the abdomen. There were no abdominal symptoms at the time of this evaluation.

As noted above, there was minimal objective findings to support his ongoing subjective complaints. The history as described was taken by the patient with some of the missing dates from the medical records. Although the plaintiff could not easily converse in English, it was felt that the history presented was adequate for my understanding of his ongoing subjective symptoms.

On the basis of his objective findings, however, he has objectively recovered from any soft tissue injury sustained. At worst, he sustained a ligamentous strain or sprain of the neck and low back. There is no objective finding at the time of this evaluation of any residuals of injury. He has objectively recovered although there is still complaints of **pain** and stiffness. The long-term prognosis is favorable on the basis of this examination. No further orthopaedic care or treatment is necessary or appropriate. The long-term prognosis is favorable.

Sincerely,

Robert C. Corn, M.D., F.A.C.S

RCC/bn

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