Highland
Muscub·Skeletal
Associates, Inc.

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

April 28,1997

Laura Ann E. Swansinger
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Roberta Fishman
Claim No .35-N241-139
File No. 14107-SF

Dear Ms. Swansinger:

I am writing to you in reference to the above plaintiff who was evaluated in my office on April 9, 1997, for an Independent Medical Evaluation. The examination was carried out specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on June 3, 1994. Throughout the history and physical she was accompanied by her attorney, Mr. Hal Levey.

She recalls that she was a driver with a rear seat passenger in a large mini-van at approximately 4:30 in the morning. She was employed at that time as an independent contractor for the Cleveland Plain Dealer in delivery. She was in the vicinity of Fairmount and Green Roads, heading in a north bound direction on Green Road. A rear end collision occurred. She was not wearing a seat belt. The car was forced forward into the intersection. The driver's seat "popped out". There was immediate pain in her spine from her neck down to her legs. There was no loss of consciousness. There was *very* severe low back and left leg pain.

She was taken by ambulance to the Meridia Hillcrest Hospital Emergency. Room. Complaints at that time were pain in the neck and low back. She underwent a thorough evaluation with x-rays of the lumbosacral spine and cervical spine. *Also* a chest x-ray was performed. These findings were all within normal limits and she was discharged with a diagnosis of "dorsal lumbar strain.

Her subsequent follow-up was with Dr. Lawrence Bilfield, an orthopaedic surgeon. He examined her and felt, with her past medical history of a herniated disc originally diagnosed in 1.992, that a new MRI scan would be appropriate. The second scan was performed on June 22, 1994 which again showed the herniated disc with no further worsening according to the radiologist, Dr. James Zelch. There was a 3 mm midline bulging of the L5 disc "similar to the study of 4/28/92". Also, in that she had good relief of her pain from her the disc in the early 1990's with a series of lumbar epidural blocks, a new series of block were performed at the Mt. Sinai IMC Campus. She also had some physical therapy at Mt. Sinai as well. There was some improvement in her overall symptoms.

She was then subsequently admitted for an in and out lumbar myelogram at the Mt. Sinai Medical Center done on October 31, 1995. The impressions of the radiologist was that "no myelographic evidence of herniated lumbar disc is seen". The test was essentially normal.

Ultimately she was started with a **pain** management program through Dr. Jennifer Kriegler and Zev Ashenberg. She went through some physical therapy but was not able to complete the program. She has multiple other medical problems, including heart disease, diverticulitis, as well as rather severe steroid dependent asthma. She continues to see a variety of physicians for her other medical problems. She has not had any care or treatment since she left the care of the pain management clinic, which she believes was in early 1996.

PAST MEDICAL HISTORY did reveal a prior motor vehicular accident. At that time she did sustain a back injury. She was seen by Dr. Craciun and Dr. Iarruzi through the Marymount Hospital. She did have a series of blocks for an L5-S1 herniated disc, as well as physical therapy. She claimed her symptoms completely resolved prior to this accident. There has been no other accident or injuries that would account for her chronic back complaints.

EMPLOYMENT HISTORY: She has not been able to work since the time of the accident. As noted above, she was previously a delivery person for The Plain Dealer working for the past eight years prior to this accident doing this. She cannot work because she cannot sit for too long. This causes back and leg pain. She also has some weakness in her left leg as well.

CURRENT SYMPTOMS: At the time of this evaluation she still continues to complain of primarily left low back pain, left buttock, and left leg pain. The pain seems to start below her iliac crest level and radiates deep into the left buttock and down the entire left leg, but most consistently the anterolateral aspect. This seems to radiate down to the feet, with the plantar aspect of her foot being somewhat less sensitive. This roughly follows the S1 distribution. The low back pain is constant and aching in nature. It seems to increase with any attempt at walking, bending or sitting. Weather does not adversely affect her. She uses a cane on a full time basis, primarily in the right hand. She also uses a lumbar pillow for sleeping, as well as a cervical pillow. There have been episodes where the left leg has given way. She has been untreated for over a year.

PHYSICAL EXAMINATION revealed a morbidly obese female who appeared in some distress, especially when changing posture and position. Her gait pattern was noted to be antalgic, favoring her left side. Her gait did not improve substantially using a cane.

A limited examination was done of her lumbar spine due to her level of pain. There was diffuse tenderness in the left lumbar region. She would not flex past the knee level. Hyperextension, side bending and rotation showed an equal amount of restriction in motion, approximately 40% of predicted normal. There was good reversal of her lumbar lordosis, however. Her straight leg raising in the sitting position was performed to 90 degrees but a Lesague's sign caused a pulling pain in her left posterior thigh and buttock area. Neurologic exam revealed only a hypoactive left ankle jerk reflex. Circumferential measurements of both lower extremities at the upper and lower thigh, and upper and lower calf level failed to show any muscular atrophy. She clearly demonstrated a fair amount of subjective complaints, but with no precise or localized objective abnormalities.

IMPRESSION: Chronic subjective left lower back pain with S1 sensory radiculopathy. This would correspond to the exact level as her previous disc herniation.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from the Meridia Hillcrest Hospital, Mt. Sinai Medical Center, Regional Diagnostic Imaging Center, as well as the two MRI and myelogram reports. No specific records from Dr. Bilfield were available for review. Records were also reviewed from the pain management clinic, as well as some records from University Hospitals of Cleveland.

After careful questioning of the patient's history and physical Imitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning the plaintiff's ongoing level of physical impairment.

In reference to this motor vehicular accident, in my opinion, at worst, she sustained a soft tissue strain or sprain of her thoracolumbar spine. There may have been a subjective aggravation of her previous disc herniation which, according to her history, was asymptomatic. She clearly had a herniated and/or bulging disc at the L5-S1 level

that was documented as far back as 1992. She had a series of epidural blocks which did give her some subjective relief of her symptoms. As a result of this motor vehicular accident there is clear objective evidence of no worsening of this pre-existing objective finding. The follow-up myelographic study was, in my opinion, normal as well.

It is my medical opinion that the care and treatment that was rendered for the soft tissue strain or sprain in the form of the ER visits, the epidural blocks, and the diagnostic testing was appropriate. This was primarily due to her significant pre-existing abnormality and the questions of her physicians as to any worsening of her pre-existing condition. It is clearly documented there is no permanent aggravation or permanent acceleration of this pre-existing disc phenomena at the L5-S1 level.

There are still continuing complaints of subjective low back pain, as well as some sensory radicular pain without any objective orthopaedic or neurological abnormalities. She claims to use a cane on a full time basis in her right hand. There was no objective finding that would account for this muscular deficit. There was no atrophy noted in her lower extremity. There was a mild diminished ankle jerk reflex compatible with her old objective abnormalities.

On the basis of this evaluation, there is no objective orthopaedic or neurological reason for her not to be able to be employed in her previous occupation. She claims she is unable to sit for long periods of time and this necessitates a cane for ambulation. There is no clear indication as to why this is necessary on the basis of the lack of objective abnormalities. The claim of weakness is purely subjective and not manifested by any objective abnormality or deep diminished muscle bulk. She continues to have rather significant subjective symptoms but without any objective orthopaedic, neurological or radiological abnormalities.

On the basis of this evaluation, she has objectively recovered. I have no orthopaedic explanation for her ongoing subjective symptomatology. Objectively no abnormalities

could be detected. The long term prognosis is favorable. There is no objective evidence of any acceleration of her pre-existing disc condition.

Sincerely,

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

RCC/bn

cc: File

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+ 10

Steven C. Merriam
Attorney at **Law**
126 West Streetsboro Street
Suite 4
Hudson, OH 44236

RE: Dixie Johnson
Case No. 295020
File No. 2565 **AS**

Dear Mr. Merriam:

As you are aware, I evaluated the above plaintiff in my office on August 9, 1996, in reference to a work-related motor vehicular accident which occurred on December 21, 1993.

At the time of that evaluation I had the opportunity of reviewing a number of medical records which included records from Dr. Harold Mars, a neurologist, including the diagnostic studies and the actual MRI scan and results, as well as the records from Dr. Bruce Bond. Since that time I have had the opportunity to review additional medical records. These include records from the Richmond Heights Hospital, records from the Bureau of Workers' Compensation, Dr. Howard Fagan, the Cleveland Clinic, as well as an additional report from Dr. Bruce Bond.

Review of the records from the Richmond Heights Hospital were from July of 1990. A cervical spinal x-ray done at that time showed some osteophyte formation at the C5-6 and C6-7 level compatible with "mild degenerative joint disease." There was clearly disc disease present in the mid cervical level as far back as 1990, as documented in these x-rays. These records correlated quite well With the subsequent MRI findings that were done in mid-July of 1996. It should primarily degenerative disc disease at the C5-6 level, as well as the C6-7 level. The herniation, as discussed in my previous report, including both anterior and **posterior** herniations. This is compatible with end stage "disc bulging" and a degenerative abnormality at two levels.

4/30/97

The records from the Cleveland Clinic from early 1990's also included x-rays of the cervical spine. This demonstrated degenerative disc disease in the lower cervical levels from the C5-6 and the C6-7 level as well.

Records were reviewed from Dr. Howard Fagan which did not include any discussion of orthopaedic abnormalities.

The final record reviewed was a consultation letter from Dr. Bruce Bond and also from Dr. Harold Mars. These physicians have certainly expressed their opinion concerning their relationship of her disc disease solely to the motor vehicular accident in question. It does not appear that either of these physicians were aware of previous abnormalities that date back to the early 1990's at virtually the exact same disc levels.

In conclusion, the original opinions expressed in my letter of September 21, 1996, have not changed. In my opinion, the ongoing subjective symptoms are related only by the patient's history to the motor vehicular accident in question. She clearly had substantial degenerative disc disease and arthritis of the cervical spine that was visible even in standard **x-rays** as far back as 1990. Clearly the chronicity of this degenerative problem would cause the ultimate MRI appearance that was present in mid-July of 1996. In my opinion, the disc abnormalities were unrelated to the accident in question. The only causal relationship is being drawn by the plaintiff herself with the residuals of this motor vehicular accident. These disc abnormalities, in my opinion, are solely degenerative in nature,

Sincerely,

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