Highland
Musculo-Skeletal
Associates, Inc.

Robert C. Corn, **M.D., F.A.C.S.**
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April 27, 1997

Roberto H. Rodriguez, Jr.
Attorney at Law
718 Terminal Tower
50 Public Square
Cleveland, OH 44113

RE: Matthew Bujoll
Case No. 311484 (Cuyahoga Co.)

Dear Mr. Rodriguez:

I evaluated the above plaintiff in my office on April 22, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on July 24, 1994. Mr. Bujoll was evaluated without friend, family or legal counsel present,

He recalls a motor vehicular accident on July 24, 1994. He was the driver and solo occupant of a Ford Taurus vehicle heading in a south bound direction at 185th Street and Neff Road on the east side. He was heading toward the Finast Foodstore. He was wearing a seat belt. He was the second car in line waiting to make a left turn.

He was rear ended and thrown forward and backwards, injuring his neck and upper back. There was primarily rear end damage although he did hit the car in front of him. No injury was claimed.

His girlfriend at that time subsequently took him to the Sixth Precinct police department where the accident was reported. She subsequently took him to the Meridia Euclid Hospital Emergency Room where he had his initial evaluation and

consultation. Records from Meridia Euclid Hospital Emergency, Room showed primarily a neck strain. Cervical spinal x-rays were performed and these were entirely within normal limits. We was essentially treated and released.

He subsequently came under the care of Dr. John Nemunaitis, a physiatrist associated with the University MedNet. His initial evaluation was on August 2, 1994, approximately a week after motor vehicular accident. Examination was perfonned. There was some complaints of neck, upper extremity and shoulder pain which was stiff and tight. There were some complaints of frontal headache. He denied any radicular symptoms suggestive of a disc or root symptoms. Clinically there was no suspicion of a neurological lesion. Despite these normal findings and the lack of documentation of a suspicion of a neurological injury, an MRI scan was ordered and performed of his cervical spine. Some very minor disc abnormalities were noted but no neurological impingement or impairment. Approximately four visits total with Dr. Nemunaitis were carried out. There was some suspicion of a thoracic outlet syndrome (a blood vessel abnormality). No symptoms; however, persisted. His neck and upper extremity symptoms gradually diminished to a great extent. Formal physical therapy was also carried out at the Meridia Euclid Hospital with a good overall reduction in his left of discomfort. An electrodiagnostic evaluation was performed, which was consistent with a right brachial plexopathy, was noted in January of 1995. As noted above, these symptoms have totally dissipated. Any abnormality noted at that time was probably inflammatory in nature and not mechanical. He has not had any care or treatment since early 1995.

He is currently on no medications. He still participates to some degree in sports although he used to run and play soccer in both high school and college. He only lost approximately a week from work following this motor vehicular accident and has lost no time since that initial period of time.

PAST MEDICAL HISTORY failed to reveal previous neck or back trauma. He did have a fracture nose related to a soccer incident.

CURRENT SYMPTOMS: At the time of this evaluation he has virtually no residual symptoms in his neck in routine and normal usage. The only discomfort he gets is at the base of the neck in the C7 vertebral process with extension only. He gets this when he is "stargazing" or looking up into the air or when watching or attempting to do ceiling wallpapering. He also notices some discomfort at the extremes of right rotation such as when turning his head while changing lanes in driving. Occasionally he still awakes with a stiff neck. He has difficulty with some neck pain when attempting to watch TV lying on the floor with his neck in a hyperextension position while lying on his stomach.

PHYSICAL EXAMINATION revealed a healthy appearing 31 year old male who appeared in no acute distress. His gait pattern was normal. We 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 no spasm, dysmetria, or muscular guarding. There was a full range of motion in forward flexion, extension, side bending, and rotation. At the extremes of flexion there was some discomfort but no objective correlation. There was excellent muscle development in the neck, upper back and periscapular muscles. Range of motion of the shoulder blades was normal in protraction, retraction, and elevation. A full range of motion of both shoulders was noted in forward flexion, extension, abduction, internal and external rotation. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal. There was a negative Adson maneuver. No clinical correlation of a thoracic outlet syndrome was present. There was no signs of peripheral neuropathy or carpal tunnel syndrome.

IMPRESSION: Resolved cervical strain or sprain. No evidence of disc injury.

DISCUSSION: I have had the opportunity to review medical records associated with his care and treatment, These included records from the Meridia Euclid Hospital including the emergency room and x-rays, as well as physical therapy, and records from the University MedNet Clinic including records from Drs. Nemunaitis and Seo.

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.

The initial evaluation was compatible with a soft tissue strain or sprain of the cervical spine. Although there was some complaints of numbness initially, there was never any objective correlation with this. The use of an MRI without neurological deficits is not indicated. The minor disc abnormalities, in my opinion, are not due to any traumatic event. No permanent injury was sustained. Within a very short period of time and with the appropriate therapy as noted, he was able to get virtual complete resolution of his symptoms. Late in 1994 and early 1995 there was some additional workup to rule out a thoracic outlet syndrome. Although there was some very minor EMG abnormalities there was no vascular compromise. These symptoms have totally dissipated. Any irritation of the brachial plexus may have been due to trauma but this was temporary, transient and has totally resolved.

The only minor symptoms he has on hyperextension of the spine are, by his history, related to the motor vehicular accident in question. There are no objective correlations with this symptom. In my opinion, with a normal physical examination, he has completely recovered from any soft tissue injury sustained. He still has some very minor subjective symptoms without objective correlation. No further care or treatment is necessary or appropriate. As noted above, he has not had any care or treatment for approximately 14 months prior to this exam. On the basis of this evaluation, no further care or treatment is necessary as he has recovered. The prognosis is favorable.

Sincerely,

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

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