Highland
Musculo·Skeletal
Associates, Inc.

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Joseph H. Wantz
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RE: Russell Rhoda
Case No. 284595 (Cuyahoga County)
File No, 1770-12623

Dear Mr. Wantz:

I evaluated Russell Rhoda in my office on August 8, 1995, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on February 18, 1993. Throughout the history and physical he was accompanied by his attorney, Mr. James Behrens.

The collision on February 18, 1993 was a work-related injury although he was the driver of his own personal car. At that time he was employed as an installer for Pana Drapery. His vehicle was headed in a north bound direction on I-271 near the Wilson Mills Road exit, just south of the exit ramp. The weather was somewhat snowy. A car passed him heading in a north bound direction in the right hand lane. He was in the middle lane. This passing car suddenly lost control, went into the median area, and a very large "white out" condition was caused by the blowing snow in front of the plaintiff's vehicle. He attempted to slow down his Jeep Cherokee. This other car, as it spun around, struck his vehicle, and he stated there were three separate distinct impacts that he could recall. The right front was Impacted, the right side, and then the right rear (passenger side) of his vehicle were impacted. At the moment of impact he stated he was thrown forward and backwards. His vehicle was not drivable

He and a passenger were conveyed to the Meridia Hillcrest Hospital by ambulance. He was "sore all over" at that time. Multiple x-rays were performed of his neck and left shoulder. No traumatic abnormalities were noted. He was ultimately discharged with a diagnosis of neck and left shoulder strain. Specifically, there was no neurological complaints registered at that time. There was absolutely no mention of a low back injury.

He was subsequently sent by a family member to Dr. Hillel Mazansky. Dr. Mazansky's records were not available for review. The initial visit was on or about February 22, 1993. He had treatments for approximately six weeks to two months with physical therapy in Dr. Mazansky's office. He claimed the soreness gradually improved in his neck, back and left wrist, but he still remained symptomatic. He could not recall exactly when the low back pain started.

He was then referred to Dr. Arthur Brickel, a neurologist associated with University MedNet. The referral was from Dr. Mazansky, and the initial date of the exam was April 2, 1993, approximately six weeks after the accident in question. Complaints at that time were left arm numbness, as well as low back pain. Neurological evaluation was essentially normal. EMG and nerve conduction studies that were performed were consistent with C6 radiculitis on the left and L5 radiculitis on the right. An MRI scan was performed of his cervical and lumbosacral spine which showed disc osteophyte complex at C3-4 indicating a chronic condition, as well as disc space narrowing and desiccation of the L5-S1 disc associated with bilateral facet hypertrophy. These also indicate chronic degenerative abnormalities. There was a small disc herniation on the right L5-S1 level as well. The neck and back studies were performed on June 17, 1993,

The only other study performed was a CT myelogram done of his neck and low back. These did not show any evidence of disc herniation and was felt to be "normal".

The medical management by Dr. Brickel included a variety of medications. He was last seen by Dr. Brickel in late 1995.

EMPLOYMENT HISTORY: He was on a temporary total disability status for approximately three or four months after the accident and has claimed to have lost a number of days off and on since that time. His job involved installation of residential and commercial draperies. He is not using any brace or neck or back support. He takes only Tylenol for pain.

PAST MEDICAL HISTORY failed to reveal previous trauma. There was no family history of spinal arthritis. He claimed not to have symptoms in his low back prior to this accident even though there were clearly degenerative changes present.

CURRENT SYMPTOMS: The plaintiff complains of a poorly described weakness or "odd feeling" in his left upper extremity. Most of the discomfort is in the mid and upper midline cervical spinal region with occasional radiation into the back of his left shoulder and into the upper left arm. The left arm and elbow "feel weird" like a "pressure" sensation. There was no true neurological symptoms such as numbness, tingling or motor weakness w i t h specific neuromuscular groups. There is a separate area of discomfort in the dorsal aspect of his left wrist. He also has a sensation of a grinding and a stiffening sensation intermittently in his neck.

In reference to his lumbar spine, he complains primarily of pain at slightly above the waist level, at approximately L3. There is occasional a radiation of discomfort into his buttock cheeks when he is sitting for long periods of time. This happens intermittently and is not a significant portion of his ongoing symptoms.

PHYSICAL EXAMINATION revealed a pleasant 25 year old male who appeared in no acute distress. He appeared to sit, stand, and move around the examining room normally. His gait pattern was normal. No limping was detected. He was able to stand up on his heels and his toes without difficulty.

Examination of his cervical spine revealed no objective signs of ongoing muscular or soft tissue irritation. There was no spasm, dysmetria, muscular guarding or increased

muscle tone. No atrophy was noted in the neck, upper back or periscapular musculature.

Range of motion of his cervical spine revealed no observable decreased range of motion in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was a full range of motion of both shoulders in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists and small joints of the hand examined normally.

There was some tenderness in the dorsal left wrist region but no objective correlation was noted, There was a full range of motion with good motor strength. No atrophy was noted on observation of either upper extremity. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally.

Examination of his lumbar spine revealed no significant objective findings on inspection. There was a full range of motion in forward flexion, extension, side bending, and rotation. His straight leg raising in both the sitting and supine positions were performed to 90 degrees bilaterally. No atrophy was noted on circumferential measurements of his upper and lower thigh, or upper and lower calf level. There was no neurological abnormality noted. Certainly there was nothing to indicate a unilateral lumbar disc herniation.

IMPRESSION: By history, acute cervical strain. Low back symptoms that started at some point in time after the accident in question. Diffuse cervical and lower lumbar disc disease by MRI scan. No **clinical** objective evidence of disc herniation.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included records from the Meridia Hillcrest Hospital, University MedNet and Dr. Arthur Brickel, the Marymount Hospital and Meridia Euclid Hospital. Four packages of x-rays were reviewed from

the Meridia Hillcrest Hospital, Meridia Euclid Hospital, Marymount Hospital, and MagnaTech, which included the actual MRI scans.

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 review, in my opinion, at worst, he sustained a strain or sprain of the cervical spine. There may have been a contusing injury to the left shoulder, but no initial low back injury was sustained. Within the days or weeks after the accident, he began having low back pain. His management was conservative in nature, performed by a family practitioners office.

The neurological evaluation, done by Dr. Brickel did not reveal any significant traumatic abnormalities. The minor abnormalities in the EMG and nerve conduction studies are not associated with a traumatic incident. There may have been some electrical evidence of nerve root dammation, but no distinct abnormalities related to this particular trauma. The MRI scan clearly showed some early changes of degenerative disc disease and arthritis in his neck and low back. These, again, are **degenerative** not traumatic abnormalities. The confirmatory test, that is the CT myelogram, was entirely within normal limits. These minor disc "bulges and herniations," in my opinion, were degenerative solely in nature. There was no evidence of neurological pressure as demonstrated by the normal myelogram.

At the time of this evaluation he had a normal physical examination. He had objectively recovered from any soft tissue injury sustained. There was no objective evidence of any ongoing muscular or soft tissue dammation. There was no evidence of any neurological abnormality. It is my opinion, within a reasonable degree of medical certainty, that the abnormalities noted on the CT scans were solely degenerative in nature and not related to trauma. He never had a symptomatic treatable disc herniation in his neck or low back region.

At the time of this evaluation he has objectively recovered from any soft tissue sustained. The long-term prognosis is favorable. There is no evidence of any permanent aggravation or acceleration of these preexisting degenerative conditions. In my opinion, his injuries, at worst, were a soft tissue stretching injury of the muscular elements in the neck and low'back. There is no clear explanation for his three to four months of lost time out of work. Injuries of this variety usually heal within four to six weeks and necessitate eight to twelve weeks of rehabilitation. He should have been able to return to work within a three month period of time.

In *summary* the long term prognosis is favorable. He has objectively recovered by the time of this evaluation. No further care or treatment is necessary or appropriate. The prognosis is favorable.

Sincerely,

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

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