Highland
Musculo-Skeletal
Associates, Inc.

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April 23, 1997

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The Superior Building, 21st Floor
815 Superior Avenue, NE
Cleveland, OH 44114-2701

RE: Lawrence Rodak
Case No. 309321
File No. 1700-13684

Dear Mr. Lazzaro:

I evaluated the above plaintiff in my office on April 15, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on June 3, 1994. He was evaluated without friend, family or legal counsel present.

He presented with a history of being the driver and solo occupant of a 1981 Dodge passenger configured mini-van in the vicinity of Crocker Bassett and Schwartz Road in Westlake, Ohio. The incident occurred approximately four o'clock in the evening on June 3, 1994. He was driving through the intersection. A car coming in the opposite direction turned in front of him and a driver's side impact occurred. He described the weather conditions as clear and dry.

At the moment of impact he stated ,that he was thrown forward and backward, and struck his head on part of the windshield. He braced himself along the steering wheel. There was a blunt trauma as his left him went into the driver's door "real hard". His left knee hit the underside of the dash board. He apparently struck his right chest and

right shoulder on the steering wheel. His vehicle was not drivable. He did not recall any cuts or abrasions. He did recall that he probably had a "black eye".

He was evaluated at the Fairview Hospital Emergency Room where he was conveyed by ambulance. Complaints at that time were in the neck, both lower legs and back. A series of x-rays were performed including cervical spinal films which showed some apophyseal joint narrowing reflecting mild degenerative changes in his mid to lower cervical spine. X-rays of his lumbar spine also showed a narrowing L5-S1 level, mildly degenerative in nature. He was transported home by his wife. He was given a diagnosis of muscle strain of the back and neck, as well as contusion of the left shin.

He did consult his personal attorney and was initial referred to the Montbarren Chiropractic Clinic in Westlake, Ohio. A series of treatments were started including manipulation, ice packs and electrical stimulation. He believes this went on for "months". The treatments were primarily related to the neck and shoulder region. His left knee was bruised and this did resolve without any care or treatment. He continued to have stiffness in his spine with moving, bending, walking, lifting, twisting and stretching. There was a history of motor vehicular accident in 1982 that was presented to the chiropractor,

He referred himself to Dr. George Mathew who started prescribing anti-inflammatories, as well as a variety of other medications. Dr. Mathew treated the plaintiff for approximately one month with absolutely no improvement in his symptoms. He continued to have neck and back pain.

He re-contacted his attorney and was ultimately sent to Dr. Harold Mars, a neurologist. A complex diagnostic workup was commenced including an MRI scan of his cervical spine performed on July 19, 1994. This showed a bulging C5 disc, as well as a bulging C6 disc. There was hypertrophy and tenting of the posterior longitudinal ligament compatible with degenerative changes. Lumbar spinal MRI showed some bulging disc at the L4-5 level. He also underwent electrodiagnostic studies with Dr.

Naomi Waldbaum. He believes this was due to "nerves in my neck causing problems". An EEC was performed on July 26, 1994, which was normal.

He was referred by Dr. Mars to Dr. James P. Bressi, an anesthesiologist associated with the Meridia Pain Management Program at the Meridia South Pointe Hospital. Further physical therapy was prescribed, as well as three nerve blocks. The last block was in the fall of 1996. He was also provided with additional medications including Skelaxen and Vicodin. He does not take these medications anymore. He also continues to use a traction unit at home and a treadmill for 20 minutes a day.

EMPLOYMENT HISTORY: He is employed as an assembly worker for the Ford Motor Company at the Avon Lake Plant. He stated he was out of work for 40 weeks. After 23 weeks he attempted to go back to work but "Ford kept me out of work for another 12 weeks. Apparently there was no work available with the limitations. This time seemed to be somewhat excessive for a strain or sprain. He currently works in the same capacity as he did prior to the motor vehicular accident in question.

PAST MEDICAL HISTORY did reveal the car accident in 1982, as well as an old work related low back injury that was incurred while employed by Invacare Corporation. He stated that he missed about seven to ten days of work. He claims to have had no further loss of time since then.

CURRENT SYMPTOMS: He has no further problems with his low back or lower extremities. He has intermittent symptoms involving his neck, right upper back and right upper extremity.

In reference to his neck, he has discomfort on the right side only. This is primarily in the trapezius muscle from slightly below the midline cervical spinal region precisely in the muscle to the lateral deltoid origin. The only activity that aggravates him is the type of work he does at the Ford Motor Company. This involves a fair amount of overhead work on the assembly process. When the neck and shoulder is at its worse

he develops some aching pain in the right arm and forearm. He has symptoms that are somewhat reminiscent of carpal tunnel syndrome with some achy feeling into his thumb and index finger of his right hand only. This seems to worsen with repetitive use and overhead use, but diminishes this when he avoids this or rests. Since he has returned back to work in April of 1995, he has had not further loss of employment hours.

PHYSICAL EXAMINATION revealed a pleasant 42 year old male who appeared in no acute distress. His gait pattern was normal. He was noted to sit, stand, and move around the exam room normally. He was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally. There was no limping detected on gait testing. He was able to stand on his heels and toes without difficulty.

Examination of his cervical spine revealed no objective signs of spasm, dysmetria, muscular guarding or increased muscle tone. On inspection there was a normal degree of muscular development in the neck, upper back and periscapular musculature. No objective signs of injury were noted. Range of motion of the cervical spine was very minimally limited with over 90% of his predicted range of motion in forward flexion, extension, side bending, and rotation. He claimed to have some "aching" in the right trapezius muscle when he looked in an upward direction. Protraction, retraction, and elevation of the scapulae were performed normally.

Range of motion of both shoulders was performed normally in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists and small joints of the hand examined normally. There was no signs of favoring in either upper extremity with decreased muscle tone or bulk. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally. No atrophy was detected in the upper extremities. Negative provocative testing for carpal tunnel syndrome was noted. Neurologic exam was within normal limits.

IMPRESSION: Subjective residuals of a cervical strain or sprain. Some MRI and x-ray evidence of degenerative disc disease and arthritis of the cervical spine. Very mild EMG abnormalities compatible with nerve root **inflammation.**

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These records included those form Fairview General Hospital, Montbarren Chiropractic Clinic, Dr. Harold Mars, and Meridia Suburban Pain Management Center including records from Dr. Bressi.

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, this gentleman, at worst, sustained a strain or sprain of the neck and back, as well as multiple contusions. The low back and leg complaints resolved very shortly after the accident. The bulk of his ongoing symptoms were related to his right side neck and right shoulder symptoms. On inspection of the medical records it became apparent that he did not undergo any **active** rehabilitative exercise program until he stated with the **pain** management group and had some physical therapy. His pain seemed to subjectively decrease and his overall condition improved once the physical therapy was initiated. There was also some temporary pain relief with the blocks that were administered. In my opinion, the disc abnormalities noted on the MRI scan were purely degenerative in nature. There may have been a transient subjective aggravation of his arthntis and disc disease involving his cervical spine during the initial time period. These soft tissue injuries resolve within a six to eight week period of time and more complicated cases, with underlying disease, resolve in a 10 to 14 week period of time.

The typical healing period for these type of injuries are not reflected in the rather prolonged period of time out of work. It is difficult to understand how this injury would have disabled the plaintiff for 40 weeks. It was clear that he was "pretty much

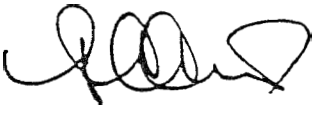
recovered" by the 28 week level. This also seems to be somewhat excessive for typical injuries of this kind. After review of the records and after careful questioning, I am still not clear as to why this period of time out of work was so lengthy. Ultimately when he did return back to work in April of 1995 there has been no further loss of work. There is no clear explanation from an orthopaedic standpoint for this rather lengthy period of time out of work.

At the time of this evaluation, he has objectively recovered from any soft tissue injury sustained. There appears to be no permanent injuries sustained. There is no objective or radiological evidence of a permanent aggravation or acceleration of his degenerative arthritis and disc disease of his cervical spine. In my opinion, the small bulges were degenerative in nature. They are somewhat reflected in the appearance of the initial spinal x-rays, although the MRI obviously gives more detail in the soft tissue about the spine.

The long term prognosis is favorable. He has objectively recovered. There are no objective residuals of injury on a clinical basis. No fiirther care or treatment is necessary or appropriate. As noted above, there is no clear musculoskeletal or neuromuscular explanation for his prolonged absence from work.

If additional records become available, such as though from Dr. George Mathew or the actual MRI scans, I would be glad to review these in the future.

Sincerely,



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

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