Highland
Musculo-Skeletal
Associates, Inc.

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June 16, 1997

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RE: Emery Singer
File No. 8101-11496
Case No. 316892 (Cuyahoga County)

Dear Mr. Havens:

I evaluated the above plaintiff in my office on June 13, 1997, in reference to alleged residuals of injury sustained in a low velocity motor vehicular accident which occurred on November 25, 1995. His wife, who was a front seat passenger in the motor vehicle, was present throughout the entire history and physical.

MEDICAL HISTORY: The incident occurred the day before Thanksgiving in 1995. They were driving down an aisle at the Eastgate Shopping Mall at a low speed. Mi. Singer was the operator of a 1994 Skylark vehicle. They were heading toward Davis Bakery to pick up bread.

A second motor vehicle backed out of a parking space and struck the passenger front end of the Singer's vehicle. He described this as the other car "shot out". He descnied the impact as a fairly hard impact, although by the description it was a low velocity impact. He attempted to avoid the collision trying to turn his wheel to the left. His left hand came off of the steering wheel and he struck the lateral aspect of his left

ann on the side door. He claimed the left ann was painful initially. Police ultimately came onto the scene, but could not file a report as this was private property. They then drove to the Mayfield Heights Police Department and made a police report. The report claimed an injury to the left elbow and left arm. There was no reference to the left shoulder specifically or the left side of his neck.

After making the police report the Singers subsequently drove home. He began having increasing pain in the left arm, shoulder and neck region, and this entire area was "black and blue". Initially he was evaluated at the Meridia Hillcrest Hospital Emergency Room with complaints of left elbow and left sided neck pain. The history presented to the nurse was that there was **pain** in the right shoulder; however, the doctor indicated this was, in fact, his left upper extremity. The examination revealed some tenderness to palpation over the olecranon region without deformity. There was full range of motion that was noted. In fact, no specific ecchymosis was noted. He was provided a sling and a number of x-rays were performed. X-rays were taken of his cervical spine which showed some spondylosis (degenerative arthritis and disc disease) with no signs of trauma. X-rays of the left elbow were essentially normal. He was treated and released.

He contacted his family physician, Dr. Steward Markowitz. He was seen by two of Dr. Markowitz's associates, Dr. Janice Granieri and initially by Dr. Paula Deuley. After the initial evaluation the first specialist to see the plaintiff was Dr. William Seitz, an orthopaedic surgeon. This evaluation was carried out on November 30, 1995. Mr. Singer was seen on one and only one occasion by this physician. The complaints at that time were primarily neurological in nature. He complained of pain in the neck, left shoulder and weakness in the hand. Dr. Seitz was quite concerned because of the progressive weakness in the left upper extremity with excessive pain on movement of his shoulder and neck. He had the inability, at that time, to tie his shoes with his left hand. The examination at that time was remarkable for weakness and limitation of mobility which was felt to be "do more to lack of neurological control than anything else...". There was pains at the extremes of motion of his neck with radiation into the

shoulder. The arm pain was quite severe. A neurological injury was suspected. X-rays done at that time showed some degenerative narrowing of the acromioclavicular joint compatible with mild arthritis in this area. The clinical impression was "acute neurological impairment of left upper extremity". There was no specific mention or suggestion of a rotator cuff injury. Mr. Singer was subsequently referred to Dr. Ben Columbi, a neurosurgeon. He never did see this physician.

His medical doctors sent him for physical therapy for the neck, left arm pain. This included heat, ultrasound and range of motion exercises. The date of the prescription of December 8, 1995. He did not start this therapy until later on that month.

The second specialist he saw was Dr. Grant Heller, a neurologist. The initial evaluation was on December 18, 1995, approximately one month after the motor vehicular accident. The neurologic examination at that time revealed about a 50% decreased range of motion of his cervical spine and diffuse weakness in his left arm, worse more proximally than distal. There was decreased sensation over the entire left arm. The suspected diagnosis was "cervical radiculopathy or brachial plexopathy. Physical therapy was suggested for cervical traction and range of motion exercises. This was ultimately started, as noted above, on December 28, 1995. The therapy continued through late February of 1996. The shoulder range of motion was noted to be somewhat diminished, even by the time of the initial physical therapy evaluation. They started him on a series of stretching exercises. Once his therapy concluded, in late February of 1996, he has had absolutely no therapy for over a year and four months.

He returned to Dr. Heller on February 28, 1996, complaining of ongoing numbness in the left hand. With the cervical traction, by mid-April of 1996, there was some diminished pain in the cervical spinal region. His final visit with Dr. Heller was on June 19, 1996, with some improvement noted. There was no EMG and nerve conduction study ever performed at this point in time. The clinical diagnosis of

"radiculopathy and brachial plexopathy" was made, primarily on the basis of his **subjective** symptomatology.

There was no medical care documented from the time of Dr. Heller's last visit until he saw Dr. Herbert Bell, a neurosurgeon. He has seen Dr. Bell on three occasions, August 29, 1996; September *12,* 1996, and most recently on January 9, 1997. Due to the symptoms, Dr. Jack Anstandig performed EMG and nerve conduction studies on September 7, 1996, which demonstrated "mild peripheral type neuropathy with no evidence of radiculopathy". This rule out the two diagnoses that were suspected by Dr. Heller. The neurological evaluation revealed some diminished left biceps and triceps reflex. This, with the EMG, was compatible with peripheral neuropathy due to diabetes mellitus. The neuropathy was noted to continue at the time of his last Visit on January 9, 1997. He was having difficulty even with activities such as cutting his meat and holding the meat with the fork so that he could cut it with his right hand. He continued with stiffness in the right shoulder. Review of the records never showed any specific rehabilitation to his left shoulder. No further diagnostic studies were performed. The x-rays done under Dr. Seitz's care were not suggestive of a rotator cuff injury.

He has not had any care or treatment since he finished with Dr. Bell. He has been taking Ultram for pain. His symptoms do persist.

PAST MEDICAL HISTORY revealed a well-controlled cardiac problem. He has had diabetes mellitus since the age of 25 and now takes Insulin twice a day.

He has had a number of motor vehicular accidents in the past. He specifically recalled only one in 1985 in which he injured his left elbow. Dr. Howard Tucker saw him at that time for a "bruised nerve". He has not had any care or treatment for many years.

EMPLOYMENT HISTORY: The plaintiff retired in 1985. He had a number of jobs, the last one was a road sign inspector for the State of Ohio. He worked in a brewery for most of his working career.

CURRENT SYMPTOMS: At he time of this evaluation he did not have much discomfort in his cervical spinal region. The bulk of his pain was in reference to his left shoulder with a diffuse aching pain. He had difficulty with function, lifting his ann above the horizontal. This was virtually identical to the same complaints he gave Dr. Bell at the time of his initial evaluation. He can use his arm in a perfectly normal fashion below the level of his shoulder. He has difficulty raising it above the shoulder. It is quite sore and painful. There is no specific pain around the left elbow.

In reference to the left hand, he complains of the same weakness that he did to Dr, Bell. This is a mixed nerve type of weakness, primarily in the distal ulnar nerve distribution. He has poor metacarpal phalangeal joint movement, as well as poor abductor and adductor movement of the hand.

PHYSICAL EXAMINATION revealed a pleasant 70 year old male who appeared in no acute distress. His gait pattern was normal. He was noted to walk normally in and out of the examining suite. He was able ascend and descend the examining table in a normal fashion. He was able to walk on his heels and toes without difficulty.

Examination of her cervical spine revealed a very mild restriction of motion in forward flexion, extension, side bending, and rotation. This limitation was approximately 20% of predicted normal and not associated with any objective findings of chronic muscle irritation or protective posturing. There was no spasm, dysmetria, muscular guarding or increased muscle tone noted. Protraction, retraction, and elevation of the scapulae gave him some discomfort in the left trapezius muscles. This was a subjective response only. The neck, upper back and periscapular muscles showed good motor development. There was no gross atrophy detected.

Examination of the left shoulder; however, was not normal. There was a limited active range of motion past 100 degrees of forward flexion and 75 degrees of abduction. There was further range of motion of, at most, 20 more degrees in all directions. Abduction and adduction; however, were preserved, as was internal and external rotation. The major difficulty was elevating the arm above his head in the forward and lateral direction.

The elbows, wrists and small joints of the hand examined normally. There was diffuse atrophy noted in the left hand. There was poor development of his hypothenar muscles, and he had poor abduction and adduction of the fingers. He had a weakened left hand grip strength due to weakness in flexion of the metacarpal phalangeal joints. There was diffuse numbness noted with decreased sensation that did not follow any particular nerve root distribution. Vascular examination was normal.

IMPRESSION: Resolved sprain of the cervical spine. Resolved contusion of the left elbow. Polyneuropathy of the left upper extremity not traumatically induced. Moderate left "frozen shoulder".

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the Meridia Hillcrest Hospital, including the ER and physical therapy, records from Drs. Seitz, Heller, and Bell. Records were also reviewed from the Mayfield Heights Police Department, the plaintiffs interrogatories, as well as a variety of billing statements.

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.

As noted above, there are definite objective findings noted at the time of this examination. The most dramatic findings were those of his neurological motor capacity in his Ieft hand primarily. In my opinion, his hand dysfunction is not

stemming from any traumatically induced pro lem. It is my opinion that it is stemming primarily from his diabetes.

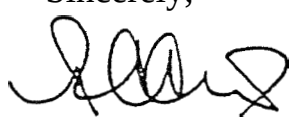
In reference to the left elbow, this was entirely recovered from any contusion, as was the cervical spine from any flexion strain or sprain.

In reference to the left shoulder, the records clearly did not note any direct left shoulder injury. He had complaints in the region of the left shoulder from the time he saw Dr. Seitz. The examination at that time was not suspicious for rotator cuff pathology. Dr. Seitz, the only orthopaedic surgeon who saw him prior to this evaluation, felt this was primarily a neurological injury. This, of course, was never documented by any objective means. It was Dr. Bell's opinion that there may have been some "bruising" of the nerves as a result of the movement of the plaintiff's head and neck. This was solely on the basis of his subjective symptomatology noted in the medical records and **never** identified by any objective neurological testing, i.e., the EMG and nerve conduction study.

The shoulder demonstrated diminished range of motion in two planes. This is primarily forward flexion and abduction. There has been no specific attempt at range of motion or stretching exercises to the left shoulder. The care and treatment was primarily to the neck, upper back, and generally to the left upper extremity. In my opinion, this is an objective finding which can improve with appropriate occupational therapy. This, I believe, was recommended and noted in Dr. Bell's records. This recommendation was never followed. There has been no additional specific diagnostic studies or scans to document any pathology in the left shoulder. It just remains "stiff". It is my opinion, within a reasonable degree of medical certainty, that there could be an 85-90%+ improvement in his range of motion with appropriate occupational therapy, including range of motion and stretching exercises. On the basis of this evaluation, no further diagnostic studies in reference to the left shoulder are mandatory. The prognosis is fair for complete recovery.

In *summary*, it is my opinion, within a reasonable degree of medical certainty, that the plaintiff has objectively recovered from any neck and left elbow trauma. There was no specific injury noted to the left shoulder. He has developed, by history, a post traumatic partially frozen shoulder. In my opinion, this can be vastly improved with appropriate physical therapy. In my opinion, the neurological complaints are unrelated to the motor vehicular accident in question. This is due to the findings of the EMG and nerve conduction study which clearly did not show any radicular or brachial plexus type of injury. In my opinion, there is no permanent aggravation or acceleration of any pre-existing condition. The plaintiff continues with a significant amount of ongoing discomfort and neurological complaints which he relates solely to the motor vehicular accident in question. On the basis of this evaluation, the original injuries as described in the medical records have resolved. He continues to have a number of subjective symptomatology which can be explained by his metabolic neurological complications related to the diabetes and less than optimal musculoskeletal management of his left shoulder stiffness.

Sincerely,



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

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