Highland
Muscub-Skeletal
Associates, Inc.

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January 17, 1997

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RE: Luella Buge (Gaither)
Case No. 301730
File No. 65171

Dear Mr. Kramer:

I evaluated the above plaintiff in my office on January 15, 1997, in the presence of her attorney, Gloria Gruhin. This evaluation was specifically in reference to alleged residuals of injury sustained in a February 1, 1994 motor vehicular accident.

As you are probably aware her history is quite complex. She has been in multiple motor vehicular accidents over the years, as well as sustaining a severe work-related low back trauma. As is well documented in the records of her primary treating orthopaedic surgeon, Dr. Robert Zaas, her low back problems are complex and have been present since the 1960's.

This specific accident took place when she was operating a 1990 mid-size Buick vehicle in the vicinity of Cedar and Green Roads on February 1, 1994. She stated that when she was exiting a local Shell service station, crossing traffic to make a left turn, the passenger side of her vehicle was struck. At the moment of impact she was thrown in a side-to-side direction striking her left shoulder region on the driver's door. She also twisted her low back. 'Her vehicle was drivable. She was on her way to her

family physician, Dr. Catherine Tawny, at the Cedar-Brainard area, who was the first physician who saw her, She was treated primarily for her hypertension. She stated that her blood pressure was "up".

Later that evening she was evaluated at the St. Luke's Hospital Medical Center complaining of primarily neck pain. X-rays were done of her cervical spine which showed some disc space narrowing at the C6-7 level. There were additional complaints of left shoulder and low back pain. Her primary diagnosis was of cervical strain.

She ultimately returned to Dr. Robert Zaas, her previous treating orthopaedic surgeon, on February 9, 1994. He did relate on his initial note the fact that her left shoulder symptoms had, in fact, started earlier that year in 1994 and she had. in fact, gone through some physical therapy between the January 1994 visit and the motor vehicular accident in question. Clearly the left shoulder and neck symptoms did not originate with the motor vehicular accident in question, as erroneously stated in Dr. Zaas' subsequent medical report dated April 27, 1995.

He started her on a conservative approach at the Paetow Physical Therapy group where she was previously going to therapy. This was no help. There was worsening of her low back pain, as well as worsening of her previously existing left leg pain. It is clear through the medical records that there has been episodic documentation of severe, at times incapacitating, low back and left leg pain for many years.

Because of increasing symptoms and a failure to improve, ultimately she was admitted to the Mt. Sinai Medical Center. An MRI scan was ultimately performed in early April of 1994 which showed "severe spinal canal stenosis at L4-5, secondary to facet hypertrophy and degenerative spondylolisthesis. There was also a left lateral disc herniation at the L4-5 level. It should be noted that she had not had any low back scans for many years prior to this.

On April 7, 1994, she underwent a wide decompressive laminectomy for "severe spinal stenosis, L4-5 degenerative spondylolisthesis and compression of L5 nerve root

in the intervertebral foramina". This was an operation that was, by description, done primarily for long-standing degenerative disease, as well as her spondylolisthesis.

She did well postoperatively from a general medical standpoint, although she continued to have back and left leg pain, numbness and weakness. She was hospitalized at the Margaret Wagner Pavilion for a period of time for postoperative rehabilitation until she could take care of herself at home. This was followed by physical therapy by a home therapy group.

In general: she felt that her surgery provided "no help". She still continues to take Naprosyn on a regular basis. She states she has used a cane since the time of surgery, but the medical records clearly indicate that she has used the cane off and on for literally decades. She continues to follow with Dr. Zaas through 1996. Follow-up x-rays done in May of 1996 showed the residuals of his decompressive surgery, as well as the ongoing spondylolisthesis at L4-5.

PAST MEDICAL HISTORY, as you are aware, is quite complex. She was initially seen by a partner of Dr. Zaas, Dr. Norman Rosenberg, who evaluated her for back injury sustained on November 30, 1968. This occurred when she was employed as a nurse's aide at the Highland View Hospital. She sustained an injury at that time to her low back and was unable to walk for about a month. X-rays at that time showed rather significant degenerative disease. She, according to his records, came under the care of Dr. Zaas who assumed some of Dr. Rosenberg's practice. There is clear documentation in the records that she has been disabled for about 20 years and has not worked since approximately September 3, 1976. Records indicate conservative treatment and hospitalization in August of 1977, as well as repeated episodes of, initially, low back and right leg **pain.** This continued through the bulk of the 1980's.

She was involved in a number of motor vehicular accidents. These included a rear end collision in 1982 which significantly flared-up her neck, upper back, shoulders, and low back. She was treated conservatively for this. Another motor vehicle accident, being struck in the rear by a van, occurred on August 29, 1954. Again, this caused a

soft tissue flare-up of her back and worsened her right leg **pain.** Throughout the mid-80's, the bulk of her problems were in the low back and right leg. **A** third motor vehicular accident occurred on May 4, 1986 in which she was a passenger struck in the front by a car that backed **up** in front of her vehicle. She again reinjured her neck and back at that time.

A fourth motor vehicular accident occurred on November 18, 1957 in which her vehicle was involved in a rear end collision. She developed soreness and stiffness in her neck, more pronounced on the right side. There is indication that her back and right leg was somewhat worsened by this collision as well.

In the late 1980's she began having severe low back, left leg, **hip** and thigh discomfort. This necessitated emergency room evaluation at the Mt. Sinai Medical Center. There was also notations of fluid retention and swelling in both of her calves. In the early 1990's she had worsening low back and left leg discomfort with pain radiating down as far as the left ankle. There was a period of time where she lost her footing and was treated for right wrist carpal tunnel syndrome, as well as a tenosynovitis of the thumb, including the extensor and flexor tendons.

On April 11, 1992, she was involved in another motor vehicular accident which was a front side passenger collision similar to the collision that was described in 1994. She again reinjured her neck and back at that time and continued to have low back and left leg pain. The last visit prior to the motor vehicular accident in question occurred OR November 19, 1993. At that time she had complaints of ongoing low back **pain** and **pain** into her legs, more left than the right. Swelling was noted in both feet and ankles. She complained of more numbness and weakness in her left leg below the knee, particularly in the L5 dermatome. This clearly indicates an L4-5 nerve root compression. This was ultimately addressed in the surgical procedure done after the motor vehicular accident in question.

It is clear by review of the past records that she had virtually identical symptoms, at least on an intermittent basis, up to three or four months prior to the February 1994

motor vehicular accident. She had treatable ongoing symptoms in her low back., left leg, as well as left shoulder and neck, **prior** to the February 1994 accident.

The patient did have a previous lumbosacral spinal operation which may have involved a fusion in 1975 done by Dr. Arthur Steffee at the Geauga Hospital.

CURRENT SYMPTOMS: At the time of this evaluation she still continued to complain of **pain,** primarily in the low back center and left side. She described this as a deep aching pain which was constant. It never changed with activity, exercise, posture or position. She continued walking with a quad cane. I visibly saw episodes of spasms, sort of like a '"charley horse" in the left calf. Heat usually helped this at home. Two of these episodes were observed in the office.

In reference to her left leg, there continues to be a burning sensation primarily along the left L5 nerve root, The evening seems to be worse. Naprosyn seems to help her symptoms to some degree.

In reference to her left neck and shoulder, they were the same ongoing complaints described in January of 1994. This is a dull, diffuse aching **pain.** She claims to have intermittent numbness in all of her fingers of the left hand. She also states that in the morning the left hand and fingers seem to be swollen.

EMPLOYMENT HISTORY: She has been permanently and totally disabled since the mid-1970's due to her chronic low back condition.

PHYSICAL EXAMINATION revealed a pleasant 71 year old female who appeared in some distress. As stated above, a number of these spasm episodes in the left calf were noted at the time of this evaluation. She had some difficulty arising from a sitting position. I did not allow her to climb up and down the exam table.

Her gait pattern showed a left antalgic gait. She used the quad cane effectively.

Examination of her left shoulder revealed no atrophy in the neck, upper back, or periscapular muscles. There seemed to be, at worst, 20% limitation of motion which was similar to the motion in her right shoulder. No stigmata or neuromuscular dysfunction was noted. There was no evidence of rotator cuff pathology on exam.

The bulk of the examination was concentrated on her low back. This revealed the well-healed scars compatible with her surgical history. There was a significant degree of stiffness in her low back region. She does wear a lumbosacral corset with metal staves which she was wearing at the time of history but removed for the physical examination. Approximately 35% of decreased range of motion of her lumbar spine was noted. Her straight leg raising in the sitting position was performed to 90 degrees bilaterally. No neurological deficits were noted in the lower extremities.

IMPRESSION: Chronic history of severe low back pain, severe degenerative arthritis and disc disease with lumbar spinal canal stenosis, spondylolisthesis at the L4-5 level with probable degenerative disc herniation at the L4-5 level. Related to this accident, subjective aggravation of her pre-existing condition. No new traumatic lesions were noted.

DISCUSSION: I have had the opportunity to review a number of medical records and documentation. These included complex records from the Mt. Sinai Medical Center, St. Luke's Hospital and MetroHealth Medical Center. There were no records available from Horizon Orthopaedics (Dr. Steffee), or Geauga Community Hospital. Records were also reviewed from the Ohio Traffic Crash Report, some answers to Interrogatories, her family physician, as well as complex records from Dr. Robert Zaas which outlined her ongoing low back condition.

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 her ongoing level of physical impairment.

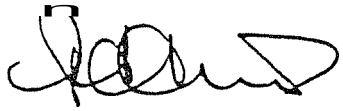
It is my opinion, within a reasonable degree of medical certainty, that, at worst, there was a subjective aggravation of a previously well documented severe low back condition. There had been numerous flare-ups of her low back, including severe low back and left leg pain, numbness, weakness and neurological evidence of left L5 nerve root entrapment for many years. She had, in fact, been disabled for her low back condition for 20 years prior to this evaluation. There was no new traumatic lesions noted. I do believe this accident, at worst, was the source of this most recent flare-up which did not seem to resolve with physical therapy. It was for that reason, and that reason alone, that the decompressive operation was performed.

There is some contradiction in the report by Dr. Zaas and review of his medical records. Dr. Zaas concluded that the trauma of February I, 1994 was the proximate cause for the neck, upper back and scapular soft tissue injury, while as the proximate cause of the disabling low back symptoms and left lower extremity pain. It was clear that this February accident, at worst, subjectively aggravated a pre-existing condition which was severely symptomatic as recently as November of 1993. It is clear that her neck, upper back, and shoulder areas were involved in multiple previous motor vehicular accidents and, in fact, she was undergoing physical therapy on her left shoulder **prior** to the motor vehicular accident in question.

It is my opinion that the surgical procedure that was performed was primarily for her ongoing degenerative condition which was documented to be worsening over many years. The motor vehicular accident in February of 1994 precipitated the need for the surgery to be done at that point in time due to the failure to Improve. The surgery, according to the patient, did not significantly improve her symptoms on a long-term basis. This is probably due to the severe chronicity of her spinal disease which was not subjectively influenced by the 1994 low back surgery. If one was to give a percentage of involvement of this motor vehicular accident in reference to the total picture of her low back condition, I would say the contribution was less than five percent towards to the need for the type of surgery that was performed. She clearly had a complex ongoing chronic condition which was not objectively worsened by the February 1994 collision.

The long-term prognosis is guarded. She has had low back and left leg pain for many years. The influence of the February 1994 motor vehicular accident, in my opinion, is minimal, as compared to the long-standing problems that the plaintiff has had with her low back condition. She has had many reinjuries to her lower spine as well documented in the records. It is doubtful that her long-term condition was significantly influenced by the February 1994 collision.

Sincerely,



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

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