Highland
Musculo-Skeletal
Associates, Inc.

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March 22, 1997

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RE: Nicholas Pirovolos
Case No. 294156 (Cuyahoga Co.)

Dear Mr. Hanson:

I evaluated the above plaintiff in my office on March 11, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on August 29, 1993. He was examined on that date without friends, family or legal counsel present. This case has a degree of complexity. It appears that most of the ongoing treatment has been related to his subjective symptoms only. He had a barrage of testing done initially after the accident, surgery on his right shoulder, and a series of spinal manipulations under anesthesia. This latter, as will be discussed below, is somewhat unusual.

He presented with the history that on August 29, 1993, he was the driver and solo occupant of a late model Cadillac heading on Route 21 near Lodi, Ohio. Route 21 was described as a four-lane highway, two lanes in each direction with a median strip. In the Vicinity of Edwards Road, a motor vehicle allegedly pulled out from the driver's side median. He was unable to avoid the collision. The front driver's side of his vehicle hit the passenger side of the oncoming car. His car then went off to the right berm and toward a ditch. There was questionable loss of consciousness. He was able to get out of the car, being assisted by individuals in the vehicle that was following

him. It was estimated that he was traveling at the speed limit, approximately 55 miles per hour. According to the Highway Patrol report, he was not wearing a seat belt.

He was evaluated at the scene and conveyed by ambulance to the Barberton City Hospital Emergency Room in Barberton, Ohio. At that time the major complaints were pain in the right side neck, right shoulder, and right chest wall. There was a question of whether he hit the windshield with his forehead. There was; however, no obvious signs of trauma. There was diffuse chest wall discomfort, especially in the right axillary area. The right shoulder discomfort seemed to change on different portions of the examination. Initially he was able to move his shoulder fairly well and then it appeared to stiffen up. Within a short period of time a right rotator cuff tear was diagnosed. He was ultimately discharged with a diagnosis of "closed head injury, right shoulder and chest wall contusion, and bilateral lumbar muscular strains".

He was subsequently referred by "my lawyer" to Dr. John Kostoglou, a chiropractor affiliated with Parmatown Chiropractic Clinic. Within a very short period of time multiple testing was performed. He was sent to Dr. Harold Mars, a neurologist, on September 1, 1993, who on that date performed an EEG which was essentially normal. Dr. Mars saw him for six additional visits from September 20, 1993 through June 24, 1994, evaluating his subjective neurological symptomatology.

He also underwent a series of MRI scans done at the Regional MRI of Parma. These were all done on September 3, 1993. An MR of his brain was normal, the MR scan of his cervical spine showed some C5-6 degenerative disc disease and an MR of the right shoulder was highly suggestive of a large right rotator cuff tear. X-rays were performed of his right wrist on September 10, 1993, and approximately a year later OR October 4, 1994, low back x-rays were performed at the same institution. This revealed only degenerative disc disease and some spondylosis. There were no traumatic abnormalities noted.

Because of his right shoulder symptoms he was referred to Dr. George Kellis, who saw him initially on September 3, 1993. At that time he was unable to raise his right arm. Dr. Kellis reviewed his MR scan and had an arthrogram performed and reviewed

at the time of his second visit on September 17, 1993. A large rotator cuff tear was found and surgery was recommended. This was performed on September 28, 1993, in the form of a right rotator cuff repair. He was immobilized for a period of time and then followed subsequently in late November and December of 1993.

His postoperative therapy for his shoulder was carried out at the Tarpen Harbor Rehab Agency in Tarpen Springs, Florida. This was initiated in late January of 1994, and carried out during his travels to Florida. He seemed to have been recovering nicely. A consultation letter to Plaintiffs attorney dated August 16, 1994, presented the opinion that the rotator cuff tear was directly related to the accident. There is no evidence in the medical records to indicate any other pre-existing trauma. This was probably correct.

Through the bulk of 1994 there were very little records available. He apparently spent an extended period of time in Florida and later that year in Greece. He was evaluated by Dr. Kellis on July 13, 1993, with continuing shoulder pain. Apparently he was "rushing" his physical therapy and it was felt by Dr. Kellis that he "re-tore his cuff' tear. The plaintiff could not recall any follow up beyond the summer of 1994. He continues with shoulder discomfort and has had only chiropractor follow up. His shoulder surgery was done at the Lutheran Medical Center.

Although not discussed at the time of the evaluation, he was apparently treated for a number of problems in 1995. Dr. Kellis saw and treated him for a right trigger thumb with a tenovaginotomy under local anesthesia at the St. Vincent Charity Hospital on May 11, 1995. The medical records did not show any direct cause and effect relationship between his thumb condition and the motor vehicular accident in question.

Also in 1995, he underwent a somewhat unusual type of treatment. He underwent manipulations of the spine under anesthesia on three consecutive days, May 21, 22, and 23, 1995. He could not recall the name of the physician that did this. Parenthetically he was cleared for surgery by Dr. James Zelch, a radiologist.

The major treatment he has had has been on a subjective basis by two chiropractic centers, the one run by Dr. Kostoglou at Parmatown Chiropractic, and Thomas Chiropractic Center in Palm Harbor, Florida. Treatments can be as often as two to three times a week. He continues to see these physicians on a routine, as needed basis. He could not recall the last time he saw Dr. Kellis.

CURRENT MEDICATIONS include on Relafen which he takes on a very occasionally basis and Vicodin for severe pain. He cannot recall the last time he took the **pain** medication.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries or problems. He did have a ruptured appendix as a young man and suffers from recurrent peptic ulcer disease.

EMPLOYMENT HISTORY: He is employed as an evangelistic minister. Although he tried to explain what his job really consists of, I have a difficult time putting this into words. He states he does interdenominational motivation speaking at local churches and through various prison systems. He claims to have been doing this for approximately 25 years. There was a period of time he was unable to do these speeches. He did claim at one point in time to have done over 250 speeches within one calendar year. He could not recall how long a period of time that his work was affected by his alleged soft tissue injuries.

Other treatments, although not mentioned in the medical records, were he did have a number of spinal injections for pain. He could not recall who performed these or where these treatments were provided. He has also consulted with a psychologist.

CURRENT SYMPTOMS: At the time of this evaluation he continued to have a variety of symptoms involving his neck, upper back, midline spinal pain, as well as some ongoing radiating discomfort. A sliding pain scale was discussed with the patient. This ranged from a "1 to a 10". A level "1" was a pain that was barely perceptible, and a level "10" was a pain that was so severe that no human on **earth** could stand the **pain** for more than five seconds. Despite this definition he claimed his

**pain** at best was a level "8" and at worst was a level "10". He claimed a level "9" of all his **pain** at the time of this evaluation.

Specifically in his cervical spine, he complained of a longitudinal **pain** from the base of his skull to the buttock crease, described as a deep aching pain. This did not radiate. It seemed to be constant. It was worse when he would stand and walk. It ranged from a "8 to a 10".

In addition, there was a diffise aching **pain** primarily in the trapezius muscle, slightly more on the right than the left. This was described as a deep ache, burning, and stabbing **pain** intermittently. He also claimed to have some aching along the posterior aspect of his right arm and aching with pins and needles around his right thumb.

In reference to his lumbar spine, he described an aching and pins and needles pain across the iliac crest region. This did not radiated and seemed to be fairly well localized in the lumbar paraspinal muscle area. He also claimed to have pins and needles along the anterior and posterior aspect of both thighs.

Concerning his right shoulder, he complains of a diffuse aching pain. The shoulder remains weak. He did not discuss any further care or treatment other than the rotator cuff repair and his physical therapy. He did not discuss the concern of a "re-tear" as mentioned in Dr. Kellis' records.

PHYSICAL EXAMINATION revealed a pleasant 50 year old male who, despite the level "8" pain, appeared comfortable throughout the entire examination. He was to stand, sit, and walk without difficulty. He was able to arise from a sitting position without any visible distress. Ascending and descending the examining table was performed in a normal fashion. His ability to walk was normal and no limping was detected. He was able to stand on his heels and toes, and ambulate without difficulty.

Examination of his cervical spine failed to show any spasm, dysmetria, or muscular guarding. He claimed diffuse tenderness in the trapezius muscle, the right side slightly worse than the left. There was; however, no objective correlation with these

symptoms. Range of motion of the cervical spine was performed without limitation in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of both scapulae were performed normally. There was no signs of disuse atrophy in the neck, upper back or periscapular muscles. No spasm, dysmetria, muscular guarding or increased muscle tension was noted in this area.

Examination of his right shoulder revealed a longitudinal scar compatible with his surgical history. This appeared to be well healed and was non-tender. There was a full passive range of motion of the right shoulder, but an active range of motion only to 140 degrees of forward flexion and 120 degrees of abduction. Internal and external rotation was normal, There was a claim of internal rotation causing neck, upper back, and right shoulder discomfort. The elbows, wrists and small joints of the hand examined normally, There was a well healed scar at the base of the right thumb compatible with the surgical history.

A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was performed. This was entirely within normal limits. No atrophy was noted on circumferential measurements of the midarm, forearm, or wrist level. There appeared to be some local diminished muscle volume in and around the right deltoid region.

Examination of his thoracolumbar spine revealed a claim of tenderness from essentially the base of his skull to his buttock crease. There was good muscular development of the paraspinal muscles and no spasm, dysmetria or muscular guarding was noted. In the iliac crest region he claimed to be sore along the bony structure. There was no objective correlation with this. Range of motion of the lumbar spine was performed without difficulty, bending forward to touch the mid tibia level. There was good reversal of his lumbar lordosis with this maneuver. 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. A detailed neurological examination including sensory, motor and reflex testing of both lower extremities was normal. Circumferential measurements of both lower extremities at the upper and lower thigh, and upper and lower calf level, were equal and symmetrical bilaterally.

**IMPRESSION:** By history, probable right rotator cuff tear. Cervicothoracic strain or sprain. MRI evidence of degenerative changes in the neck and low back. These are not related to trauma.

DISCUSSION: I have had the opportunity to review a number of records associated with his care and treatment. These included *the* State Highway Patrol, Ohio Traffic Crash report, Barberton City Hospital, St. Vincent Charity Hospital, Lutheran Medical Center, and the Parma Community Hospital. Records were reviewed from the Richfield SurgiCenter, the Cleveland Spine and Arthritis Center, Thomas Chiropractic Center, Parmatown Chiropractic Center, the Tarpen Harbor Rehab Agency, Regional MRI of Parma, Dr. Harold Mars, and various billing statements.

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.

In my opinion, the initial care and treatment was somewhat extensive on the basis of only soft tissue symptoms. I am excluding his right shoulder in this part of my discussion. Within a week's period of time, he saw a neurologist, had three MRI's, and was scheduled for an orthopaedic evaluation for this right shoulder. There was no indication of the neurological necessity of an MRI of the brain, cervical or lumbosacral spine. There was evidence of a need for the right shoulder scan.

He has received only chiropractic treatment for his ongoing spinal complaints. The decision for these appeared to be solely based on subjective indications. Other than minor degenerative changes in his neck and low back, no significant abnormalities were ever noted. He describes a significant amount of pain over a long period of time, purely soft tissue in nature. His level of **pain** and his general appearance did not match at the time of this exam. He clearly did not appear or move as someone who is in a level "8 or 9" degree of pain. It is also my opinion there was no particular indication in the records for the need of a spinal manipulation. This series of treatment and care in May of 1995, was somewhat unusual. It did not have any long term subjective benefit.

In reference to his right shoulder there is clear reasonable cause and effect relationship between the onset of his right shoulder symptoms and the right rotator cuff tear. Although there was probably some degree of degeneration there was no claim or evidence of prior medical treatment for his right shoulder. The MRI scans and the surgical findings seemed to correlate. There was report of a good early result for the first six months after his rotator cuff repair. There was some indication by Dr. Kellis that he may have retorn his tear. If this, in fact, did occur then his current symptoms are related to a reinjury and not the original trauma.

In summary, there is a paucity of objective findings to support his ongoing subjective complaints. There is not a great deal of spinal pathology that was noted in the medical records after diagnostic workup. Clearly, none of these were traumatic in nature. The plaintiff continues with ongoing chiropractic care without any clear orthopaedic explanation for his severe level of pain. There was no direct correlation at the time of this evaluation with a level "8" pain. The physical examination was, other than the right shoulder exam, within normal limits.

On the basis of this evaluation, he has objectively recovered from any soft tissue injury sustained to his spine. His ongoing right shoulder symptoms can be related to a reinjury to his right shoulder. The long-term prognosis is favorable. On the basis of this examination, no further care or treatment is necessary or appropriate from an objective standpoint.

Sincerely,

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

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