Highland
Musculo-Skeleta
Associates, Inc.

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April 1, 1997

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RE: Benjamin Rice
File No. 14189-A
Case No. CV 96 06 2200 (Summit Co)

Dear Mr. Kuri:

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 July 21, 1994. This case, as you know, is somewhat complicated. There have been a number of operations performed on his low back. He stated that prior to this injury, his low back was "fine". He claimed to be an athlete playing basketball in a number of leagues, as well as volleyball, softball, etc. He stated that he even went for a long bicycle ride on the day prior to this accident.

The accident, as he recalls, he was the driver and solo occupant of a 1986 Buick Regal vehicle at approximately 6:35 in the evening on July 21, 1994. He was heading north bound on South Hawkins in a light commercial area. At the intersection of Wooster he was going through the intersection when a car pulled out from the driver's side in front of his car. He was unable to avoid the collision and there was a kont end impact with the rear quarter panel of this passenger van. His vehicle was "totaled".

He stated he had the tow **truck** driver tow his car "back to my home so my insurance company and lawyer could see it". He did not go to the emergency room Immediately.

When his girlfriend came home from work she took him to the emergency room Iater that day.

He was initially evaluated at the St. Thomas Hospital Emergency Room complaining of low back and neck **pain.** There was a history presented of a car accident four to four and a half years prior this accident. The records indicate a "broadside" collision. X-rays and an examination were performed. X-rays of his low back showed endplate sclerosis at the L5-S1 level suggestive of degenerative changes. He was discharged with a diagnosis of acute cervical and lumbosacral strain, indicating soft tissue and/or muscular injury. He was essentially treated and released.

The following day he went to see Dr. Roger Farreri, his family physician. Dr. Farreri is in general practice and pain management. Mr. Rice was a previous patient of this physician, being seen prior to this motor vehicular accident on or about May 20, 1994. It was quite difficult placing Dr. Farreri's notes in precise order. He was complaining of **pain** in the right buttock and right sacroiliac joint, as well as in the gluteal region OR the right side. It appears that he was being seen on a regular basis through the early months of 1994, being followed for both his diabetic condition and, what appears to be chronic back pain. Dr. Farreri started him on a series of physical therapy treatments, some at his office. He also stated that he went to Dr. Farreri every day for a period of time for daily **pain** injections. This was no documented in Dr. Farreri's records. He claimed to have low back and worsening leg **pain** from the time of the injury. He was managed conservatively.

His hours at work seemed to diminish through October and November of 1994. Allegedly he used sick days and vacation days. He stated the last time he worked during this time period was on December 5, 1994, and literally had to be "carried out of work and taken to the doctor's office". He was employed as a service technician and did training for Diebold on ATM machines.

He stated in early December of 1994, but actually on January 4, 1995, he was re-evaluated by Dr. Barry Greenberg, a orthopaedic spinal surgeon affiliated with the Crystal Clinic. Dr. Greenberg had previously seen him in May of 1989. Diagnostic workup at that time showed bulging of the L5-S1 disc, but no neurological deficit. It was felt that, as a result of this previous injury, that the plaintiff incurred "discal injury at L5-S1 which has caused chronic low back pain and muscle dysfunction".

On his re-evaluation on January 4, 1995, he states there have been "several' motor vehicular accidents. It clearly states in Dr. Greenberg's notes that prior to a short period of time before this re-evaluation in January of 1995, he had mostly **back pain** with intermittent leg pain. Approximately a week and a half prior to Dr. Greenberg's re-evaluation he began having severe leg pain in both legs with marked straight leg raising. An MRI scan done in September of 1994 suggested degeneration at the L5-S1 level. This was not significantly different than what was previously diagnosed in 1989.

A new MRI scan was ordered. He was seen by a neurologist and diabetic neuropathy was ruled out . The new MRI scan in early 1995 showed a "huge extrusion" of the L5-S1 disc. It was felt that he needed to undergo a surgical procedure in the form of an L5-S1 disc excision. It is clear that there was a significant difference in the description of the MRI of September of 1994, two months after the accident, and the MRI in early 1995. This clearly indicates the "huge disc herniation'' occurred after the September 1994 incident.

There were two operations performed during the next two months on his lower lumbar spine. The first was on January 14, 1995. This involved a wide decompression from L4 to the sacrum and two large herniated disc fragments were noted. **A** foraminotomy was also performed to open up the spinal canal. Initially he was noted to have done well after his operation but then his condition worsened once again. **A** new MRI scan was done in February of 1995 which showed a recurrent disc herniation at the L5-S1 level. **A** re-operation was recommended and performed on February 21, 1995. **A** large sequestrated disc material at the L5-S1 level with multiple large fragments were also removed. Essentially, the same disc level was operated on. The second surgery

he felt did not help him to a great extent. Subsequ ntly he went through physical therapy at the Crystal Clinic and ultimately back to work on a light duty status on June 1, 1995. He claimed to have been out of work from December 5, 1994 until June 1, 1995. In his work be was not supposed to do any lifting or bending and to work only as a "advisor".

He stated that he was back to work for a very short period of time when his diabetes severely flared-up. He has been followed by a number of physicians for this. He was out of work from July of *1995* through March of 1996. He then went back to work, worked for 3 weeks and he sustained a new foot injury on or about March 28, 1996. This was to the dorsal aspect of his left foot. He was evaluated at the Cleveland Clinic for this and has not worked since March 28, 1996.

He continued intermittently to be followed by Dr. Gresnberg, being seen in the end of November of 1995. It was noted in Dr. Greenberg's record that he, in fact, had had a stroke, as well as a heart attack. This was primarily due to complications of his diabetes. New EMG and nerve conduction studies were recommended which showed a peroneal neuropathy. It was not sure whether this was due to his low back condition or his diabetic condition. He continued with physical therapy for his foot condition. Follow-up x-rays showed continuing degeneration at the L5-S1 level and a third surgical procedure was ultimately recommended. This was performed on November 12, 1996 which was an L5-S1 fusion with left iliac bone graft and the implantation of an internal bone stimulator. He was in a spinal brace for a period of time and was just weaning out of this approximately two weeks prior to this evaluation. He has just started physical therapy on his back approximately two weeks ago. He continues to follow with Dr. Greenberg. The most recent visit was in February of 1997.

PAST MEDICAL HISTORY revealed "no problems with my back". He explained to me a motor vehicular accident in 1992 in which he sustained a "strain". Only therapy was recommended. He neglected to mention the severity of his back condition in the late 1980's and the fact that the L5-S1 disc was noted to be abnormal as long as five years prior to this motor vehicular accident.

He also claimed that up to the age of 35 he was playing semi-professional basketball and semi-professional baseball on the east coast. He stated he was active in sports up to the 1994 accident. He did not freely discuss his prior back condition.

CURRENT SYMPTOMS: At the time of this evaluation he had been in his physical therapy program for two weeks. He goes three times a week. These are the days he has the most recurrent pain problems in his low back. He also claims to have a radiating pain in his left leg and foot, as well as left foot "spasms".

In general, his back pain has diminished since the time of the surgery. It only worsens with increased activity. The left leg also is improved since the last surgery. Activity also worsens his leg pain. This is described as diffuse burning and aching in nature in the midline and left side paraspinal area. He claims there is patches of numbness and tingling in his left lower extremity as well.

CURRENT MEDICATIONS include Vicodin for severe pain, one every 12 hours or Tylenol #4 every six to eight hours as necessary. He also takes Valium to help him sleep.

PHYSICAL EXAMINATION revealed a pleasant, somewhat subdued, 47 year old male who appeared in some distress. He tended to complain of pain throughout the entire exam. He seemed to be uncomfortable trying to get a comfortable position. His gait pattern; however, was normal. He was able to stand on his heels and toes, but claimed that this caused pain in his low back. On inspection there was no gross atrophy noted in either of his lower extremity. There was numerous healed and unhealed skin sores on his lower extremities.

Examination of his lumbar spine revealed well-healed midline scar compatible with his surgical history. There was also a left oblique incision for the bone graft site. There was very poor flexibility of his lumbar spine. He could barely bend forward in the standing position to touch the mid thigh level. However, in the sitting position he could bend down to the mid tibia level. Hyperextension, lateral bending and rotation

was also severely limited by 35 to 40% of predicted normal. Although no spasm was noted, there was a great of muscle guarding. It was difficult to tell whether this was involuntary or voluntary in nature. His straight leg raising in the sitting and supine positions were performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. His leg lengths were equal. Circumferential measurements of both lower extremities at the upper and lower thigh, and upper and lower calf level, showed less than one-quarter inch of atrophy in the left thigh as compared to the right. Neurologic examination revealed diffuse weakness on muscle testing. This did not correlate with a lack of atrophy below his knee level. He claimed to have decreased sensation in a mixed type of pattern. Some of the pattern was the L3 nerve, but there was other patches of L4, L5 but no S1 diminished sensation. Vascular examination revealed diminished pulses in both lower extremities.

IMPRESSION: Probable lumbosacral strain or sprain. Previously diagnosed degenerative disc disease at the L5-S1 level. No disc hemiation as a direct result of the motor vehicular accident in question. The L5-S1 disc hemiation occurred in late 1994.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include comprehensive records from the St. Thomas Medical Center, Professional Therapy Associates, Akron Radiology, Diebold, Inc., Drs. Barry Greenberg, Grant Heller, and Robert Farreri, and records from Endocrine Associates and William Schiavone.

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,

It is quite clear that this gentleman's medical history is quite complex. This was made even more complicated by the lack of the patient's straightforwardness in explaining the details of his medical history. Clearly this plaintiff did not have a normal back prior to July of 1994. According to the records from his treating physicians he was

symptomatic with right low back and right sacroiliac joint pain within two months of the motor vehicular accident in question. The early diagnostic workup including an MR scan in September of 1994 did not show any disc herniation. The disc herniation only became apparent after the episode in late December when he began having severe bilateral leg pain. It is my medical opinion, within a reasonable degree of medical certainty, that the disc herniation was not a direct result of the motor vehicular accident in question. There was an MR that did not show a herniated disc two months after the car accident and a second MR that showed the disc herniated at the end of December of 1994. This correlated well with the clinical picture. The facts did not correlate with the patient's claim of his back condition stemming solely from the motor vehicular accident in question.

There was a period of time that he lost work. It was not clear by the medical records that this was related at all to the motor vehicular accident in question. This period of time was lost after the disc herniated and his two early back surgeries. The time out of work related to his diabetic complications, his stroke and heart attack, were clearly unrelated to the motor vehicular accident in question. All surgeries involved, in my opinion, were unrelated to the motor vehicular accident in question. These were more likely than not related solely to his progressive degenerative disc disease of the lumbar spine primarily at the L5-S1 level. This was diagnosed as early as 1989 and showed a clear progression over the years. It was the degenerative disc disease that resulted in the most recent surgery for which he is recovered

The substantial abnormalities on the clinical examination, in my opinion, are due to his stage of recovery from his most recent spinal surgery. The lumbar spine was still quite stiff, but one recalls that he was only two weeks out of his brace and just starting his low back physical therapy.

The long-term prognosis is guarded. He has a substantial medical condition with complications. There is clearly a long standing history of degenerative disc disease in his low back. Despite the claim of no prior problems before this 1994 car accident, there is clearly, according to the medical records, substantial objective abnormalities

including ongoing symptoms. As noted above he was not entirely honest in his description of his prior medical condition.

In my opinion, his overall condition will improve with the physical therapy that is contemplated. His current condition does not reflect any residual abnormalities solely related to the July 21, 1994 motor vehicular accident. Clearly the problems with the L5-S1 disc became much more severe and included a disc herniation. This, in my opinion, did not occur until December of 1994, five months after the motor vehicular accident in question. There is no direct chronological cause and effect between his lumbar disc herniation and the motor vehicular accident in question. His long term prognosis remains guarded solely on the basis of his progressive multiple level lumbar degenerative disc disease, as well as the multiple spinal surgeries. The herniated disc was not a result of the motor vehicular accident nor was the subsequent surgeries and/or care and treatment. In my opinion, he sustained a strain or sprain of the lumbar spine only. There was no objective residuals of injury from this soft tissue trauma. His current condition reflects his degenerative disc disease and failed low back surgeries.

Sincerely,

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

RCC/bn

cc: File