Highland
Musculo-Skeletal
Associates, Inc.

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May 3,1997

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RE: Gene F. High
Case No. 96 CIV 0015 (Medina Co)
File No. 97-007

Dear Mr. Palik:

I evaluated the above plaintiff in my office on **April** 25, 1997, in the presence of both his wife and his attorney, Mr. Arthur Clark. This evaluation was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on February 2, 1994.

The history presented was that the plaintiff was the driver of a mid-size Dodge Dakota vehicle in York Township, heading east bound on Route #18. **A** car coming in the opposite direction turned in front of him. **A** front and driver's side impact occurred.

He stated that the primary injury at that time was when his knees hit the dashboard. He stated that his right knee was more severely injury, but according to the records, the left knee was the one that was most troublesome in the initial few days. He also

claimed to have hit the back of his head on the glass on the back of his cab: There was absolutely no complaints in reference to the right knee initially.

He was conveyed to ambulance to the Medina General Hospital emergency room. At that time a thorough trauma evaluation was performed. Again there were no complaints of right knee pain, only head and left knee pain. In fact, no x-rays were done of his left knee. X-rays at that time revealed some degenerative changes in his patellofemoral joint, but no traumatic evaluations were noted.

He subsequently came under the care of Dr. R. Daniel Cevasco, Jr., his family physician. He was seen on February 3, 1994, again complaining only of left knee and neck **pain.** Objectively there was a full range of motion of his neck. There was tenderness along the lateral aspect of the quadriceps, as well as tenderness in the peripatellar area. Again, no mention was made of the right knee pain.

His initial orthopaedic consultation was not until February 18, 1994, approximately two weeks later. He went to Dr. Thomas Ebner complaining of essentially a head-on collision injury his left knee. Three or four days he began having pain in the right knee, primarily along the anterior medial aspect of his knee. The left knee had abrasions that had pretty much healed by that first visit. He complained of medial right knee pain which was aggravated by walking. Occasionally it felt like something was slipping out of place, but no true locking was noted. Physical exam showed no instability. Very mild arthritis was noted of the right knee. Initially this felt to be a strain of a possible meniscal injury.

He was seen approximately 3 weeks later again with about a "50%" improvement in his knee. He did have some crepitance in his knee noted at that time. It was recommended that he continue with his anti-dammatory medication, as well as his bicycling. On follow-up examination on April 12, 1994, approximately two and one-half months later, he was about "70%" normal now, having episodes of discomfort along the medial side. Range of motion was excellent with no effusion,

although he still had some tenderness. A knee injection was done at that time with Decadron and Marcaine, and he was told to continue his exercises.

There was .absolutely no care and treatment rendered to either of his knees from mid-April until early December of 1994. He continued throughout that eight month period of time with continuing knee pain. It was felt that he may have had a tom cartilage and that the arthritis needed to be evaluated. He underwent diagnostic arthroscopy on or about December 6, 1994, at which time a Grade II chondromalacia of the patella and Grade II chondromalacia of the medial femoral condyle was noted. This essentially is not true chondromalacia, but actually chondrosis or early degenerative arthritis. A comminuted meniscal tear was also noted and this was debrided at that time as well.

He never really improved much. He was followed through the bulk of 1995, being seen three months later (four months postop). His work also seemed to aggravate his knees symptoms, walking on concrete floors eight to ten hours a day at the Career Center where he was employed as a teacher. X-rays showed further narrowing of his medial knee joint. He was switched to a stronger arthritis medication when he was seen on June 30, 1995.

Because of increasing varus deformity (this was noted on the initial x-rays as well), he underwent a high tibial osteotomy at the Medina Community General Hospital on February 7, 1996. This was essentially and solely for correction of an angular deformity in the knee to relieve medial knee joint pain and to also diminish the forces along the arthritic inner aspect of the knee joint. The lateral aspect appeared to be fairly well maintained. He was casted for about two weeks, placed in a brace, and started with cycling again. He never went through any formal physical therapy. Ultimately a third procedure was performed on April 9, 1997, and this was a hardware removal. Apparently a partial plate long screw and a staple were employed to hold the osteotomy in place. This healed without consequence and he

actually has an excellent radiological result. The plaintiff, in fact, brought his hardware in for me to view.

Since that time he still continues to complain of a fair amount of pain in his knee. He had to retire from teaching in June of 1995. There was no past history of a previous knee injury or problem.

In reference to his neck, he had x-rays that were done which showed some degenerative changes. He was having primarily chiropractic treatments from a Dr. Thomas L. Funk. He has given him cervical spinal manipulations, as well as some therapy.

CURRENT MEDICATIONS include Lanoxin, Aspirin, and Darvocet for pain.

CURRENT SYMPTOMS: At the time of this evaluation he still complained of right sided neck pain. This was primarily in the midline and radiated into the right trapezius muscle. Heat seems to help it. The flexibility and stretching exercises seem to help it as well. Rainy and cold weather seems to aggravate his neck symptoms. He still complained of some stiffness.

In reference to his knees, he has no symptoms in his left knee, although as noted OR the examination below, he has a very prominent varus deformity. His right knee still bothers him when he is going up and down steps, and slopes. These are primarily patellofemoral joint problems. Sitting and driving for long periods of time also gives him some increased discomfort, primarily in the patellofemoral joint. The osteotomy seemed to help his joint line pain. He does not use a cane or a crutch, but has a Velcro hinged knee brace which he wears on occasion. Standing and walking still bothers him. He did explain his classroom situation which he retired from was three classes in the morning and three hour "labs" in the afternoon.

PHYSICAL EXAMINATION revealed a pleasant, somewhat subdued, 58 year old male who appeared in no acute distress. He was observed walking in and out of the exam room, and did not have any discernible limp. 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 no objective signs of spasm, dysmetria, muscular guarding or increased muscle tone. There was a very minimal degree of stiffness with over 85% of the normal predicted range of motion in forward flexion, extension, side bending and rotation. There was some tenderness noted in the **right** trapezius muscle, but this was not accompanied by any objective abnormality.

Examination of his right knee revealed a well-healed transverse scar compatible with his surgical history. There was also a number of arthroscopic incisions that were well-healed as well. No effusion was noted in his right knee joint. The knee examined with a perfect straight non-angular position. The left knee had a very prominent five degree varus positioning. (It should be noted that the initial x-rays showed an identical deformity in the right knee prior to the osteotomy.) Range of motion of the knee was performed from full extension to 135 degrees of flexion. His medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no rotational instability. **A** negative Lachman sign was noted. There was some crepitance noted in the patellofemoral joint which is where he was somewhat tender. Circumferential measurements of the upper and lower thigh and upper and lower calf level showed no atrophy in the right leg. He appeared to have objectively recovered.

IMPRESSION: Contusion of left knee as **part** of the injury with a cervical strain. Subsequent development of right knee **pain.** Degenerative arthritis of the right knee (unrelated). Status post debridement and meniscectomy, as well as high tibial osteotomy (unrelated to claim).

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the Medina Community General Hospital including the emergency room and two surgical procedures, Dr. Thomas Ebner, Dr. Thomas Funk, and Dr. R. Daniel Cevasco, Jr. I have also had the opportunity to review the records from the Medina Life Support team, as well as the x-rays from Dr. Ebner's office.

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.

According to the medical records, the injury sustained was to his **left** knee. There is no clear documentation when the right knee **pain** began. There was no mention of **right** knee discomfort in the emergency squad report nor in the emergency room records. There was no notation of a right knee injury in Dr. Cevasco's records as well. It was not until he appeared in Dr. Ebner's office that he had primarily right sided knee joint **pain.** He was treated extremely conservatively for this progressive arthritic pattern. There was absolutely no objective evidence on review of the x-rays and medical records of any permanent aggravation or acceleration of this arthritic condition. It is only a **subjective** aggravation that is the source of his claim.

There is clearly a bilateral varus deformity noted on the initial x-rays done by Dr. Ebner. In my opinion, this is a **symmetrical** deformity. Ultimately some progression of the arthritis would have been expected. It is by the patient's history that this accident aggravated the symptoms. There is no indication that the arthritis; however, progressed at any more rapid rate than would be expected as **part** of its normal natural history. In fact, the postop osteotomy films show excellent preservation of the medial knee joint. On the basis of the objective findings, I cannot understand why he is unable to return to some gainful employment working as a carpenter.

This physical examination as noted, other than the scarring, was quite normal. There was no ongoing clinical abnormality that could be detected in the radiological review or on my examination. On the basis of this evaluation, without any substantial physical abnormality, as comparing one leg to the other, I see no clear explanation why he cannot stand and walk intermittently for three hours per day or supervise the laboratory part of his previous employment. On the basis of this evaluation, it is not clearly apparent why he cannot work at this point in time.

I did have the opportunity of reviewing an Independent Medical Evaluation done by Dr. Paul Steurer, Jr. This evaluation was carried out on September 3, 1996. It is clear after review of Dr. Steurer's records that there has been a good improvement in the claimant's ongoing objective findings, although his subjective complaints continue. As stated above, it is only by the patient's history, that the arthritis and the treatment for the arthritis was related to the motor vehicular accident in question. In my opinion, the meniscal tear that was noted at the first surgical procedure (arthroscopy) was unrelated to the motor vehicular accident. Had the meniscus been torn as a result of the accident there would have been immediate noticeable pain in the right knee. There were no complaints in the immediate post injury period.

The long term prognosis is quite favorable. There is an excellent result with the reconstructive procedure performed. I do not anticipate any further care or treatment that would be necessary for this gentleman. He certainly has excellent cartilage space, both medially and laterally at this point in time. The probability of a total knee replacement at some point in the future is very low. A similar procedure, undoubtedly, will be performed on his left knee. This would be to correct the varus deformity and to diminish the potential for severe unicompartmental arthritis. Any surgery on his left knee, in my opinion, would be related solely to the progressive arthritic picture and not related to the motor vehicular accident in question.

The overall prognosis is favorable. He is employable by all objective standards in the previous capacity. There may be some restriction in the ability to squat, kneel or

climb in precarious types of footing. I do believe these symptoms could be eliminated by a comprehensive exercise program including weight lifting which has never been recommended.

Sincerely,

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

RCC/bn

cc: File

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Robert C. Corn, M.D., **F.A.C.S.**
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June 19, 1997

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RE: Gene F. High
Case No. 96 CIV 0015 (Medina Co.)
File No. 97-007

Dear Mr. Palik:

I have recently been forwarded additional medical records which are, in fact, the complete medical records from his family physician, Dr. R. Daniel Cevasco, Jr.

In my initial letter to you, dated May 3, 1997, it was reported that there was no previous problems noted with his right knee. However, on review of the complete records from Dr. Cevasco, there, in fact, was one entry on May 26, 1989 in which there was reported a two week sudden onset of right knee anterior and posterior pain, hurting with stair climbing. This would be typical of patellofemoral disease. Physical examination revealed only some tenderness, as well as pain on stressing of the medial collateral ligament. It was felt that the primary problem of his knee was a collateral ligament strain or tear or contusion of the meniscus. There was no specific follow-up with this physician for his knee complaints. Similar symptoms were noted in his opposite knee which necessitated arthroscopic evaluation by Dr. Ebner.

After review of these records the initial opinions expressed have not changed. Intermittent severe symptoms are quite typical of early arthritic problems, especially with activities that are stressful. One of the most stress related activities to the patellofemoral joint is repetitive squatting, kneeling and stair climbing. Bi-mechanical studies that are well recognized and respected in the orthopaedic literature clearly show that these types of activities increased the weight bearing joint surface forces five to six times the individuals body weight. For the average 200 pound male, these forces are in excess of 1000 pounds per square inch. If there is some mild arthritic changes, this would certainly be the type of stress that would aggravate it.

These symptoms may have indicated early arthritic symptoms as far back as May of 1989.

Sincerely,

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

RCC/bn

cc: File