Highland
Musculo·Skeletal
Associates, Inc.

Robert C. Corn, **M.D., F.A.C.S.**
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Orthopaedic Surgeons

February 3,1997

Hunter S. Havens
Attorney at Law
800 Leader Building
526 Superior Avenue, East
Cleveland, OH 44114-1460

RE: Charles T. Anzalone
Case No. 304637 (Cuyahoga County)

Dear Mr. Havens:

I evaluated the above plaintiff in my office on January 31, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on March 11, 1994. As you are aware, there were a number of previous significant treatable injuries, as well as a subsequent motor vehicular accident.

He described the collision as his being the driver and solo occupant of a 1991 Miata vehicle. We was heading in a north bound direction on South Green Road between Cedar Road and near Notre Dame College. A vehicle pulled out from a side street and struck the passenger side of his car. The force of the impact allegedly forced him over to oncoming traffic and back to the passenger side berm. The impact was essentially "broadside" on the passenger side. He was wearing a seat belt.

The only injury he initially recognized was a left ankle sprain. Police came on the scene and the South Euclid police towed the car to his house and he went home.

The following day he was evaluated at the University Hospitals Green Road Urgent Care Center. He is employed as an optician in that same building. Results of the evaluation included a normal cervical spine examination on x-ray. It was felt that he had a "soft tissue neck injury".

He subsequently returned to his previous treating physician, Dr. Jeffrey Biro. He saw him "a couple days" after the injury. Physical therapy was initiated at the Western Reserve Physical Therapy. This was essentially for his neck and upper back. He also had a brace for his ankle which he wore for a very short period of time. The physical therapy consisted of modalities in the form of heat, ice, a TENS Unit, and a MEMS unit. He was also tried on a variety of muscular rubs, as well as Ultram. There was gradual improvement noted, at least according to Dr. Biro, his musculoskeletal physician. The diagnosis was primarily that of a soft tissue strain or sprain.

In addition, a number of trigger point injections were performed. He believed a total of six injection were given to him which gave him some temporary relief. There was some limitation in his sports and recreational activity, including outdoor sports. He was also treated for post traumatic depression.

There was a reaction to one of the medicines. He has been seeing a psychological and a psychiatrist for alleged psychological residuals of trauma.

He was in a subsequent motor vehicular accident in front of his home in March of 1996. This was a rear end collision with a fair amount of property damage. He reinjured his neck and upper back. He returned back to Dr. Biro for massotherapy, which has been his primary treatment modality at the time of this evaluation.

PAST MEDICAL HISTORY also revealed a number of significant injuries. In 1988 he was involved in a 50-car pile-up in which he sustained a rear end collision. He has also had a "whiplash" injury to his neck and back. He was treated by Dr. David Thomas in Mentor for this.

In 1968 he was struck by a tractor trailer which threw him a number of feet into the air. He was disabled for two months from this accident.

CURRENT CONDITIONS: He still undergoes massotherapy and occasional use of the MEMS unit. This is, by history, related to the same areas that were injured in the 1994 trauma. He takes only Advil or over-the-counter medication for ongoing **pain** relief.

CURRENT SYMPTOMS: He complains of pain primarily in the midline trapezius muscle and interscapular area, the left side slightly greater than the right side. Prolonged sitting seems to bother him, as well as cutting his grass. This causes a burning pain along the left medial scapular border. When he is cutting his grass for more than 20 minutes he gets these symptoms. He also has limited ability to fish, water ski, and play golf. He has difficulty with his back swing. He is left handed and gets a "snapping sensation like a rubber band snapping" in his left side neck area. He also complains of an anterior aching pain in the left scapular area. He also complains of right sided headaches.

PHYSICAL EXAMINATION revealed a somewhat anxious appearing, 44 year old male who appeared in no acute distress. He was noted to sit, stand, and move around the exam room without difficulty. His gait pattern was normal. He was able to walk on his heels and toes without difficulty.

Examination of his cervical spine revealed no signs of objective spasm, dysmetria, or muscular-guarding. He claimed to have tenderness in the left trapezius muscle, as well as long the left medial scapular border. There was no objective correlation of these symptoms. There was full mobility of his cervical spine in forward flexion, extension, side bending and rotation. Rotation to the left seemed to be more uncomfortable, but was performed normally. There was a normal exam of the sternocleidomastoid, scalene, trapezius, upper back and periscapular muscles. Mobility of the scapulae were normal in protraction, retraction, and elevation. No sips of muscular atrophy **and,** in fact, good motor development was noted in the neck, upper back and periscapular muscles.

Examination of both shoulders revealed a full range of motion noted in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists and small joints of the hand examined normally. A detailed neurological examination including sensory,, motor, and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally.

In summary, despite the ongoing symptoms and the multiple motor vehicle collisions, he has objectively recovered from any soft tissue injury sustained.

IMPRESSION: Subjective residuals of recurrent neck and upper back soft tissue strain or sprain. No neurological involvement. This must be considered a reinjury.

DISCUSSION: A number of medical records were reviewed concerning the patient's ongoing care and treatment. These included the Ohio Traffic Crash Report of March 11, 1994, Answers to the Interrogatories, records from the University Suburban Urgent Care Center and Dr. Biro. The records of the physical therapy sessions were reviewed, as well as records from Drs. Robert Katz, Alan Bachers, and Michael Hackett. A number of records of diagnostic scans were reviewed. There was no records of any MRI scan results in the records provided. I will be glad to review any additional medical records that become available.

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 the plaintiffs ongoing level of physical impairment.

At the time of this evaluation he had, at worst, minor soft tissue complaints. These are as a result of multiple soft tissue injuries, one in March of 1994 and the second, as recent as March of 1996. With both of these accidents he sustained injury to the same area. He *still* continues to complain of ongoing subjective symptoms related to the neck paraspinal muscles, trapezius and medial scapular border.

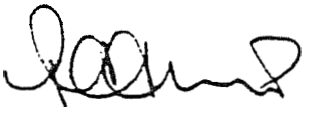
The physical examhation as discussed above, was entirely within normal limits. To my knowledge, no diagnostic testing ever showed any objective orthopaedic or neurological abnormality or injury. At worst, this was felt to be recurrent cervical strain or **sprain.** There is still ongoing subjective symptoms without objective orthopaedic or neurological abnormalities.

Review of the medical records clearly indicate a number of the types of previous and subsequent injuries sustained. Any of these injuries were capable of producing a soft tissue strain or sprain with temporary soft tissue symptomatology. Certainly the recurrent nature of his injury plays a role in his ongoing medical and psychological "makeup". At the time of this evaluation, however, he had completely objectively recovered on a clinical basis from any soft tissue injuries sustained.

There is still continuing subjective symptoms without objective findings. No treatabte orthopaedic abnormalities were noted at the time of this evaluation. He continues with massotherapy which gives him, at best, temporary relief. In my opinion, modality type therapy treatments should be used judiciously and for a limited time period. It is difficulty to state within a reasonable degree of medical certainty, that any care and treatment after March of 1996 was related to the 1994 injury.

The long term prognosis is favorable. He has made a complete objective recovery, No further care or treatment is necessary or appropriate. His examination was normal. Despite his ongoing symptoms, he has recovered objectively.

Sincerely,



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

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February 3,1997

Robert G. Hurt
Attorney at Law
7029 Pearl Road
Suite 310
Middleburg Heights, OH 44130

RE: Allen Shipman
CaseNo. 311013
File No. 360.001-C-103

Dear Mr. Hurt:

I evaluated the above plaintiff in my office on January 29, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on February 5, 1995. As you are aware, his medical history is somewhat complex in that he has had a number of previous injuries to the exact same areas. There is some indication that there ongoing symptoms prior to this motor vehicular accident.

He described this injury as occurring on February 5,1995. He was the driver and solo occupant of a 1983 Buick Century vehicle. He was heading north bound on West 117th Street near Linnett. His was stationary and the first car in a turning lane. There was a great deal of traffic in the right hand lane. **A** car allegedly pulled out from this line of traffic and rear ended his vehicle. The car that hit him was described a 1981 Ford Bronco. The force of the impact allegedly pushed his vehicle through the intersection.

He did state his car was drivable and he drove to his home nearby. Later that day he was taken by his ex-wife to the Fairview General Hospital Emergency Room where he had an **initial** evaluation and consultation. According to the medical records he was

seen on the date of injury, February 5, 1995, in which he was evaluated for an injury sustained to his neck and low back. X-rays were taken of both these areas. The original x-rays demonstrated no traumatic abnormalities. There was mild degenerative changes noted at the *C5-6* level, as well as joint space narrowing and neural foraminal narrowing. I reviewed these x-rays and I would consider these changes moderate to moderately severe. X-rays of his lumbar spine were also reviewed and these were essentially normal. He was essentially treated and released.

He stated he was evaluated by Dr. Peter Poolos, a neurosurgeon. This physician previously operated on his left hand for an unrelated carpal tunnel syndrome. He referred him to Dr. William Mourad, an orthopaedic surgeon.

According to Dr. Mourad's records he was initially evaluated on May 17, 1995. This was specifically in reference to "multiple injuries to his neck". Dr. Mourad accurately described his initial injury on April 4, 1987, in which he received a significant injury to his neck in a work-related truck driving incident. His vehicle went off the road. We had extensive care and treatment by a number ofphysicians. He was able to return to work in a different type of job as a truck and automobile mechanic subsequent to this injury. Dr. Mourad noted chiropractic treatment over the years, as well as numerous diagnostic studies.

His records also indicate he was evaluated by Dr. Bambakidis, a neurologist, who saw him in Dr. Poolos' absence, He has had significant problem with continuing neck pain and stiffness, and radiating pain into the left arm associated with numbness. A complex physical examination revealed some decreased range of motion. Repeat x-rays showed spondylosis at the C5-6 level indicated a degenerative not traumatic condition. There was spur formation as well. He reviewed an MRI scan that was performed at the Fairview General Hospital on February 18, 1995. This again showed only spondylosis at the C5-6 level with disc disease.

Dr. Mourad saw him approximately three months later in late August of 1995. He had changed his job at that time and was then driving a truck. There was continuing and

somewhat worsening pain and numbness down his left arm. X-rays of his neck showed no change, only the narrowing of the C5-6 disc space, as well as spur formation. He discussed with him anterior spinal surgery for the spondylitic condition.

The surgery was carried out at the Fairview General Hospital on September 21, 1995. This was in the form of an anterior discectomy at the C5-6 level with an interbody fusion. A bone graft was taken from the left iliac crest region. Specific review of the hospital records, as well as the doctor's records, do not tie this spondylitic condition or the need for surgery related to the February 1995 accident, but related to his progressive degenerative changes. He only relates the "acute and progressive symptoms" related to the February accident by the patient's history.

Postoperatively he was followed on a regular basis. The bone graft completely healed. The last evaluation with any physician was December 29, 1995, over a year prior to this evaluation.

PAST MEDICAL HISTORY, in addition to what was reviewed in Dr. Mourad's records, indicates a number of evaluations, and ongoing care and treatment related to the 1987 injury. He was seen by a number of physicians including a mechanotherapist, Dr. Adams. The Ohio Bureau of Workers' Compensation records were also available for review. As recently as mid-April of 1994, he was still having significant symptoms aggravated by prolonged maintenance of a position, repetitive motions of his head, cold and damp weather, and changes in the weather. The upper back symptoms were aggravated by lifting and carrying anything more than Light weights. It was recommended that he received a permanent partial impairment of 24% on the basis of his preexisting claim. Medical records were also reviewed from the Southwest General Hospital which confirmed the ongoing treatment for his 1987 injury.

CURRENT SYMPTOMS: As a result of the surgery, he had about a 40% improvement in his neck and upper back symptom. There is no numbness or radicular pain. He needed to change his job from rebuilding heavy truck transmissions.

He had difficulty lying on the floor and looking in an upward direction. He also had difficulty picking up parts prior to the operation. This did improve.

At the time of this evaluation, he is able to work on cars and trucks. He has to limit his driving and now he drives container trucks. He had difficulty climbing up and "chaining down and tarping" heavy equipment. He was unable to do this after the accident.

Residual symptoms include right neck and shoulder pain. This is primarily in the trapezius muscle area which was the exact same area described in the Workers' Compensation record. This is associated with intermittent "tightening". He has episodic stiffness in the neck, upper back and clavicular area. This is worsened by excessive driving, by repetitive physical labor, and loading and unloading trucks or containers. He had no arm pain. The pain is confined to the upper back and neck area.

PHYSICAL, EXAMINATION revealed a pleasant 41 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 performed normally. He was able to walk on his heels and toes without difficulty. He appeared to sit and move around freely during the history portion of the examination. He did not appear in any distress.

Examination of his cervical spine revealed a well healed scar on the anterior neck region compatible with his surgical history. He had very minimal restriction of motion, less than 10% of predicted restriction in forward flexion, extension, side bending, and rotation. There were no ongoing signs of spasm, dysmetria or muscular guarding, or increased muscle tone in the cervical, upper back or paraspinal musculature. Protraction, retraction, and elevation of the scapulae were performed normally. There was good muscle and motor development of the neck, upper back and periscapular muscles. He did claim to have some tenderness which was primarily in the right trapezius. Although he was not terribly symptomatic at the time of this evaluation, this

was the area in which he hurt on an intermittent basis. There was also some discomfort localized dong the medial scapular area. There was no objective findings to correlate with this.

Range of motion of both shoulders was normal in forward flexion, extension, abduction, internal and external rotation. There was good motor and muscle development in both upper extremities on visual inspection and this was confirmed on circumferential measurements of the *axillary,* midarm, forearm and wrist level. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

In *summary,* the neck, upper back and shoulder exam was essentially normal with the exception of his skin incision.

Examination of his left hip revealed a well healed scar compatible with his surgical graft donor site.

SSION: Residuals of a soft tissue strain or sprain, specifically related to the motor vehicular accident in question. Long standing history of neck, upper back and shoulder pain, virtually identical to his current symptoms. Degenerative disc disease which was not objectively aggravated by the motor vehicular accident in question. Status post successful C5-6 anterior disc fusion.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included rather extensive records from the Bureau of Workers' Compensation including his multiple exams, records from the Fairview General Hospital, Southwest General Hospital and Dr. William Mourad. Actual x-ray films were reviewed, both pre- and postoperatively from Dr. Mourad's office.

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.

Concerning the accident, at worst, in my opinion he sustained a strain or sprain of the neck and upper back. This subjectively reaggravated his preexisting condition. This was a rather significant condition that he had received ongoing treatments, for some time. These are clearly documented in the Workers' Comp records. There was a substantial degree of permanent physical impairment as a result of this preexisting 1987 injury.

Review of the medical records concerning this accident indicates absolutely no permanent aggravation or acceleration from an objective standpoint of the C5-6 spondylosis (arthritis and disc disease). There were a number of x-rays taken shortly after the accident and these were repeated approximately seven months later. There was no substantial change noted in Dr. Mourad's records and no worsening of the condition. The MRI scan that was performed only indicated disc disease and spondylosis. These findings were solely degenerative in nature. It is by the patient's history that the "aggravation" occurred according to the notes of Dr. Mourad.

The surgery was quite successful. He has no objective ongoing residuals of injury. He still has persistent soft tissue complaints that are virtually identical to those in the Workers' Compensation records. In my opinion, any reinjury that occurred as part of the February 1995 accident has resolved. His ongoing symptoms, in my opinion, are related to his chronic cervical strain or sprain which he suffered with for at least seven years prior to this accident in question.

Also on the basis of this examination, he has objectively recovered from any soft tissue injury sustained. There was a virtual normal physical examination no ongoing neurological symptoms or objective findings. The arthritic spine was "cured" by the surgical arthrodesis. The long term prognosis is favorable. No other MRI abnormalities were noted. No further care or treatment is necessary or appropriate.

He has received no medical care for over a year. It is not anticipated that any care or treatment would be necessary or appropriate in the future. He has objectively recovered. There is no evidence of any permanent aggravation or acceleration of his previous condition other than by the history present by the plaintiff.

Sincerely,

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

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