Highland
Musculo.Skeletal
Associates, Inc.

Robert C. Corn, M.D., F.A.C.S.
Timothy L. Gordon, M.D.
Orthopaedic Surgeons

March 1, 1997

Joseph G. Ritzler
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Mark Novak
Case No. 306687
File No. 12934-SF

Dear Mr. Ritzler:

I evaluated the above plaintiff in my office on January 20, 1997. This was specifically in reference to alleged residuals of injury stemming from a fall at a rental property on April 14, 1994. His medical history is somewhat complex. This will be discussed in the chronological sequence. The plaintiff was evaluated without legal counsel, family members or friends present.

His low back pain started when he sustained a work-related injury on February 11, 1991. At that time he was employed as a delivery man for the Crusader Office Supply's Company. In the course of his employment, in carrying a bookshelf, he fell of the back of the truck in a forced sitting position. He injured his low back.

He was followed over those two to three years by Dr. Bernard Charms and Parma Therapy with basically modality and stretching type exercises. The records have not been reviewed prior to 1994. He also was followed by Dr. Robert Anschuetz, an orthopaedic surgeon. The main treatment over these years was conservative in nature. Ultimately, a suspicion for lumbar disc herniation was developed.

Unfortunately, this Workers' Comp case got "lost in the shuffle" according to the plaintiff and he ultimately did not have the appropriate authorization to proceed with low back surgery until February 2,1994. At that time, Dr. Anschuetz admitted him on a 23 hour status to the Meridia Hillcrest Hospital at which time a micro lumbar discectomy was performed at the lowest vertebral level. This is somewhat confusion in the medical records in that this is sometimes called L4-S1 and sometimes L5-S1. To clarify, this is the lowest level of spinal movement and due to a mild congenital abnormality, there appears to be only four lumbar vertebrae. This is only **part** of the confusion.

After this surgery the severe testicular and groin pain which he had preoperatively gradually improved. There was some noted improvement in his left leg pain as well. He was still symptomatic when the slip and fall incident developed.

SECOND INJURY: This incident occurred on April 14, 1994, approximately six weeks after his low back surgery. He was living in a rental property at 921 Spring Road in Cleveland. A friend was visiting him. He walked off the back porch and down the driveway, and was walking towards the front door and a large wooden porch that was in the front of the house. Allegedly he stepped onto the flooring and it was "rotten". He fell directly downward into a hole up to the armpit level. He was able to climb out by himself while he was assisted by a friend. There was some increased back pain and some reoccurrence, initially, of his groin pain.

His initial medical contact was with the Deaconess Hospital Emergency Room Iater that evening with the complaints of "fell, injuring back and right thigh". He had a thorough examination, as well as a number of x-rays. He was discharged with a diagnosis of acute lumbar strain and a contusion of the right thigh. X-rays were performed and showed no evidence of fracture, subluxation, or arthritis. The general bony anatomy appeared to be normal.

He subsequently returned back to the care of Dr. Charms and underwent additional x-rays when evaluated on **April** 21, 1994. X-rays were repeated of his pelvis, **right**

knee, and sternum. No additional orthopaedic trauma or injury was noted. He was gradually started back on a physical therapy program once again, and returned to the care of Dr. Robert Anschuetz. It appears that he did not see Dr. Anschuetz nor was there any other diagnostic testing done for the bulk of 1994 into 1995. An MRI scan was performed on March 15, 1995, at Regional MRI of Parma. This showed a 2 mm posterior bulge and left paracentral protrusion at the L5-S1 level. This was the same level that was operated on previously. A scan with gadolinium to enhance the low back was repeated on March 23, 1995 at Parma, and again no additional abnormalities were noted other than some postoperative scarring. According to the results there was absolutely no mention of a higher herniated disc on either of these two studies.

He underwent a CT myelogram at the Meridia Hillcrest Hospital on April 11, 1995. This showed a left L3-4 posterior lateral disc herniation. They also felt that there was a previous lateral discectomy at this L3-4 level. Again there was some confusion concerning the appropriate level of surgery in that the MRI scanning techniques cannot identify each and every vertebral body and their appropriate level, especially on cross section.

It was Dr. Anschuetz's opinion that the fall on April 14, 1994 was responsible for the L3-4 lateral disc herniation and fibrosis, and responsible for his left leg sciatica. I did have an opportunity to review the MRI performed on September 16, 1996. To my review there was absolutely no abnormality at the L3-4 disc level. There was, at worst, a very slight bulging. Certainly there was no herniation of the L3-4 disc.

He last saw Dr. Anschuetz approximately two weeks prior to this evaluation (records not available for review), as well as Dr. Charms in late 1995. To date, in 1996, he has had some heat and ultrasound sessions, as well as a Medrol Dosepak. This gave him a severe headache. He also takes a muscle relaxant.

EMPLOYMENT HISTORY: He never went back to his delivery job that he had in 1991. He has had a number of jobs over the years, including working in sales at the Old Navy Store. He is currently working as a porter for a local Chevrolet Dealership.

He had some difficulty with the sales job in that it involved standing for prolonged periods of time.

CURRENT SYMPTOMS: At the time of this evaluation he still complains of some low back, groin, buttock, and bilateral leg discomfort. The groin pain is not as bad as it was prior to the surgery, but it has definitely recurred subjectively. He complains of a bilateral deep aching pain in his buttocks and both thighs. He believes the left side complaints are due to the Workers' Comp injury and the right side pain due to the fall through the flooring. He also has complaints of his right knee. X-rays were negative as noted above. He has difficulty squatting and kneeling. There were no radicular or radiating pains that go below his knee level. The bulk of the pain is concentrated in the buttock, thigh, and groin region. This is mostly on the right side.

PHYSICAL EXAMINATION revealed a 35 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 in a normal fashion. He was able to heel and toe walk without difficulty. No atrophy was noted in either lower extremity.

Examination of his lumbar spine revealed the well-healed, very small, one inch scar, compatible with the microdiscectomy performed six weeks prior to this injury. There was good flexibility of his lumbar spine being able to bend forward to easily touch the mid shin level. There was good reversal of his lumbar lordosis with this maneuver. Hyperextension, side bending, and rotation were performed without significant limitation. His straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. Specific examination of the right knee, including ligaments and other soft tissue components, were normal.

A detailed neurological evaluation including sensory, motor and reflex testing failed to show any objective abnormality. I could not detect any sciatic stretch or response on a Patrick figure four sign or in a straight leg raising which was normal bilaterally.

IMPRESSION: Chronic low lumbosacral disc disease status post surgery. Probable lumbar strain related to this accident with some recurrence of his back symptoms.

DISCUSSION: I have had the opportunity to review some medical records associated with his care and treatment. Records reviewed included consultation reports and records from the Parma Therapy and Dr. Robert Anschuetz, as well as records from Dr. Frank Picklow. A rather large packet of x-rays and scans from the Meridia Hillcrest Hospital were actually 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 conclusions concerning the plaintiffs ongoing level of physical impairment.

As stated above in the body of the report, there seems to be some confusion in the x-ray interpretation in that there appears to be only four lumbar vertebrae. The numbers seemed to be interchanged between "L4-S1" and "L5-S1". The herniated disc that was operated on, prior to the accident in question in this evaluation, was at the lowest vertebral segment which would be between the last lumbar and first sacral vertebrae, Residual disc bulging was noted on the most recent MRI scan. No evidence of herniation or nerve root impingement was noted.

On review of the actual MRI scan there was no herniation of the L3-4 disc noted whatsoever. There was a generalized bulging, both anteriorly and posteriorly, but, to my review, no gross herniation. It is my opinion, therefore, within a reasonable degree of medical certainty, that no new L3-4 disc herniation occurred as a result of the second incident. No further surgery is indicated or appropriate.

At the time of this evaluation, he had objectively recovered from any soft tissue injury sustained. He still complains of **pain** on a daily basis. It was unclear from the review of the records to date, whether there was an aggressive physical therapy exercise program, including flexibility and strengthening exercises. The complete records from Dr. Charms and Parma Therapy, as well as Dr. Anschuetz, have been requested. This

specific time frame of interest was whether there had, in fact, been **any** pain free episodes since 1991.

On the basis of this evaluation, the long-term prognosis is favorable. There are multiple levels of degenerative disc disease and some residual disc bulging at the surgical level. At the time *ofthis evaluation, there was no objective correlation **with** his ongoing symptoms and the findings of the MRI scan. He still complains primarily of back pain with no radicular or radiating pain below the knee joint level. On the basis of this evaluation, no surgical procedure is necessary or appropriate. There has been good objective recovery to date. An ongoing home flexibility and strengthening spinal conditioning program is necessary as a "maintenance" therapy for his chronic back conditioning. In general, the prognosis is favorable.

Sincerely,

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

RCC/bn

cc: File

NOVAK, **Mark**
3/31/97 Patient was originally evaluated for an IME exam earlier this month.

New records were obtained from Dr. Picklow and the actual x-rays from Deaconess Hospital.

The original opinions are unchanged. (RCC/bn)

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March 1, 1997

William T. Neubert
Attorney at Law
Suite 616 - The Arcade
401 Euclid Avenue
Cleveland, OH 44114

RE: Patricia Wolf
Case No. 327279
DOI: 7/9/95

Dear Mr. Neubert:

I evaluated the above plaintiff in my office on October 23, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on July 9, 1995. Throughout the history and physical her husband and her attorney, Mr. Jerry Davidson, accompanied her.

As you are aware the past medical history of this patient is quite complex. He has had a long-standing problem of arthritis and disc disease with back and right and left leg numbness since the summer of 1984. She has had a number of diagnostic workups for both her neck and her low back, including MRI scans which revealed disc disease and, in fact, disc herniations. These will be discussed in part below. She did have EMGs and nerve conduction studies done as far back as 1984 which were consistent with radiculopathy at the low lumbar levels. CT and MRI scans have shown significant disc bulges, as well as arthritis since August of 1994. There is also clear evidence in the medical records of significant ongoing problems including back and leg pain, as well as leg weakness and symptoms of a foot drop prior to the motor vehicular accident in question.

MEDICAL HISTORY: She was the driver and solo occupant of a late 1980's Volvo sedan on a residential street, Canterbury Road in Bay Village, Ohio. A car apparently pulled out of a side driveway and struck the passenger side of her vehicle. She described this other car as "flying down the driveway". She tried to avoid the collision but a passenger rear impact occurred. The car was spun in a clockwise direction. She sustained a twisting injury to her neck and low back. She was wearing a seatbelt. Police were on the scene. There was no emergency room visit and her vehicle was drivable.

After the accident she did not seek any medical attention until she returned to her family physician, Dr. Below. She had seen this physician both nine days before this accident, on June 30, 1995, and also the day before the accident, complaining that the "left foot drags while walking". It was not until approximately three weeks after the collision when she again revisited Dr. Below and physical therapy was initiated. The date of his re-evaluation was on August 2, 1995. At that time she reported that her left leg was numb. At this point the physical therapy was re-initiated. Dr. Below saw her again on August 30, 1995 and then not again until January of 1996.

During this interim she consulted with Beachwood Orthopaedics from August 3, 1995 to October 17,1995. Physical therapy was performed during this period of time at the St. John and Westshore Hospital from August 17, 1995 until September 6, 1995.

An MRI scan was performed at the St. John and Westshore Hospital of the lumbar spine which showed essentially spinal canal stenosis L2-3, L3-4 and L4-5. There was a questionable degenerative disc protrusion at the L2-3 level. EMGs and nerve conduction studies were also performed that showed some mild neuropathy consistent with lower lumbar or upper sacral nerves but definitely not diagnostic. Subsequent EMG done in 1997 showed similar findings which were felt to be a polyneuropathy possibly due to her old alcoholism. Dr. Kaufrnan's working diagnosis was, by history, an acute exacerbation of her lumbosacral disc disease.

Since that time she was followed by Dr. Below who has been managing her somewhat conservatively. He has tried a variety of medications with intermittently

favorable results. Additional studies have been performed including, on July 7, 1997, and Open MRI scan of her lumbar spine. She has also had an MRI scan of her cervical, as well as thoracic spine. Recently she has was evaluated by a neurosurgeon, Dr. Atef Eltomey. She has had no further diagnostic studies that she could recall. These records have not been made available for review.

CURRENT SYMPTOMS: At the time of this evaluation she still had some ongoing symptoms. She stated that her back was "pretty good" prior to the motor vehicular accident with no numbness of weakness in her left leg. This is clearly not what is shown in the medical records with the "foot drag" clearly manifesting itself in the pre-injury period. She still complains that her left leg feels weak and has become worse since the time of the accident. She occasionally catches her foot when she is more fatigued. She said on a number of occasions that this did not start until "after the car accident". Since the time of the accident she also noted that both legs are progressively getting worse with increased pain and diminished walking distance, and difficulty with activities around the house. When she travels she uses a cane in her right hand. Housecleaning and vacuuming seem to bother her with increased pain and numbness. The bulk of her symptoms seem to be in her lower extremities. She generally feels that her waking is becoming more difficult as well as difficulty "maneuvering".

Other symptomatic areas include the left upper back and trapezius muscles. She also complains to have some diffuse numbness in both of her hands. This is the reason that she went to see Dr. Eltomey who did a workup during the summer months of 1997.

EMPLOYMENT HISTORY: She was previously employed as a critical care nurse in 1993 when she retired. She also worked in the chemical dependency unit.

PAST MEDICAL HISTORY clearly notes longstanding problems with her low back. She was hospitalized and had a series of diagnostic testing which showed diffuse degenerative arthritis and degenerative disc disease. She even went as far as to have a neurological consultation in the mid and late summer months of 1984. According to Dr. Below's records she clearly has had some ongoing complaints of

pain since he started her care in February of 1990. There has been numerous references to left sided low back, left leg pain, and weakness, as well as numbness and tingling in the left buttocks and down to her left foot. These have been repeatedly complained about since the spring of 1991. As noted, Dr. Below saw her on a number of occasions just prior to the accident. On June 30, 1995 she had diffuse complaints of pain in her low back with numbness in both of her legs. On this same date she also complained that when she walks she begins to drag her left foot. These symptoms seemed to have gotten worse over the past month prior to that. Again on July 8, 1995, she had complaints of the left foot dragging while walking, indicating that the spinal canal stenosis was symptomatic right before the motor vehicular accident.

I was able to review the MRI scan of her cervical spine done on August 25, 1997. This did reveal some congenitally small spinal canal with some degenerative disc osteophyte formation at C5-6 level, as well as similar changes, but to a lesser extent, at the C6-7 level. There was no spinal cord compression at the C7 level. There was, however, some narrowed foramina compatible with her arthritis and disc disease.

The actual MR scans were also reviewed from July 7, 1997 of her low back. I agree with radiological interpretation.

She also has a rather strong psychological history with chronic complaints of pain for many years, as well as a history of substance abuse and chronic depression. Records from the Social Security Administration were available, clearly indicating chronic complaints of back dysfunction.

PHYSICAL EXAMINATION revealed a pleasant 61 year old female who appeared in no acute distress. She was observed waking short distances in the office in the exam room, and to and from the medical building to her motor vehicle. There was no limping detected. She was able to stand on her heels and toes without difficulty. No gross atrophy was noted in her lower extremities. Arising from a sitting position was done with minimal difficulty. Ascending and descending the exam table was performed in a very minimally labored fashion.

Examination of her neck and upper back revealed no signs of spasm, dysmetria, and muscular guarding or increased muscle tone. No muscle atrophy was noted in the neck, **upper back,** or periscapular muscles. No tenderness was noted in the sternocleidomastoid or scalene muscle group. There was no anterior or retoclavicular discomfort noted. The bulk of her subjective pain was in the trapezius muscles which seemed to be tender but no objective abnormalities were noted. Protraction, retraction, and elevation of the scapulae were performed normally. Range of motion of the cervical spine showed minimal diminished motion, approximately 85% of her normal predicted range of motion were observed. Range of motion of both shoulders was 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 normal. No atrophy was noted on circumferential measurements of her upper extremities at the axillary, midarm, forearm or wrist level.

Examination of her lumbar spine revealed most of her discomfort being at below the level of the iliac crest. There was some limitation in forward flexion and hyperextension that was not associated with spasm, dysmetria, muscular guarding, or increased muscle tone. Lateral bending and rotation were restricted. Her total restriction of motion was about 20-25% of predicted normal. Her straight leg raising both actively and passively was performed to 90 degrees in the sitting position. There was good motor strength noted in both lower extremities. No atrophy was noted on circumferential measurements of her upper and lower thigh or upper and lower calf level. Neurologic exam of both lower extremities revealed some slight hypoactive ankle jerk reflexes. These were symmetrical bilaterally.

IMPRESSION: Chronic arthritic and disc problems involving her cervical and lumbosacral spine. Related to this accident, a probable lumbosacral strain with a subjective aggravation of her symptoms. She clearly had symptoms of numbness and weakness just prior to the motor vehicular accident in question.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from Dr. Richard Below, Dr. Richard Kaufman and Beachwood Orthopaedics, Dr. Michael Bahntge,

Dr. Waghray (previous treating physician), records from Dr. Phillip Barry, St. John and Westshore Hospital. Records were requested but not yet received from Dr. Eltomey. Records were also reviewed from the Rehabilitation Services Commission and The Social Security Administration.

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.

The details of the motor vehicular accident as well as any property damage were not discussed. She did not, as you are aware, seek any immediate medical attention. In my opinion, due to the fact that she has had a longstanding back problem, it is somewhat incredible that if she felt she had an injury that she ignored this for a number of week. In individuals with a chronic problem and with an acute exacerbation seek medical attention and some remedy to their complaints in a very short period of time. In my opinion, there was not a substantial injury to her low back. **At** worst there was a subjective aggravation in a previously symptomatic condition involving both back pain, as well as leg pain and weakness. The diagnostic studies that were performed in the months after the motor vehicular accident were probably indicated on the basis of her early July 1995 symptomatology. **A** new workup, including an MRI scan and EMGs and nerve conduction studies would have been appropriate solely based on her complaints prior to the motor vehicular accident.

These studies; however, did not show any thing new. There may have been some slight progression over the years of her degenerative arthritis and disc disease which is normal and appropriate. This is the natural history for this phenomena. On the basis of this evaluation no traumatic objective abnormality was noted on review of the diagnostic workup.

It is my opinion, within a reasonable degree of medical certainty, at worst, she sustained a lumbar strain or sprain injury. There is no permanent aggravation or acceleration of her preexisting condition which was quite symptomatic and significant prior to the car accident. The fact that she did not seek any immediate

care and attention also lends credibility to the fact that this was a somewhat less than significant injury sustained to her spine. She still has some ongoing symptoms which, in my opinion, are related to her chronic degenerative condition. In my opinion there is no objective evidence that these conditions were permanently aggravated or accelerated. There may have been a transient **subjective** aggravation as noted in the medica1 records. There was inconsistency between the history presented and the medica1 records provided for review.

In my opinion, the long-term prognosis is favorable for any soft tissue injury sustained. The natural history of her arthritis precludes recovery from this condition. This will undoubtedly worsen with time. In my opinion, any worsening in the future would be unrelated to this singular episode of trauma.

Sincerely,

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

RCC/bn

cc: File