Highland
Musculo-Skeletal
Associates, Inc.

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Rose **A.** Patti
Attorney at Law
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Suite #1
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RE: Donald Schuller, Sr.
Case #289404
File #G0021/S1419

Dear Ms. Patti:

I evaluated the above plaintiff, Donald Schuller, Sr., in my office in the presence of his attorney, Mr. James Koplow. This was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident, which according to the plaintiff occurred on June 22, 1993, but according to the medical records occurred on June 19, 1993.

The patient presented with a history at that time of a motor vehicle accident in which he was the driver of a Plymouth Mini-van and solo occupant of this vehicle. The accident occurred on Center Ridge Road in front of the Westgate Shopping Mall at one of the mall exits. This was on a Friday or Saturday. He was wearing a seat belt. A car coming out of the parking lot struck the passenger side of his vehicle.

At the moment of impact he stated he was thrown into the driver's door and struck his left side, His left foot was on the floor. He does not remember any specific injury to his left knee. There was a twisting injury to his neck and back. There was no loss of consciousness. The vehicle was drivable, he went home, and the following Monday he brought his car in for repair. Over the next few days he began having increasing **pain** and stiffness in his neck, upper back and shoulder area. His neck was very painful.

Initially he was evaluated at the Fairview Hospital Emergency Room three days after the motor vehicle accident where he complained of pain primarily in the left trapezius muscle. He said there was also **pain** radiating down into his hand but that was not **part** of the emergency room records. X-rays were performed which showed multiple level degenerative disc disease and arthritis at the C3-4 and C6-7 level. X-rays of the **hip** were done which were interpreted as normal.

He subsequently came under the care of Dr. Donald Ross, his family physician. **The** primary treatment rendered was specifically for his neck, upper back, and left shoulder. There is no direct reference to any treatment provided by his family doctor to his left knee until June 28, 1994, about a year after the motor vehicular accident. X-rays were reviewed of his cervical spine and lumbosacral spine which revealed basically just degenerative arthritic changes **with** no signs of trauma. Physical therapy was prescribed through the Fairview Hospital Wellness Center for his left side neck and **hip** region. He continued to follow with his doctor for over a year without complete resolution of his symptoms. He had a few sessions of physical therapy. The total number was difficultto ascertain from review of the medical records.

The following summer, that is **one year post** injury, he was seen by two orthopaedic surgeons, Dr. Kenneth Chapman for his spine, and Dr. Duret Smith for his left knee symptoms.

In reference to his spine, when he saw Dr. Chapman he related the neck pain and discomfort to the motor vehicular accident in question. Essentially on examination he did have a full range of motion with normal muscle power. There was no objective findings at the time of the examination. Although there was a decreased sensation along the lateral aspect of his left hand, there was no neurological inflammation that was detectable on clinical exam. The impression was "cervical spine disease". Ultimately, in December of 1995, an MRI scan was finally done which showed degenerative changes of the spine at the C3-4 **with** bilateral foraminal stenosis. **This** indicates long-standing degenerative disc disease and arthritis. It was Dr. Chapman's opinion that this arthritis, by the patient's history, was aggravated. There was no **objective** signs of worsening of his spinal condition.

In reference to his left knee, initial evaluation with an orthopaedic physician was on June 22, 1994, about one year after the injury, with Dr. Duret Smith, his previously treating orthopaedic surgeon for some problems related to systemic gout. At the time of the initial evaluation there was absolutely **no mention of the motor vehicular accident.** The plaintiff described to the physician ongoing problems of his left knee for a period of time. There was occasional swelling of the left knee. Physical examination revealed retropatellar crepitance; a small effusion. X-rays at that time showed degenerative arthritis with chondrocalcinosis indicating long-standing degenerative changes probably related to gout. He was started on Indocin, an anti-inflammatory medication which seemed to help. There was absolutely no history of multiple steroid injections. This was suggested in the operative notes, as will be discussed below.

He was followed for his knee approximately one month later, again not mentioning anything about the automobile accident. Arthroscopy surgery was discussed. He was followed intermittently through the balance of 1994 for both his spine and knee condition. In early February of 1995 it was diagnosed that he had a slight heart attack and underwent a cardiac evaluation for this.

Review of the records from 1995 show very minimal care or treatment for either his spine or back condition. He was seen on January 9, 1995, February 13, 1995, August 8, 1995, and then on November 7, 1995. They were all specifically for his knee symptoms and not his spine. In November of 1995 he was also evaluated for his spine. Ultimately on November 9, 1995, he underwent arthroscopic surgery at the Fairview Hospital for "torn meniscus with partial lateral meniscus tear, chondrocalcinosis and arthritis of the knee". According to the operative note, there was a great deal of calcifications noted throughout the entire suprapatellar pouch and scattered throughout the undersurface of the patella. There was a tremendous amount of synovitis which was encrusted with calcium deposits as well. This was a verbal description of a degenerative or inflammatory condition which was rather advanced versus a traumatic type finding.

Postoperatively he seemed to do quite well and was followed with the appropriate physical therapy and follow-up care. He has not had any substantial medical care or treatment for many months, other than oral medications.

CURRENT **MEDICATIONS** are only Indocin, an anti-inflammatory medications, as well as cardiac medications.

EMPLOYMENT **HISTORY:** He is employed as a manufacturer's representative for camping and outdoor sporting endeavors. He states he lost about six weeks of work.

PAST MEDICAL HISTORY failed to reveal previous medical care for his spine or left knee. He did have a history of a sprained ankle with a gouty complication. There were signs and treatment of systemic gout for many years.

CURRENT SYMPTOMS: At the time of this evaluation he complained of pain primarily in two areas, the neck and left upper extremity, as well as the left knee.

In reference to his neck, he complains of primarily aching discomfort in his left trapezius muscle. This occurs primarily when he is maintaining one position for long periods time, such as driving. Lifting items at the trade shows seem to aggravate his left shoulder as well. There was no true radicular or radiating type of pain. The bulk of his pain was in the left trapezius area. He also had a home traction unit which seemed to help him. He has never had any electrical studies of his ripper extremities.

He does complain of some numbness on an intermittent basis in the left ring and little finger. As will be noted below on the physical exam, there was specific irritation around the ulnar nerve at the elbow. This, in my opinion, was related to an elbow problem, not related to the neck.

The left knee is still somewhat symptomatic. The arthroscopic surgery helped to some extent. There is less effusion (water on the knee) although it still feels swollen. It feels weak. The Indocin seems to help the aching pain.

PHYSICAL, EXAMINATION revealed a somewhat large-frame 61 year old male who appeared his stated age. He appeared to sit, stand, and move about the examining room normally. His gait pattern was normal. He was able to arise from a sitting position without difficulty. Ascending and descending the examining table was also performed normally.

Examination of his cervical spine revealed very minimal decreased range of motion, less than 10% of predicted normal at forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. He did claim to have some tenderness in the left trapezius muscle area, but in no other area. There was no anterior, lateral or any right-sided posterior upper shoulder or neck problem. Range of motion of both shoulders was symmetrical in forward flexion, extension, abduction, internal and external rotation. The patient is right handed. The elbows, wrists, and small joints of the hand examined normally to observation. Palpation and tapping of the left ulnar nerve at the elbow mimicked his "numbness" precisely. No movements of the neck created the left hand numbness. Circumferential measurements of both upper extremities at the axillary, midarm, forearm, or wrist level were equal and symmetrical bilaterally. Neurologic examination was normal.

Examination of his left knee revealed well-healed scars compatible with his arthroscopic surgical history. He appeared to have a boggy type of synovitis. There was full extension with medial lateral stability. There was no rotational or anterior posterior instability noted. Some very minor crepitance was noted in the patellofemoral. This was noted to a lesser extent on the right knee. Circumferential measurements of both lower extremities showed no atrophy. There was increased girth about the knee joint of 1-1/5 cm. This would be compatible with his very slight synovitis.

IMPRESSION: By history, strain or sprain of the neck and low back. No evidence of a left knee injury. Objective findings revealed degenerative arthritis and disc disease of the cervical and lumbosacral spine. Gouty and degenerative arthritis of the left knee with a probable degenerative tom medial and lateral meniscus. Operative

findings indicate a long-standing chronic process with calcium deposits in the synovium..

DISCUSSION: I have had the opportunity to review a number of records associated with his care and treatment. These included extensive records from Fairview Hospital, Dr. Donald Ross, Orthopaedic Associates, Inc., including Drs. Chapman and Smith, records from Dr. Comerford, and the Cleveland Clinic.

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.

It is my opinion, based on a reasonable degree of medical certainty, that the **primary** injury was multiple contusions and a soft tissue strain or sprain of the neck and back. There was absolutely no indication in the records of any precise injury to his left knee. The first time the knee was documented as a problem was one year after the injury. **At** that time there was no mention of a motor vehicular accident. It was not until the theoretical issue was addressed by the plaintiff's attorney that it was felt that the meniscal injuries could have been caused by the accident. There was, of course, no documentation of a knee injury. Injuries of this type that are competent to produce meniscal damage, cause immediate symptoms. It is difficult to understand how the plaintiff could have sustained a significant knee injury without bringing attention to this problem to his medical care givers. In my opinion, his knee symptoms are solely related to his gout and degenerative arthritic conditions. The findings at the time of the arthroscopic surgery clearly indicated along-standing process with chronic synovitis and calcium deposits. This description is not a traumatic picture.

Specifically in reference to his cervical spine, in my opinion, this was primarily a strain or sprain. There may have been a **subjective** aggravation of his arthritic condition, but this was not recognized or opined until one year post injury. He has objectively recovered from his neck trauma, although he still complains of pain, primarily in the trapezius muscle area.

It is my opinion that the numbness and tingling complaints in his left upper extremity area solely related to a peripheral neuropathy about the left elbow. There was no documentation of any specific trauma to this area. The symptoms did not originate with the motor vehicular accident by his history or by review of the medical records. In all likelihood this is due to prolonged resting of his left arm on the armrest on his motor vehicle during his long drives. In my opinion, this is not related to trauma.

The long-term prognosis is favorable for the soft tissue injury component. There is no objective evidence at the time of this evaluation of any ongoing treatable orthopaedic abnormality related to the injury. In my opinion, the gouty arthritic condition of his left knee will continue in the future. He should be followed more closely by an endocrinologist in order to more efficiently treat his systemic gout condition. In my opinion, he has objectively recovered from any soft tissue injury sustained. The prognosis for his arthritic condition is guarded as this degenerative condition always worsens in both the neck, low back and knee. There is, in my opinion, no objective permanent aggravation or acceleration of his degenerative conditions. The prognosis is favorable.

Sincerely,

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

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