Highland
Musculo-Skeletal
Associates, Inc.

February 27, 1996

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Orthopaedic Surgeons

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615 Superior Avenue, West
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RE: George Stubbs
DOT: *3/6/95*

Dear Ms. Gervinski:

I evaluated the above plaintiff in my office on February *26*, 1996, in reference to alleged residuals of injury sustained in an RTA bus accident. He was sitting in the most rear seat, all tlie way on tlie left side just in back of the left rear wheel well on Route #16 bus. This **was an** East 55th Street route bus. There was apparently some construction, the bus sideswiped another vehicle, and the force of tlie impact twisted the patient to some degree. There was mention of a twisting injury to his knee which "popped real loud". Despite this, there was no complaint of knee pain, swelling, or problems to the EMS crew that conveyed him to Deaconess Hospital. There was no mention of his left knee in the Deaconess Hospital records as well. No swelling was noted on physical examination. **This** was felt to be a minor low back strain or sprain,

Subsequently he was evaluated and treated at the Shaker Square Medical Center where he was initially evaluated on or about March 14, 1995. Complaints were made **primarily** of low **back pain** and some aching pain in the left knee. The low back and knee pain gradually became better through the end of March 1995, according to the records. There was gradual improvement through early **April** as well. **By April** 6, 1995, **the** left knee was "fine" with a normal range of motion.

It was not until April 13, 1995, where it was noted that "patient stated while turning sharply, left knee hurts". There was clearly an improvement in his knee initially and then with this second incident it seemed to worsen. From that point on the knee was symptomatic.

The patient was subsequently referred to Dr. Jeffrey Morris, an orthopaedic surgeon, who evaluated him on May 22, 1995. There was tenderness along the medial joint line, as well as no obvious signs of clinical instability. There was some tenderness as well. When seen on a subsequent evaluation on October 24, 1995 by Dr. Gabelman, the knee exhibited slight instability with signs of an anterior Drawer and Lachman, consistent with chronic anterior rotatory instability. It was at that point that he was referred to Dr. Fumich for further evaluation.

Patient initially was evaluated by Dr. Robert Mark Fumich, an orthopaedic surgeon, OR October 26, 1995, over seven months after the actual injury in question. Dr. Fumich seemed to rely heavily on the history that was presented and seemed to be unaware that his left knee symptoms completely improved within a few weeks after this accident. He was unaware that a second incident occurred in April of 1995.

Review clearly indicated an anterior cruciate deficient knee with the expected degenerative changes. It was elected to proceed with an arthroscopic procedure which was done at the Meridia Hillcrest Hospital on November 3, 1995. This was for partial medial meniscectomy, debridement of arthritic condition which was due to his long-standing anterior cruciate deficiency. The arthroscopic noted are those that are typically seen with long-standing anterior cruciate deficiency.

There was some physical therapy that was ordered afterwards, carried out initially at the Beachwood Orthopaedic Center. He has not had any formal therapy for a number of months. He is scheduled to return back to work on March 4, 1996,

EMPLOYMENT HISTORY: He was employed as a laborer for Garfield Alloy. He worked until September when he was "laid off'. He decided at that time to "have my knee checked out" which was done. As noted above, he is scheduled to return to work a week after this evaluation.

PAST MEDICAL HISTORY failed to reveal any previous injury or problem with his left knee. Clearly he had a significant ligamentous injury at one time tliat could not be recalled. There were signs of degenerative arthritis, as well as a degenerative meniscal tear associated with his chronic ligamentous instability. The patient **denied** any problems prior to this accident.

CURRENT SYMPTOMS: He is currently on no medication. The surgery definitely helped his painful symptoms. He now has intermittent aching pain with no swelling. He is able to use his stationary bike evety other day. He also does a fair amount of walking. He feels completely recovered.

There are no complaints in reference to his low back other than some occasional aching pain.

PHYSICAL EXAMINATION revealed a pleasant 54 year old male who appeared in no acute distress. His gait pattern was normal. He was able to arise from a sitting position without difficulty. Ascending and descending the examining table was perfonned normally.

Examination of his left knee revealed well .healed scars compatible with the arthroscopic surgical history. There was no effusion. There was definite medial lateral laxity of Grade I-II. There was also a definite positive anterior lateral rotatory instability compatible with his chronic anterior cruciate deficiency. Also, there was some tenderness and osteophytes palpated along the medial aspect of the joint. No atrophy was noted on circumferential measurements of his thigh and calf.

IMPRESSION: Low back strain, resolved. Alleged' twisting injury to left knee, Chronic anterior cruciate deficiency with long-standing meniscal and arthritic sequela.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the EMS run, Deaconess Hospital, Shaker Medical Center and Dr. Robert Mark Funich, isolated records from Meridia Hillcrest Hospital, and records from Beachwood Orthopaedics. The actual MRI scan was reviewed.

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 conclusion concerning his ongoing level of physical impairment.

In refereuce to his low back, at worst, he sustained a minor twisting injury. There was no objective findings noted at the t h e of his initial emergency room evaluation. His symptoms completely resolved with simple physical therapeutic modalities.

The major concern is his left knee. There was clearly no documented injury. Had there been an acute aggravation of his pre-existing cruciate deficient knee, in my opinion there would be immediate symptoms. These would include pain and effusion, as well as diffuse swelling. Most prominently I do not believe he would be able to ignore these symptoms arid iiot mention them to the emergency room staff. He allegedly reported them to the emergency room staff, but there is absolutely no mention of this.

It is clear from reviewing the Shaker Medical Center records that there was some pain in his left knee when initially evaluated, but this completely resolved within a few weeks. There was then a second incident at sometime in early April in which there was a change in symptoms. This may have involved a twisting injury to the knee. From that point on he remained symptomatic. This prompted the MRI scan and the subsequent surgery. In my medical opinion, based on a reasonable degree of medical certainty, the only linkage between his knee arid the subsequent treatment and surgery, was the plaintiff's history.

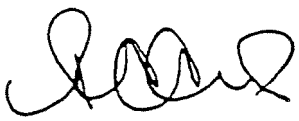
It was interesting to note that on initial review by Dr. Moms, no signs of rotatory instability or angular instability was noted. However, at the time of die follow-up evaluation in October of 1994, Dr. Gabelman found signs of chronic anterior cruciate insufficiency. After review of the medical records, it was Dr. Funich's opinion that this was a chronic instability riot related to the RTA accident in question.

It is my opinion that the cruciate deficient knee was riot significantly influenced by the accident and injury in question. It clearly completely resolved and then a second incident occurred. This was riot discussed at all by the plaintiff and only rioted on

review of the medical records. From this point in there was a definite change in the patient's symptoms.

He has made a good recovery. Clearly there were some permanent abnormalities due to his long-standing anterior cruciate deficieucy. In my opinion, there was no permanent aggravation or acceleration of this condition. The only linkage of the increased symptoms was on the part of tlie plaintiff. He did not mention to Dr. Fumich the complete improvement of his knee. Dr. Fumich's opinion is based solely on the patient's statements and the history provided. I do believe that all of the abnormalities noted at the time of arthroscopy were solely due to this pre-existing problem. There is no objective evidence that this condition was permanently aggravated or accelerated. Has this accident not occurred it is, within a reasonable degree of medical certainty, that ultimately tlie same operation would have been necessary. He has made an excellent recovery. He, in fact, is returning back to his job in manual labor within a week of this evaluation. No further care or treatment is necessary or appropriate for his condition.

Sincerely,



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

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