Highland
Musculo-Sk
Associates, Ir

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

April 7, 1997

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

RE: Scott Cox
Case No. 314139
DOI: 8/26/94

Dear Mr. Neubert:

I evaluated the above plaintiff in my office on April 3, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on August 26, 1994. Throughout the history he was accompanied by Carey Kasiguean, a paralegal working for the plaintiffs attorney's law firm.

As you are aware, this case is somewhat complex. There was a significant pre-existing condition in his lumbar spine which will be discussed under the past medical history section. These pre-existing conditions include a developmental condition, as well as chronic back and radiating lower extremity symptoms for many years.

MEDICAL HISTORY: The plaintiff stated he was the driver of 1986 Lincoln vehicle with his wife in the front seat, and two young sons in seat restraints in the back seat. They were on Old Oak Boulevard preparing to turn into the Southwest General Hospital Emergency Room. They were making a right turn when a rear end collision occurred. He was, in fact, wearing his back brace at the time of the collision. He felt

his body go forward and "something exploded in my low **back".** There was immediate **pain** in his low back with radiating pain into his left lower extremity. He had previous low back and left lower extremity symptoms prior to this injury.

He was then conveyed to the Southwest General Hospital Emergency Room in Middleburg Heights, Ohio. At that time there were complaints of low back **pain.** There was a history of a spondylolisthesis and that he had been on medication for about a year. There was no neck discomfort. He did have some positive straight leg raising on both sides with back pain. The initial impression by the physician was that he may have Sustained a T-12 fracture and there was pre-existing spondylolisthesis. However, a CT scan done within a few weeks of the injuries revealed only the Grade II to III spondylolisthesis at the L5-S1 level. This seemed to have progressed since 1992. There was also rather significant disc disease at the L5-S1 level. No fracture was confirmed. In the emergency room there was complaints of low back pain with radiation to his left great toe. This had been present in the past.

He subsequently returned to his previous treating physician, Dr. K. R. Kuschnir, an orthopaedic surgeon, who saw him on September 2, 1994. He had previously seen him in late June of 1994, being followed for "herniated disc symptoms". Dr. Kuschnir's notes indicated that he, in fact, had been doing well over that summer but after the accident the pain became worse. An epidural block was suggested. **A** discogram was ultimately performed. Again "herniated disc syndrome'' was noted. He ultimately underwent a percutaneous lumbar discectomy at the L5-S1 level on October 13, 1994. Postoperatively there were continuing symptoms, but the **pain** gradually subsided. He continued to wear the brace and was taking a number of medications, including Tylenol and Naprosyn, an anti-inflammatory medication.

Specifically, he has had no postoperative physical therapy. He has had follow-up with Dr. Kuschnir and continues to wear the same back brace as before. We continues to see Dr. Kuschnir intermittently, He still is on an anti-inflammatory medication.

Concerning his job and employment, he was working as a loader and handler, as well as a truck driver for Federal Express. August through December of 1994, he claims to

have lost a period time out of work. He ROW works as a courier for Federal Express and works on a full-time basis. When he returned after his back injury, he returned as a truck driver and now as a courier. His last visit with Dr. Kuschnir was approximately six weeks prior to this evaluation.

CURRENT MEDICATIONS include Naprosyn, Soma a muscle relaxant which he occasionally takes a bedtime. If and when the pain is severe, he has Tylenol with Codeine available.

PAST MEDICAL HISTORY is significant as suggested. There was a significant pre-existing low back condition which dated back to July of 1988. At that time he was employed by a moving company and documentation was reviewed from Bureau of Workers' Compensation. They clearly indicate symptoms which were intermittently severe in nature that were lumbosacral in origin. These include both radiating and radicular type of discomfort. Some records were reviewed from late July and early August of 1994, just about three weeks prior to the automobile accident in question. This was approximately five weeks after the last visit with Dr. Kuschnir. He noted in the Workers' Comp form that he had **pain** in the low back with light duty lifting of 20 to 30 pounds. Intermittently his left leg, radiating down to the big toe, would feel an electrical shock sensation with the left leg going numb. He claimed to have numbness in the left leg 90% of the time arid also in the left buttock cheek and left foot region. Clearly, there was significant pre-existing problem with virtually identical symptomatology.

In the past, x-rays were also performed. As far back as July of 1988 he was suspected of having the spondylolisthesis which was Grade I to 11 for quite some time. He strained his back again in July of 1991, pushing a large x-ray machine with a number of other people. The last injury was in May of 1992 when he again had burning sensation in his low back, as well as radiating pain into this left lower extremity. There was also a burning sensation in his groin. The CT scan at that time showed the severe disc disease and spondylolisthesis related to a bilateral spondylolysis. This was all clearly documented prior to the motor vehicular accident in question.

Although the disc abnormality in the past was noted to be at the **L4-5** level, it was, in fact, at the L5-S1 level. The discogram clearly indicated the bulk of the pathology was at the L5-S1 level.

It was also apparent from review of his past records that the discogram performed on October 1, 1992, created virtually the identical symptoms as did the findings **post-accident.** There was no documentation of his lumbar spine from September of 1992 to September of 1994. Sometime during this time period there was worsening of his spondylolisthesis. One could summarize that over the years he has had multiple episodes of flare-ups of low back **pain** and virtually identical leg **pain** as described after the motor vehicular accident in question.

CURRENT SYMPTOMS: The plaintiff described that after the surgical procedure there was a decreased pain and burning sensation in both his back and lower extremities. His left leg remained weak for a period of time but this is gradually improving. He currently has less pain in his left low back region and less **pain** in his left leg. He is not terribly symptomatic at the time of this evaluation. He claims the back and leg continues to be **intermittent** in nature. This is very similar to his previous low back history. He **never** has independent left leg pain. He only develops buttock and upper left leg pain (does not go below the knee) only when the back **pain** is most severe.

The back **pain** seems to increase with a great deal of stair climbing, jumping **up** and down, running or repetitive bending and lifting. Occasionally when raising his left leg up as to take a high step, he has some left posterior thigh discomfort. He also claims to have had one spinal block prior to the percutaneous discectomy and four injections afterwards. All of these were done in the doctor's offices.

PHYSICAL EXAMINATION revealed a robust appearing 29 year old male who appeared in no acute distress. His gait pattern was normal. He was able to arise from a sitting position, as well as ascend and descend the examining table normally. He was able to walk on his heels and toes without difficulty. Inspection of his low back and lower extremity did not reveal any gross muscular wasting.

Examination of his lumbar spine revealed a very tiny incision compatible with the percutaneous discectomy. (This will be discussed below.) There was excellent range of motion of his lumbar spine in forward flexion and hyperextension, as well as side bending and rotation. There was less than 10% reduction of predicted normal. Hyperextension was still somewhat uncomfortable, as expected, from his chronic "slip". There was excellent development of his lumbar paraspinal musculature. 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 neurologic examination including sensory, motor and reflex testing failed to show any precise deficits. He did have a normal ankle jerk reflex and absolutely no objective sips to indicate an L5-S1 abnormality. Circumferential measurements of both upper and lower thigh, and upper and lower calf level, were equal and symmetrical. There was no measurable atrophy noted.

IMPRESSION: Related to the motor vehicular accident, a lumbar strain or sprain. This is superimposed upon a previously symptomatic condition. Chronic lumbosacral disc disease, more severe at the L5-S1 level dating back to 1992. Chronic degenerative and/or post-traumatic disc disease at the L5-S1 level related to an initial 1988 work injury.

DISCUSSION: I have had the opportunity to review a number of medical records concerning his ongoing care and treatment. These included complex records from the Bureau of Workers' Compensation, records from the Surgery Center associated with Southwest General Hospital, both pre- and post-accident, records from Southwest General Hospital pre- and post-accident, as well as from his treating physician, Dr. Kuschnir. I have also had an opportunity to review x-rays from the Brunswick Orthopaedic Incorporated, his orthopaedic surgeon's practice.

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.

It is my opinion, within a reasonable degree of medical certainty, that the following conditions **pre-existed** the injury: 1) Remote history of work related low back injury in 1988 with a number of reinjuries in the early 1990's. 2) Documented lumbosacral disc disease most severe at the L5-S1 level dating back at least five years prior to the motor vehicle accident in question. 3) Grade I to II spondylolisthesis as of September of 1992. There was a progression between that date and the next date the study was performed after the motor vehicular accident. It is doubtful that this increased slip was solely due to the motor vehicular accident in question. 4) Significant recurrent symptoms of back and left lower extremity pain, numbness, and weakness characterized by multiple episodes of back and leg pain. 5) Severe degenerative disc disease L5-S1 dating back many years.

It is my opinion, within a reasonable degree of medical certainty, that the percutaneous lumbar discectomy was solely due to a **recurrent** aggravation of his pre-existing severe low back condition. This surgical procedure involves, under a fluoroscopic control, the introduction of a small 4 mm probe into the disc space. The probe is hollow and contains a suction blade which removes disc material. This is not a formal open discectomy but a palliative procedure to remove some of the disc material. It, in fact, does not remove the material that is actually "herniated". It basically only debulks the disc. This is a somewhat controversial procedure.

At the time of this evaluation he has objectively recovered from the flare up that is, by his history, related to the motor vehicular accident. As noted above, this was a previously symptomatic condition. Forms were noted in the Workers' Comp files of symptoms of low back and leg pain within weeks prior to the motor vehicular accident in question. At worst, in my opinion, the accident recurrently aggravated a pre-existing degenerative and developmental low back abnormality. It is my opinion that the condition that was ultimately operated on was not caused by the motor vehicular accident in question. The flare-up, as described above, was, by his history, related to the motor vehicular accident. It should be noted that the patient was, in fact, wearing his low back brace when the car accident occurred. It is doubtful With the brace on that the low back was significantly reinjured. The brace would prevent any further slippage at the L5-S1 level.

On the basis of this evaluation, the plaintiff has objectively recovered. The physical examination, other than a very slight degree of stiffness, was within normal limits. There was no residual neurological impingement or impairment. The long-term prognosis for this "flare-up" is favorable. There has been a complete resolution of his objective findings. I neglected above that the plaintiff also saw Dr. David Grunstein, a chiropractor, on March 25, 1996, in connection solely With the July 5, 1988 Workers' Comp claim. There was no mention of the automobile accident in this report. This physician felt that there was over 30% permanent impairment based solely on the 1988 workinjury. .

On the basis of this evaluation, no further care or treatment is necessary or appropriate. If a spinal fusion is necessary in the future, in my opinion, it is unrelated to the motor vehicular accident in question. There was no **objective** acceleration or permanent aggravation of a pre-existing condition as a result of this car accident. There was, at worst, a subjective aggravation which was quite similar to the incidences that are well documented in the medical records. The prognosis is good.

Sincerely,

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

RCC/bn

cc: File

Highland
Musculo-Skele
Associates, Inc.

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

April 7, 1997

Joseph H. Wantz
Attorney at Law
The Superior Building, 21st Floor
815 Superior Avenue, N.E.
Cleveland, OH 44114-2701

RE: David J. Richards
Case No. 300266
File No. 1700-1331

Dear Mr. Wantz:

I evaluated the above plaintiff in my office on February 6, 1997 in reference to alleged residuals of injury sustained in a series of motor vehicular accidents. These accidents occurred within minutes of each other on February 8, 1995, in the University Circle area on the east side of Cleveland. He was examined Without friend, family or legal representation present.

On February 8, 1995, approximately two years ago, he was involved in a series of accidents. The first accident was described as a "fender-bender". He apparently was the cause of this. He was intending to make a turn into the left hand lane. His vehicle was struck in the front driver's side. He started unbuckling his seat belt and was attempting to exit his car, when his vehicle was struck again by the defendant's car, Julia Murphy. The impact was again to the driver's side of his 1937 Blazer. He stated that the first accident involved "just a touch of my fender". His vehicle was at approximately a 45 degree angle when it was struck again in the driver's side. He was thrown forward and backwards.

At the scene "I knew I was hurt", He developed neck **pain** within minutes **with upper** back and low back discomfort. He claims to have developed right ann pain also at the same time.

There was no immediate medical attention documented. Approximately two days later he was evaluated at the Lakewood Hospital Emergency Room. These records indicate **3** suspected soft tissue strain or sprain to the neck and back region . **A** number of complained were registered including neck, back **pain,** and numbness in the right hand. X-rays were done of the cervical spine. These indicated no acute fractures and no instability. **A** normal lumbar spine and right knee exam were noted. **A** CT scan of the upper cervical spine was also performed. There were within normal limits. Apparently by that time there was significant right hand pain and numbness, as well as a pins and needle sensation. This was not precisely documented in the emergency room records. He had a CT scan of his cervical spine which suggested a herniated disc accordmg to the patient's history. This was; however, interpreted as normal as noted above. He was essentially treated and released from the emergency room.

He was subsequently came under the care of Dr. Matt Likavec, a neurosurgeon, An MRI scan of the cervical spine was performed on February 24, 1995. This showed a small left C4 disc herniation, a small midline C4-5 disc herniation, a moderate size central and right sided C5-6 disc herniation, a small central and right sided C6-7 disc hemiation. The date of the initial evaluation with Dr. Likavec was February 27, 1995, about 10 days after the car accident. He had previously been seen by Dr. Galvin, who gave him a Medrol Dosepak. The C5-6 was the level that was mostly the concern of Dr. Likavec.

Follow-up exam on March 10, 1995 showed there was still some **pain.** He was feeling better. There was still a little numbness by March 14, 1995.

However, by **April** 5, 1995, his symptoms again worsened. He had a decreased right biceps reflex. Surgery was recommended. He underwent an anterior cervical discectomy at the C5-6 level without a fusion.

Postoperatively he has really done quite well. He claimed the surgery virtually eliminated the bulk of his ongoing right arm pain. Within weeks or months his numbness and tingling resolved. His neck pain significantly improved. He wore a collar for approximately a month and has followed up with Dr. Likavec on a routine basis.

There was a flare-up of his pain in recent months. A repeat MRI scan was done at Westside Imaging. This showed some osteophyte formation at the C5-6 level. A future fusion was discussed but this was not seriously entertained. His symptoms seemed to have improved since this flare-up.

He has seen no other doctors in reference to this injury. All of his care and treatment has been to his neck. He claims to have some ongoing symptoms in his low back as well, but never had any care or treatment for this as far as he can recall.

PAST MEDICAL HISTORY revealed a previous rear end car accident when he was 19 years old. He could not recall any details of his care and treatment. He also sustained a stab wound of the abdomen which included a liver laceration when he was younger. This was repaired in an open, rather extensive, life saving procedure.

EMPLOYMENT HISTORY: He is employed full-time as a hairdresser. He stated that he lost a couple of months around the time of the accident but cannot recall the exact dates. His ongoing symptoms occur primarily after work when he is standing and working for many hours.

CURRENT CONDITION: He is currently on no prescription medications. The bulk of his symptoms seem to be intermittent in nature and occur after work. This is somewhat related to fatigue. Weather changes do no affect it. There is no arm or hand pain, but he still feels that the right upper extremity is somewhat weak. He feels some stiffness in rotation of his cervical spine, but has minimal limitations. He has not "pushed myself" physically. He has given up golf as rotational movements of *the* neck seem to bother him. He does not regular conditioning exercise program. He does

occasionally use his Therabands, an elastic exercise unit. He also claims to have given up coaching baseball for his child.

In reference to his low back he complains of a dull aching pain that is there essentially when he is standing for prolonged periods of time. This is midline with no radiation. There is no numbness or tingling or mechanical type symptoms noted. He has never had any treatment or physical therapy for his low back.

PHYSICAL EXAMINATION revealed a pleasant 43 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.

Examination of his cervical spine revealed a well-healed scar in the left anterior aspect. There was no spasm, dysmetria or muscular guarding noted. There was good preservation of his range of motion with less than 10% restriction of motion in forward flexion, extension, side bending, and rotation. Right rotation and hyperextension seemed to give him the most discomfort in positioning. Protraction, retraction, and elevation of the scapulae were performed normally. There was good muscle and motor development in the neck, tipper back and 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.

The patient is right handed. The right upper extremity showed approximately 1.2 cm enlargement at the axillary and midarm level, and approximately 1 cm larger in the forearm of the right side, as expected with his occupation. A detailed neurologic examination of both upper extremities was normal.

IMPRESSION: By history, cervical strain and probable traumatically induced herniated cervical disc at the C5-6 level. It was impossible to separate which accident, in fact, was the cause of the disc herniation.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the Parma Community Hospital, the Lakewood Hospital, MetroHealth Medical Center, Dr. Matt Likavec, as well as the result of the CT and two MRI scans. In addition, the actual x-rays were reviewed from the Lakewood Hospital, MetroHealth Medical Center, and the MRI scan from the Westside Imaging and Oncology Center.

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.

It is my opinion, within a reasonable degree of medical certainty and probability, that as a result of this incident, an acute herniated disc at the CS-6 level probably occurred. His symptoms were that of a soft tissue disc superimposed upon multiple level degenerative disc disease. It is likely that there may have been a small disc herniation present prior to this accidents, but he was never symptomatic. As a result of the traumas sustained, in my opinion, the history and physical examination was compatible with an acute C5-6 disc herniation.

After a failure of conservative care, a surgical procedure was performed. This relieved most, if not all, of his radicular symptoms. He had a very benign postoperative course. Recently there has been a flare up and some additional osteophyte (bone spurs) have developed. These, in my opinion, are not due solely to the injuries and surgeries, but are more likely than not due to the progression of his multiple level degenerative disc disease. It is not unusual in individuals with multiple level degenerative disc disease that the C5-6 is the most abnormal. This, in my opinion, is the etiology of his further degeneration.

The long term prognosis is favorable. On the basis of my evaluation, he has objectively recovered from the soft disc herniation incurred. There was a very minimal restriction of motion. There was complete neurological return.

It is my opinion, within a reasonable degree of medical certainty, that no permanent injury was sustained. He did have, in my opinion, a herniation of a degenerative disc at the *C5-6* level. This did necessitate the care and treatment, and there was an excellent postoperative result. The further degeneration of the C5-6 disc, in my opinion, is due to the progression of his degenerative disc disease and not to the motor vehicular accidents in question. On the basis of this evaluation, no further care or treatment is necessary or appropriate, and certainly no surgery is indicated at this point in time. It is impossible to separate the exact traumas sustained and ascertain which trauma, in fact, cause the cervical disc herniation. The herniation, by history, is related to the sum of the two accidents. I cannot separate the "responsibility" on the basis of this retrospective analysis.

Sincerely,

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

RCC/bn

cc: File