Highland
Musculo-Skeletal
Associates, Inc.

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April 2, 1997

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RE: Kathleen J. Meador
Case No. 296633,296946 (Cuyahoga Co)
File No. 3430

Dear Mr. Fillo:

I evaluated the above plaintiff in my office on March 4, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 23, 1994. Throughout the history and physical she was accompanied by her husband, Byron.

She presented with the history of being a front seat passenger in a Mazda MX6 vehicle that was her vehicle, but being driven by her daughter. He grandson was in the rear seat. The accident occurred in the Gates Mills/Mayfield Village vicinity at the intersection of Cedar and Lander Roads. She was heading an east bound direction on Cedar, waiting to make a left hand turn to go north bound on Lander. A rear end collision occurred. This happened at approximately four o'clock to six o'clock in the evening.

She recalled being thrown forward and backwards, and possibly even in a sideways direction. The vehicle was totaled.

She was conveyed by ambulance to the Meridia Hillcrest Hospital Emergency Room with complaints of neck and low back pain. No x-rays were performed and she was essentially examined, treated and released. Her discharge diagnosis was cervical and lumbar strain. No neurological abnormalities were suspected.

She was subsequently referred to Dr. Louis Maggiore, associated with the Euclid Therapy Clinic. She received some hot packs and ultrasound with temporary relief only. She received two to three treatments per week for a period of time. This modality type of treatment was provided to both the neck and low back regions. She was also treatment with some muscle relaxants, Soma 350 mg. Dr. Maggiore treated her on a decreasing frequency basis from November 29, 1994 until May 24, 1995. There was documented short term improvement with the therapeutic modalities prescribed.

Subsequently her family physician referred her to an orthopaedic surgeon, Dr. Tim Nice, who saw her initially on July 25, 1995, approximately eight months after the motor vehicular accident in question. The complaints at that time were mostly low back pain. She did have some neck discomfort, but the bulk of the symptoms had subsided. On examination there was some stiffness in the paraspinal muscles. Dr. Nice recommended additional forms of medications. A follow-up examination was carried out on April 4, 1996, approximately 17 months after the motor vehicular accident in question. The back was re-x-rayed at that time and marked hypertrophic degenerative arthritis at the L4-5, L5-S1 level was noted. There was also a Grade I to II spondylolisthesis of L5 on S1. There was still no radicular symptoms and she had primarily central low back pain at that time.

Dr. Nice tried her on a different medication, Relafen, a nonsteroidal anti-inflammatory medication. She also stated she had physical therapy at NovaCare in Mayfield Village. This again consisted essentially of heat and ultrasound. She did receive some instructions on exercises. Heat also seemed to help her temporarily.

Ultimately on July 3, 1996 (approximately 20 months after the motor vehicular accident) she consulted with Dr. John Nemunaitis at Rehabilitation Medicine at University MedNet facility. She revealed at that time some diminished range of motion of her neck and low back with some "spasm" noted. He ordered an MRI scan of her neck and low back. These were carried out in mid-July of 1996. 'The cervical spinal region appeased somewhat more involved with a generalized degenerative condition than the lumbar spine. There was multiple levels of degenerative disc disease and arthritis. There was; however, no **physical** correlation in the form of any neurological deficits noted in the records. EMG and nerve conduction studies were done the following month, in August of 1996. The nerve conduction study was normal and the EMG showed evidence of "bilateral cervical radiculopathy or nerve root irritation.

Because of the electrodiagnostic studies demonstrating multiple root involvement, primarily in the cervical spinal area, she was evaluated by Dr. Hlavin, a neurosurgeon. The plaintiff saw Dr. Hlavin on only one occasions, October 15, 1996. The last visit with Dr. Nemunaitis was August 12, 1996. She has not had any care or treatment since that time. She continues to have some neck, but mostly low back **pain.** She continues on some home exercises.

CURRENT MEDICATIONS include regular Tylenol, 0-8 tablets per day. She alternates between Relafen and Lodine.

EMPLOYMENT HISTORY: She does promotional work for the Liz Claibome Company. She is an independent contractor. She has limited her hours since the accident. It was clear, by description of her husband, that all of the diminished time was not solely due to the motor vehicular accident.

PAST MEDICAL HISTORY failed to reveal any previous neck or back problems. This is despite the rather significant degenerative arthritis and disc disease of her neck and low back.

CURRENT SYMPTOMS: At the time of this evaluation she continued to have pain in the neck region. This was not really cervicospinal but more below the C7 area. Most of the discomfort was in the midline trapezius area. She described the discomfort as mostly aching in nature. There were no true radicular symptoms in the form of numbness, tingling or weakness in either upper extremity. She occasionally has what she describes as "pins and needles" radiating down to the upper arm level, left usually worse than right. There is no particular activity or weather changes that aggravate her. When she changes positions the pins and needles "goes away". Most of the severe **pain;** however, that she has in the neck and upper back region, seems to be in the midline region. Eight-five to 90% of her pain is back pain and less than 10% is the arm discomfort. Again, the arm is only symptomatic when the back **pain** is at its worst or when she awakens during a sleep period. **As** noted above, just changing her position seems to alleviate this pain.

The bulk of her ongoing discomfort is a deep, dull aching pain, usually below her waist in the midline low back region. On occasion she has radiation of pins and needles on to the lateral aspect of both thighs. Eight-five to 90% of her discomfort is in the midline low back region with 10%, at the worst, being this numbing and tingling **pain.** Standing for prolonged periods of time seems to aggravate her low back. Sitting, lifting, bending or carrying objects, seems to cause a back ache. Changing position seems to help. There is no true radicular symptoms and only numbness and tingling along the lateral thigh region. There is absolutely no complaints at or below the knee level.

PHYSICAL EXAMINATION revealed a pleasant 56 year old female who appeared in no acute distress. She was able to sit, stand, and move about the exam room without difficulty. Arising from a sitting position was performed normally, as was ascending and descending the examining table. Her ability to walk was normal with no **limp** detected. She was able to walk on her heels and toes without difficulty.

Examination of her cervical spine failed to show any objective signs of ongoing muscular irritation. There was no spasm, dysmetria, or muscular guarding, or increased muscle tone. Range of motion of the cervical spine did show some limitation of motion of approximately 10% of predicted normal in forward flexion, extension, side bending, and rotation. This appeared to be just due to "stiffness". Protraction, retraction, and elevation of the scapulae were performed normally. There was some tenderness noted, all of this was **below** the C7 region and would be considered more upper back or thoracic tenderness. There was no atrophy noted in the neck, upper back, or periscapular muscles.

A full 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. Neurologic examination of both upper extremities was normal. There was good muscle development on inspection. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level, were equal and symmetrical bilaterally.

Examination of her lumbar spine demonstrated some claim of tenderness in the midline paraspinal region . There was good flexibility being able to bend forward to touch the distal tibial level. There was good reversal of her lumbar lordosis with this maneuver. No spasm, dysmetria, muscular guarding or increased muscle tone was noted- Hyperextension, side bending and rotation was somewhat uncomfortable subjectively, but no significant limitations of motion were noted. Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. 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, a cervical and lumbosacral strain or sprain. Moderately severe degenerative arthritis and disc disease of the neck and low back region,

Subjective aggravation of previously asymptomatic degenerative arthritis and disc disease of the neck and low back.

DISCUSSION: I have had the opportunity of reviewing a number of medical records to date. These include records from the Meridia Hillcrest Hospital, Dr. Louis Maggioreorie, University MedNet including the neurodiagnostic studies, as well as the MRI scan results, records from Drs. Tim Nice, John Nemunaitis, and a neurosurgeon, Dr. Hlavin. The actual MRI scans of her neck and low back done at University Hospitals of Cleveland, were 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 her ongoing level of physical impairment.

On the basis of the history, the injury sustained was a strain or sprain of the neck and back. By the history presented, this may have aggravated a preexisting previously asymptomatic arthritic condition. She has had a variety of modality type of physical therapy sessions, all without any significant long term improvement. The initial x-rays were not performed at time of the emergency room evaluation, but subsequently performed by Dr. Tim Nice in 1996. These showed multiple level degenerative changes of the lumbar spine.

It was not until approximately two years later that she had MRI scans performed. These were done of the neck and back, and showed much more significant objective skeletal and disc disease in the cervical spine despite the fact that her symptoms were always less in the neck than in the lumbar spinal region . Review of the records from the neurosurgeon indicate a recommendation for a myelogram, if her symptoms deteriorated. This was never performed. She has not had a great deal of medical care since the summer of 1996.

It is my opinion, within a reasonable degree of medical certainty, that, at worst, she sustained a strain or sprain of the neck and low back region as a result of the motor vehicular accident. This may have, **by her history,** aggravated a preexisting arthritic condition in her neck and back region. There is no objective evidence of any permanent aggravation or acceleration of her spinal arthritic condition. She does seem; however, to be symptomatic from these conditions. With proper management of her arthritic condition, no physical limitations will be necessary in the future. There are no restrictions in her ability to be gainfully employed in her current occupation. There is no contraindications on the basis of this evaluation to an active exercise program. The prognosis for her soft tissue residuals are good. Undoubtedly her arthritic condition will worsen as the years progress. She has recovered objectively recovered from any soft tissue injury sustained. Her primary complaints are arthritic in nature.

On the basis of this evaluation, no further care or treatment, other than for her arthritic condition, is mandatory. On the basis of this examination no further neurodiagnostic studies are indicated. If her symptoms do worsen or if she develops distinct neurological deficits, then additional testing may be necessary. There are no surgical indications present. She should continue with her flexibility and strengthening exercise program and should not restrict her activity.

Sincerely,

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

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