Highland
Musculo·Skeletal
Associates, Inc.

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Mark R. Chulick
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RE: Richard Summers

Dear Mr. Chulick:

I evaluated Richard Summers in my office on May 3, 1996, in reference to alleged residuals of injury stemming from a motor vehicular accident which occurred on December 4, 1991. Throughout the history and physical he was accompanied by a paralegal from the plaintiffs law firm, Ms. Kim Pardue.

In general, as you are aware, this is a somewhat complicated case. There is a question as to what were the original injuries and whether these have resolved with development of subsequent other problems. As you are aware, the symptoms and areas of complaints changed to some degree over the years following this accident. I will try to present this in a chronological order using both references from the medical records, as well as from the history obtained.

Mr. Summers is employed as a part-time police officer and an attorney. He was on his way to the Lake County Courthouse when the accident occurred. This was on December 4, 1991, described as a light snowy day. He was operating a large Chevrolet Blazer 4-wheel vehicle, heading; east-bound on Route #2. He was in the left of these three lanes, heading east toward Lake County. A car in front of him spun out of control and ended up facing toward his vehicle. This occurred "in seconds". He

attempted to slow down and stop his vehicle, but a front-end impact occurred. What essentially happened is that in that his vehicle was a somewhat large 4x4, he essentially ran over the other car. The impact was on the front aspect and his wheels when over the car. Both cars hit the median. His vehicle was operable.

From what he can remember, his left knee struck part of the interior of the car, his right lower extremity he said was "twisted". There was no emergency room visit and there was no medical care rendered until the following day.

At that time he saw Dr. Pogorelec, his family doctor who has been treating him for a variety of problems since his childhood years. He had been treating him intermittently with steroids for many years for an allergy-asthma problem. He had previously seen this physician in the months prior to this accident. Dr. Pogorelec was the physician who was carrying for his back over the years prior to this motor vehicular accident. It is difficult to review Dr. Pogorelec's records in that he apparently has kept two charts as of the December 4, 1991 accident. There was clearly references to pain in his lumbar spine in the months just prior to this accident. The details are somewhat obscure in that his writing is somewhat eligible. There was complaints of back pain as close to the accident as November 15, 1991, less than one month prior to the accident.

Within two days he was seen by a second physician, Dr. Gerald Yosowitz of Beachwood Orthopaedics. This initial visit was on December 6, 1991. Primarily complaints at that time were pain in the low back and **left** leg. There was only minimal reference to **right** leg that seemed to radiate from the groin along the inside of the leg. It was felt that his initial injury was a "cervical and lumbosacral myofascitis and contusion of left knee, headaches".

Dr. Yosowitz followed Mr. Summers for a period of time on a very intermittent basis. According to the records this was December 6 and 16, 1991; May 19, 1992, and then not until May 6, 1993, a full year later. A great deal of discussion was carried out in May of 1992 concerning his **left** knee and the possibility of arthroscopic surgery. There was never any mention by this orthopaedic surgeon of any suspicion of any problems going on in the **right** knee region. Dr. Pogorelec, during this time period, was treating his neck, back, and left knee symptoms. His neck was improved. There

was some aching pain in his back, but absolutely no findings that could be remotely considered radicular in nature.

When he returned to see Dr. Yosowitz in May of 1993 the neck, low back, and left knee still continued to bother him. There was mechanical symptoms specifically directed to his **left** knee only at that time. By May of 1993 some suspicion of a radiculopathy was being entertained as there was a positive straight leg raising sign. Recommendations for a CT scan was made and this was carried out on May 18, 1993. This was interpreted as normal. Dr. Yosowitz continued through 1993 to see him on two additional occasions, July 9, 1993 and for a final visit on October 4, 1993. At that time, again no suspicion was raised for any disc problems in his lumbar spine specifically nor were there any symptoms whatsoever in reference to his right knee.

An IME evaluation was carried out by Dr. Mark Fumich on May 17, 1994. At this point in time there was actual right lower extremity discomfort, left knee pain, and low back pain. Dr. Fumich does not mention anything in reference to an isolated **right** knee problem. It was felt that he had a probable herniated lumbar intervertebral disc on the right side with pain radiating down into the right lower extremity. Again, absolutely no mention of his **right** knee was made.

In early 1994 the patient returned under the care of Dr. Howard Tucker who had seen him previously for his residuals of injury. Dr. Tucker saw him initially for this accident on February 11, 1994. He had seen him for his previous 1987 residuals of injury. The first MRI scan of his lumbar spine was ordered on February 15, 1994, and revealed a disc herniation at the L5-S1 level including some mild compression on the right nerve root. He was treated conservatively during 1994 with five or six epidural blocks in September and October of 1994, and again in March and May of 1995.

A different group of physicians saw him again throughout the bulk of 1995. Dr. Robert Zaas, an orthopaedic surgeon, saw him on January 25, 1995; Dr. Ben Columbia, a neurosurgeon, on June 8, 1995; and he began chiropractic treatment that Spring on March 18, 1995 by Dr. Bondra. It was not until Dr. Zaas saw him in January of 1995 that symptoms were localized to the **right** knee. I inquired as to his right symptoms and the plaintiff stated that "the pain was there all the time but no one

ever found any problems with my knee." An MRI of the right knee ultimately revealed a torn medial meniscus and Dr. Robert Leb performed arthroscopic surgery in mid-December of 1995. This relieved some of his right leg symptoms.

He also came under the care of Dr. Richard Zinni through his private health insurance. This evaluation was not again until 1995. Dr. Zinni was the physician who referred the plaintiff to Dr. Leb for his knee surgery and Dr. Columbi for his neurosurgical evaluation. Second and third MRI scans of his low back were performed on October 28, 1994 and again on July 5, 1993. Apparently this herniated disc began to dissolve and took on the appearance of a degenerative Qsc. This disc apparently "desiccated" in other words the degenerative process continued. One must recall there was absolutely no diagnosis of a herniated disc until 1994, over two years after the motor vehicular accident in question. This is when the pain became more right leg in nature and more neurological in nature.

In recent weeks, he continues to follow with Dr. Tucker, Dr. Zaas, Dr. Zinni, and Dr. Pogorelec. Apparently surgery was recommended but has not been performed as of yet, It also should be noted that the patient developed insulin dependent diabetes as a result of "cortisone administration". It is doubtful that it was the cortisone from the epidural blocks, but more likely the cortisone he had been receiving on a yearly basis which ultimately produced rather significant diabetes. He has never had any EMG and nerve conduction studies to ascertain whether the below described radicular type symptoms were diabetic in nature or whether they were strictly from the L5-S1 disc abnormality.

CURRENT MEDICATIONS include a Duragesic Patch, Lorcet 10/65 a headache medication which he has been taking since 1957, and Valium 10 mg, all on an intermittent basis.

PAST MEDICAL HISTORY revealed the two previous injuries in the 1980s. He clearly stated that his low back symptoms were resolved by "four to six months after the 1987 accident". This clearly is not true on the basis of review of Dr. Pogorelec's records which clearly indicate narcotic analgesics being prescribed into 1990 and early 1991, and complaints of low back pain as late as November of 1991.

CURRENT SYMPTOMS are confined to a number of areas. These include the right knee and right leg, low back and left knee symptoms.

In reference to his lumbar area, he Complains of a constant aching pain in his low back, the right side slightly worse than the left. This can be anywhere from a mild to a severe ache and stabbing pain. The pain seems to be located along the iliac crest region just to the right of the midline mostly and this radiates into the buttock and upper thigh, and then along the lateral aspect of the right leg and along the lateral aspect of the right foot, following the S1 nerve distribution. He states that it was the entire right leg that was bothering him prior to his knee surgery and just that "no one figured out that I had somethmg wrong with my knee".

Specifically in reference to the right knee, he occasionally has a dull aching pain along the medial aspect. He feel this is greatly improved over the past. few months since the surgery.

In reference to his left knee, he still has a dull aching pain. This clicks and gives way. He has problems on stair climbing and when he is on his leg for too long, the leg gives out.

PHYSICAL EXAMINATION revealed a pleasant, well-groomed 42 year old male who appeared his stated age. He was able to arise from a sitting position without difficulty. Ascending and descending the examining table was done in a very minimally labored fashion. He was able.to heel and toe stand without difficulty. When observed leaving the medical facility; he did not have any visible limp.

Examination of his lumbar spine failed to reveal any spasm, dysmetria, or muscular guarding. There was a number of discrepancies noted during the physical examination. In the standing position, he could barely bend forward to touch his mid-thigh level. However, in the sitting position, he could easily bend down to touch the upper or middle calf level, showing me where the numbness started. This was able to be done with his hips at 90° and essentially in a straight leg raise position. Hyperextension, side bending, and rotation were performed with minimal limitation with only

complaints of pain at the extremes of motion. There was good reversal of his lumbar lordosis when he attempted to flex forward.

His straight leg raising in the sitting position was performed to 90" bilaterally. There was a mildly positive Lasegue's sign on the right side with his legs at 90". However, in the supine position the right leg could barely be lifted 20" off the table. The left leg could be easily lifted to about 85-90°. His leg lengths were equal. Neurologic examination revealed symmetrical reflexes. He claimed to have a decreased sensation along the lateral aspect of the right leg and foot. Circumferential measurements failed to show any atrophy in his thigh, and less than 1 cm of atrophy in his left calf. The balance of the examination was w i t h normal limits.

IMPRESSION: Accident related, probably strain or sprain of the low back. Contusion of left knee. Other diagnosis, progressive degenerative disc disease at the L5-S1 level, tom medial meniscus left knee, insulin dependent diabetes mellitus, and chronic subjective pain - not specifically related to this motor vehicular accident.

DISCUSSION: I have had the opportunity to review a significant number of medical records. These include the pre and post accident records from Dr. Pogorelec, Dr. Yosowitz, Richmond Heights General Hospital, Dr. Zinni and Meridia South Pointe Hospital, Drs. Shafi-on and Columbi, Dr. Fumich, Drs. Bondra, Zaas and Columbi, results from the MRI scans done at Advanced Imaging, as well as records both pre and post accident fi-om Dr. Howard Tucker, and finally records from Dr. Robert Leb.

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

At the time of this examination he clearly has signs of right SI radiculopathy. The etiology is probably this degenerative disc which ultimately herniated in either late 1993 or 1994. It is my opinion, within a reasonable degree of medical certainty, that this herniated disc was <u>not</u> related to the motor vehicular accident in question but due to the degenerative disc disease process. It is clear that the later MRI scans show degenerative disc disease only at the L5-S1 level. It was not until late 1993 that this

right leg radicular abnormality developed. This was approximately two years after the motor vehicular accident in question. If, in fact, the herniated disc developed solely related to this accident, it would have appeared at a much earlier time interval.

In reference to his left knee, in my opinion, this was merely a severe contusion at worst. He has some vague chondromalacia symptomatology, that is patellofemoral joint symptoms. There are no objective findings at the time of the evaluation. There was no any palpable retropatellar crepitance at the time of this exam.

In reference to his right knee, in my opinion, the medial meniscal tear suddenly appearing as an isolated symptom in 1995, is unrelated to the motor vehicular accident in question. Although the plaintiff states the right knee bothered him all the time, he never mentioned this to any of his treating physicians nor was this investigated until 1995. This tear was accurately and adequately treated by Dr. Leb. In my opinion, the relationship of the right knee problem has nothing to do with the motor vehicular accident in question.

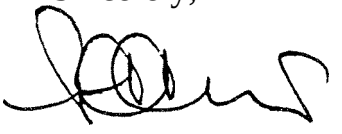
The last remaining area is the "radiculopathy". This clearly did not develop until 1993, many months after the motor vehicular accident in question. I am not sure whether this radiculopathy is on the basis of neurological pressure (not terribly well defined by the MRI scan) or due to his diabetes. An EMG and nerve conduction study would be appropriate before any surgery of the low back is entertained. If this shows signs of diabetes and not compression radiculopathy, then surgery would be inappropriate, not indicated, and if performed, unrelated to the radicular symptomatology.

As stated above there are some objective findings which correspond with his subjective complaints. There are outlined above. There were a number of discrepancies noted at the time of this evaluation including the difference in lumbar spinal flexibility and the difference in the supine and sitting straight leg raising. In that these two tests test same the same anatomical area, any discrepancy in the testing indicates a degree of malingering or at least an attempt by the patient to exaggerate his symptoms.

The above medical findings indicate Qfferent area of complaint as the years go on. There are definite objective findings, both from the MRI and on physical examination, compatible with radiculopathy. It is yet to be established whether this is due to his diabetes or due to a neurological compression by this degenerative disc. In my opinion, this disc "hernia" was due to progressive degenerative disc disease related probably to the type of work that he has been performing and his previous accidents. If, in fact, a surgery is necessary, in my opinion, this results from degenerative disc Qsease and his previous injuries and occupation. On the basis of this evaluation he has substantially recovered from any soft tissue injury sustained. The long-term prognosis is generally favorable.

If any of the 1996 records become available or if the MRI scans can be reviewed these will be done and additional opinions rendered.

Sincerely,



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

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