Highland
Musculo-Skeletal
Associates, Inc.

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RE: John Staschiak
File #6417-382

Dear Mr. Murphy:

I evaluated the above plaintiff in my office in the presence of his wife in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on October 31, 1991. The patient at that time was a self-employed individual working for his company that is owned by his Wife, called Jelco. This is a construction company that works out of Girard, Ohio. The company is still operational but the patient states he does absolutely no work for the company.

The injury occurred when he was a pedestrian standing on the side of the road, leaning against the passenger seat with the passenger door open. His pickup truck was parked on the side of Sharon Masuri Road in Brookfield, Ohio. He was leaning against the vehicle with his buttock region on the front seat and with his feet on the ground. He was talking to his wife who was standing more toward the side. This vehicle was rear-ended. The force of the impact forced the car forward and he struck his right hip region. He was then flipped over the door, approximately 14 feet, and landed on his head and neck. He feels that what saved his life was that he landed on a piece of conduit.

He was assisted on the scene and taken to the Northside Hospital in Youngstown, Ohio, where he was x-rayed, examined, treated and released. X-rays of the cervical spine were performed, as well as a CT scan. He was discharged with a diagnosis of cervical strain in that there was no back injury noted at that time.

He subsequently returned back to his family physician, Dr. Denise Bobovnyik. The care and treatment at that time was performed primarily for neck, mid back and low back pain. The low back pain started shortly after the accident. We began having left greater than right leg pain in a somewhat unusual neurological pattern within a few weeks of the accident. Physical therapy was initiated and ultimately an MRI scan performed. This revealed a degenerative and slight herniated disc at the L5-S1 level, more toward the left side. The physical therapy was not improving his subjective symptoms and he was evaluated by a neurosurgeon, Dr. Murali Guthikonda for a one-time evaluation on February 5, 1992. The chief complaint was low back pain with numbness. Review of the MRI scans showed a central disc bulging with slight extension toward the left side and it was felt by this physician to necessitate surgery. Review of the actual MRI scan revealed primarily a degenerative disc with bulging and narrowing. There was clearly long-standing disease at the L5-S1 level which the plaintiff states was asymptomatic.

He subsequently came under the care of Dr. David M. Baroff who has remained his treating physician since the initial evaluation. A conservative approach has generally been followed with no further diagnostic scans being down until fairly recently. His initial consultation was on February 12, 1992. He was treating him with a variety of medications, as well as extensive physical therapy. The therapies that were performed included some work conditioning. He had a series of four lumbar epidural blocks in two sessions which seemed to help his symptoms for a very short period of time. When the last injection did not help him, these were discontinued.

He recently had a CT scan/myelogram done which again did not show any operable lesions. Essentially he is suffering from degenerative disc disease with a subjective dysesthesia, that is, decreased sensation and numbness down the lateral aspect of his left leg. He did state that he tried to return to work in 1993. This is discussed below,

This was unsuccessful after a three week period of time. It was mentioned that he has been scheduled to see Dr. Sanford Emery for a second opinion. Dr. Emery is an orthopaedic surgeon at University Hospitals of Cleveland.

CURRENT SYMPTOMS: At the time of this evaluation he complained that his **pain** pattern was essentially 80% in the low back region, 20% in the leg. He complained of diffuse dull aching pain when climbing, walking, standing or sitting. The **pain was** poorly localized in the lumbosacral region from about the L3 to L5 area. Any attempt at walking on uneven ground, vibration of the heavy equipment, or climbing would bother him. He has a diffuse numbness which essentially radiates from the lateral iliac crest region along the entire lateral aspect of the leg and some anterior aspect of the thigh. This did not follow any particular neurological pattern. He clearly had symptoms above the knee and below the knee, strictly along the lateral aspect, left leg worse than the right leg. He also complains of numbness occasionally associated with some sharp burning **pain.** The left leg gives out frequently. He reached his point of maximum medical improvement on July 5, 1995. He takes over-the-counter medications and occasionally a Darvocet for pain.

EMPLOYMENT HISTORY: The patient has had a number of jobs all of his life. He worked for a time as a semi-truck driver. He was a heavy equipment operator for a local fill company, and more recently in the early 90s, self-employed through a company that was owned by his wife. This company still remains in operation although he claims to have no part of the management or the working of the company,

PHYSICAL EXAMINATION revealed a pleasant 50 year old male who appeared in minimal distress. As will be noted below, there were a number of discrepancies noted at the time of the physical examination. His gait pattern was normal. He was observed walking in and out of the medical building, and he walked without a limp. He was able to heel and toe walk in the examining room. There was no gross atrophy noted in either lower extremity.

Examination of his cervical spine revealed very minimal restriction of motion in forward flexion, hyperextension, side bending and rotation. There was a subjective

limitation of approximately 15% of predicted normal. This was not associated with any objective findings of spasm, dysmetria or muscular guarding. Protraction, retraction, and elevation of the scapulae were performed normally. There was a normal examination of both shoulders.

Examination of his thoracolumbar spine revealed two very small subcutaneous lipomas. These apparently surfaced after the accident. These are not typically traumatic in origin.

Examination of his lumbar spine revealed a normal posture and station. There was no spasm, dysmetria, or muscular guarding noted. The first discrepancy was noted in lumbar flexibility. In the standing position he could barely bend forward to touch his upper thigh. However, in the sitting position he could reach down clearly beyond the mid tibia region bilaterally showing how the numbness traveled distally in his lower extremity. Hyperextension, side bending, and rotation showed subjective limitation of approximately 15% of predicted normal. His straight leg raising in the sitting position was performed to 90" with a negative Lesague's sign. In the supine position; however, I could barely lift his legs past 45°. He did not appear in any distress throughout this examination. His leg lengths were equal. Circumferential measurements of both lower extremities at the upper and lower thigh, and upper and lower calf level, were equal and symmetrical bilaterally. He claimed to have a decreased sensation along multiple nerve roots from the lateral iliac crest all the way down to the lateral ankle to the lateral malleolar region. Reflexes were symmetrical.

IMPRESSION: By history, a cervical strain and lumbosacral strain. MRI evidence of degenerative disc disease with bulging and/or herniation. Objective discrepancies noted during the exam.

DISCUSSION: I have had the opportunity to review a number of medica1 records associated with his care and treatment. These include the records from the Trumbull Memorial Hospital. Northside Medical Center, Drs. Bobovnyik, Guthikonda, and Baroff; records from Johnson Physical Therapy, Austin Woods, and records from Dr.

Gary Katz and **Mark** Anderson and Associates who evaluated his "rehabilitation potential".

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.

On the basis of this evaluation, in my opinion, he sustained a soft tissue strain or sprain of the neck, mid and low back region. He developed subjective numbness which did not follow any neurological pattern. He did; however, have failure to improve in his overall symptoms with the physical therapy and care by his family doctor. An MRI scan ultimately was performed which was abnormal showing degenerative disc disease at the **L4-5** and L5-S1 level. It was slightly worse at the lower level. There was **a** very slight "'herniation". There was no neurological impingement. There was no objective reason for his radicular symptoms.

On the basis of physical examination there was no objective neurological abnormalities. **As** noted, there were significant discrepancies between the sitting and supine straight leg raising, as well as in the lumbar spinal flexibility. There was also complaints of neurological pain without objective findings, and minimal objective imaging studies. These findings when summarized usually indicate a degree of malingering or at least an attempt by the claimant to exaggerate his symptoms.

On the basis of this evaluation, I have no clear explanation why this gentleman cannot return to work as a heavy equipment operator. There is excellent lumbar flexibility. I have reviewed the Mark Anderson report and I am at a loss as to the explanations given that would prevent him from returning back to work. Clearly, the bulk of this evaluation is on the basis of his **subjective** complaints. As stated above, there are minimal verifiable objective abnormalities to correspond with his various subjective complaints.

It is my opinion, within a reasonable degree of medical certainty, that he has recovered from the bulk of his soft tissue injuries. His ongoing symptoms can be solely related to

degenerative disc disease of the lumbar spine and the minor "herniation". He does not have any neurological deficits on physical examination. I am at a loss as to why he cannot return to active employment, even in a sedentary fashion, assisting and operating his family business. There is no clear indication for any surgical procedure. In my opinion, any further care or treatment is solely related to his degenerative condition.

Sincerely,

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

RCC/bn

cc: File

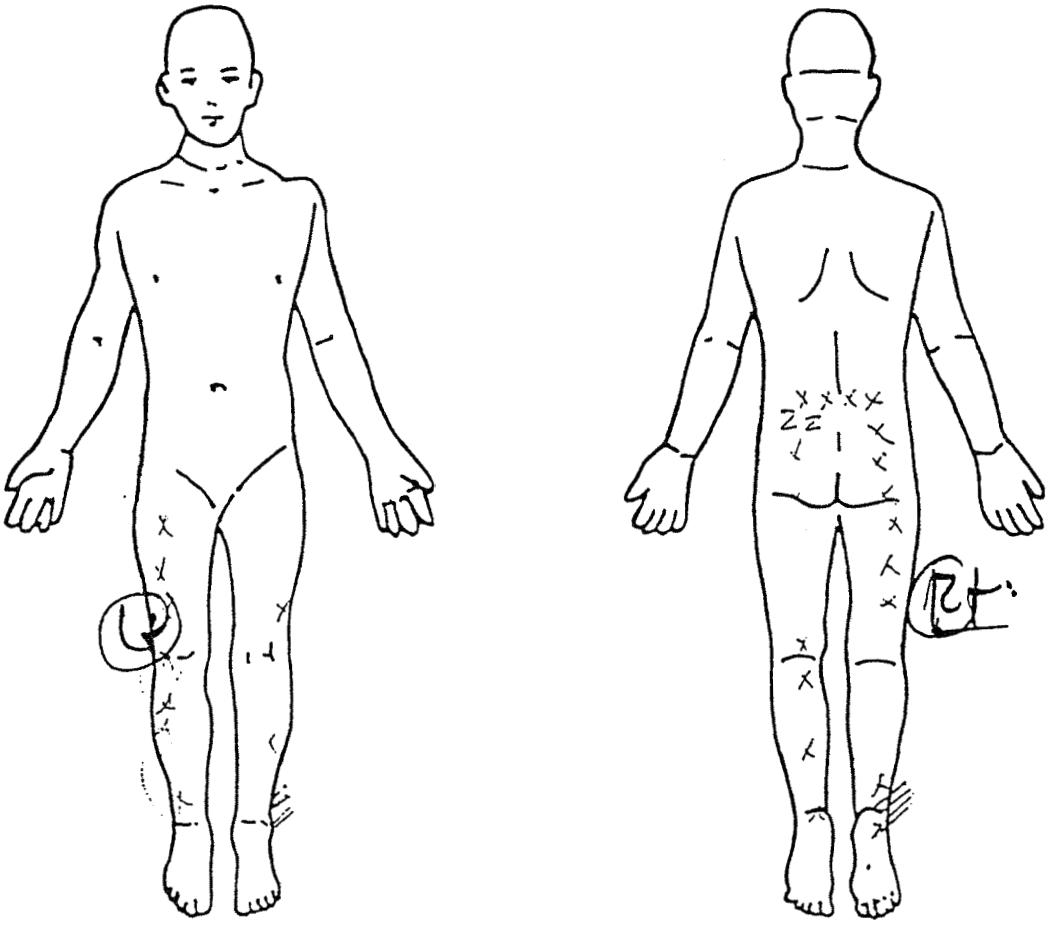
HIGHLAND MUSCULO-SKELETAL ASSOC., INC.

PAIN PATTERN DRAWING

PLEASE INDICATE ON DRAWING TYPE AND LOCATION OF PAIN USING CHOICES BELOW:

PINS AND NEEDLES = OOOO BURNING = XXXX STABBING = //// DEEP ACHE = ZZZZ

NUMBNESS



FRONT VIEW BACK VIEW

RATE YOUR PAIN 0 = No Pain ⟶ 10 = Extremely Intense

1. Right now	0	1	2	3	4	(5)	6	7	8	9	10
2. At its worst	0	1	2	3	4	5	6	7	8	(9)	10
3. At its best	0	1	2	3	(4)	5	6	7	8	9	10

PATIENT NAME: