Highland
Musculo-Skeletal
Associates, Inc.

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RE: Ann M. Jackson
Case No. 297729
File No. 1700-13241

Dear Mr. Margolis:

I evaluated the above plaintiff, Ann Jackson, in my office on February 4, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 2, 1993.

HISTORY OF INJURY: She recalls that at approximately 7:30 in the morning she was heading west bound on 1-90 with traffic moving slowly. She was operating a 1993 LeMans vehicle. A rear end impact occurred. The impact forced her car into a car or van in front of her. She had great difficulty remember the details. She did recall that there was "$6,000" damage to her car. She does not believe she lost consciousness.

She was taken by ambulance with full protection to the Meridia Huron Hospital Emergency Room. She underwent a thorough diagnosis and evaluation and that time.

Complaints of pain were primarily that of pain in the back of the head with lightheadedness. She also had some aching pain in the back of her chest and the neck area. X-rays of the cervical spine were interpreted as normal. She was discharged with a diagnosis of "cervical and lumbar strain".

She then came under the care of Dr. M. P. Patel, who according to the medical records, saw her initially in the office on or about November 15, 1993. This was primarily for neck pain, headaches, and subsequent development of cervical and lumbar radiculopathy. According to his initial series of consultations, however, there was really no neurological cornplaints registered.

She underwent a series of physical therapy treatments which allegedly did not help her to any extent. She was seen by a number of consultants, including Grant Heller, a neurologist. This evaluation was in April of 1994. At that point in time there was absolutely no complaints of any cervical pain radiating. She complained of numbness, tingling, lightheaded, and a numb left leg while walking, and a heavy and tingling feeling. There was also complaints of blindness in the left eye off and on, ringing in the ears, and a variety of other neurological complaints. However, on physical and neurological examination there was no signs of lumbar radiculopathy. He evaluated her for headaches with visual and brain stem evoked potentials, which were normal, as well as some other neurological tests which were entirely within normal limits. He felt that most of her symptoms were corning from a "cervical and lumbosacral myofascitis". There was no diagnosis of radiculopathy made.

Subsequently she had an MRI scan of her cervical and lumbosacral spines done at Advanced MRI in Richmond Heights, Ohio. These were done on May 2, 1994. The cervical spine MRI was entirely within normal limits. The lumbar MRI showed degenerative disc disease with desiccation at the L5-S1 disc. There was some disc "prolapse," also known as a "subligamentous disc herniation". This measured only 3 mm in size. There was no neurological impingement or impairment noted at that time. Review of the MRI scan shows essentially degenerative disc disease including

desiccation (drying out) at the L5-S1 level. These findings, in my opinion, are not traumatic but degenerative in nature.

Subsequently she was evaluated in June of 1994 by Dr. Robert Zaas, an orthopaedic surgeon. Review of his very detailed report clearly shows absolutely no complaints that would be considered radicular in nature. There was only slight limitation in motion of her lumbar spine. He felt this was soft tissue in nature only. There was absolutely no hint of any radiculopathy. His evaluation was on June 10, 1994, seven months after the accident in question.

The following month she was evaluated by Dr. Raheja, a neurologist, at Grace Hospital. At that time she was complaining of radiating pain into both lower extremities, the right side worse than the left side. Neurological evaluation, including EMG and nerve conduction studies, showed "irritative proximal S1 nerve root lesion on the right side". There was no other significant abnormality noted at the time of this evaluation. The last visit with Dr. Patel was OD. August 23, 1994.

There was a fairly large treatment gap between the summer of 1995 and her next treatment that I could discern in the medical records. She was seen at the Carnegie Surgical Center on April 18, 1995, one year and five months after the motor vehicular accident in question. She was seen by Maria Griffith who felt that she had radicular symptoms. It was interesting to note that at no point in time was a history presented of her previous low back and neck conditions which significantly predated the motor vehicular accident in question (discussed below). She underwent a series of three cervical and three lumbosacral blocks through the mid portion of 1995. There was little or no improvement in her symptomatology. The blocks certainly would have helped any objective neurological inflammation.

She subsequently returned 'back to University MedNet. Review of these records indicate documented intermittent neck and back pain which was chronic in nature starting December 13, 1989 (page 26). She was seen with a chronic low back condition in 1990 and underwent extensive physical therapy at that time.

She returned to University MedNet facility in July of 1995. She was evaluated by a neurologist, **Dr.** Dashefsky. This was specifically in reference to an emergency room follow-up on July 27, 1995. There was a history of "back pain which comes and goes". Physical examination at that time revealed a full range of motion with absolutely no neurological deficit whatsoever. Her straight leg raising was normal and it was felt that she had basically low back pain and chronic anxiety. An repeat MRI scan was recommended. He saw her again on August 30, 1995, in which she had "persistent back pain and pain radiating into the left leg. This was different than the radiating pain that was demonstrated a year before in July of 1994. At that point in time it was right leg radiation that was mostly present. **A** repeat MRI scan was performed which revealed a focal central disc hemiation at the L5-S1 level associated with degenerative changes.

Dr. Dashefsky subsequently referred her to Dr. Mary Louise Mavin, a neurosurgeon affiliated with University Hospitals of Cleveland. She evaluated the claimant on December 2, 1995, over two years after the motor vehicular accident in question. Because of the chronicity of her symptoms and this worsening of her disc herniation in her lumbar spine, surgery was recommended. Two lumbar surgeries, unfortunately, were performed. The first on **January** 26, 1996. She had fair relief of her **pain** subjectively. This lasted only a month and then the pain recurred. Eventually it got so bad that in June of 1996 she had a CT myelogram and on July 1, 1996, a repeat surgery for discectomy at the same level. Apparently this was due to a recurrent disc herniation.

Even after the second surgery she did not improve significantly. She was previously evaluated during the Spring of 1995 at the Cleveland Clinic where she was hospitalized from the Psychiatric Department with recurrent major depression, panic disorder, personality disorder, and a history of chronic back **pain.** She was referred to the Cleveland Clinic Pain Management Clinic earlier this year on January 9, 1997. Her chief complaint was chronic low back pain and left leg **pain.** The only *history* that was presented was of this musculoskeletal complaint was due to the motor vehicular accident. This clearly was not an accurate representation. She again underwent a

psychiatric evaluation in late January of 1997 in which she was presented with a diagnosis of chronic pain with psychological factors affecting her physical condition. She stated she had one epidural block which helped. She is on a number of medications, including Vicodin, Aleve, and extra- strength Tylenol. She is unable to take any anti-inflammatory medications.

EMPLOYMENT HISTORY: She was performing office work at a machine shop. She has not worked since the time of the accident.

PAST MEDICAL HISTORY failed to reveal previous injuries to her neck or low back as stated at the time of this evaluation. This is clearly not an accurate representation of her past medical history. As noted above, in the late 1980's and early 1990's she was treated for chronic neck and back pain through the Euclid MedNet clinic. She did have extensive physical therapy on a number of occasions for her chronic neck and low back complaints.

Review of extensive records (over 500 pages), from the Kaiser Foundation records clearly show a long standing history of left sided back pain starting as far back as 1984. She was seen by a number of physicians, including urologists. She continued to have intermittent musculoskeletal back aches and had multiple visits throughout the early 1990's as well. It does not appear that she discussed the problem with the University MedNet physicians.

Of particular interest was an emergency evaluation on August 11, 1992. At this time she had severe low back pain radiating into the right posterior legs. She gave a history of this for over "four years" on an intermittent basis. She was seen on May 25, 1993, with a two day history of acute recurrent low back pain with radiation into the left leg, the buttocks and down to the left shin. There was also slight right low back pain. There was no injury reported. This recurrent episode of low back pain with sciatica was noted approximately six months before the motor vehicular accident in question.

She was also seen by a number of Kaiser physicians including rheumatologists, orthopaedic physicians, as well as a neurosurgeon. Dr. Itani evaluated her on September 21, 1994, with reference to the motor vehicular accident in question. He reviewed the MRI scans that were done at that time and found no neurological deficits and only some degenerative changes at the L5-S1 level.

It is quite apparent that there had been a rather long standing *history* of recurrent episodes of low back pain with right and left radicular symptoms on a fairly regular basis.

CURRENT SYMPTOMS: At the time of this evaluation she still complained of an occasional aching pain in the left side of her neck. She does her stretching exercises and this relieves itself. She has not had any care or treatment for her neck since early 1995.

The bulk of her symptoms remain in her low back region. She describes this as a constant, daily back pain, the left side greater than right, described as a deep aching **pain.** It seems to increase with any prolonged sitting or increase in activity. In addition, sitting for a long period of time she gets an aching pain in her ischial (buttock) area.

There is no right leg **pain.** She still has symptoms in her left leg in which it feels gradually "more heavy and weak". Standing for more than 20 minutes or putting any pressure on her left leg gives her a "heat **pain".** This is primarily in the thigh and groin area. Resting for long periods of time also seems to aggravate her left leg pain.

Concerning her left foot and ankle, she has "barely no feeling" in a stocking-type of arrangement below her malleolar area. The pain is described as diffuse tingling. The medial side feels about the same as the lateral side. In general, the left leg **pain** is deep, throbbing and aching in nature. It goes from her groin down to just above her knee for the most part. Sometimes there is radiation of pain below her knee. This can wake her up from a sound sleep.

PKYSICAL **EXAMINATION** revealed a pleasant, but somewhat apprehensive, ***45*** year old female who appeared in no acute distress. She complained of a significantly painful low back at the time of this evaluation, rated as a level "8" on the pain scale. **A** level "10" was explained to her as a pain that no human on earth can stand for more **than** five seconds. She did not appear to move around with any great level of discomfort. She certainly did not appear to be in a level "8" pain.

Her gait pattern was normal. There was no limping detected. She was able to stand on her heels and toes without difficulty.

Examination of her cervical spine revealed no signs of increased muscle inflammation. There was no spasm, guarding, or dysmetria. There was no significant diminished range of motion **with** over 95% of her motion preserved in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. She did claim to have some tenderness, that is pain to direct pressure, over the left trapezius muscle. There was good muscle development in the neck, upper back, and periscapular muscle region. A full range of motion was noted in both shoulders in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists and small joints of the hand examined normally.

Neurologic examination including sensory, motor and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm or wrist level were equal and symmetrical bilaterally.

Examination of her lumbar spine revealed a well-healed scar compatible **with** her surgical history. She complained of diffuse paraspinal muscle tenderness. No spasm, dysmetria or muscular guarding was noted. There was a slight increased muscle tone on the right side, which did not correspond **with** her level of discomfort, mostly on the left side. Range of motion of the lumbar spine did show some discrepancy. In the standing position she could barely bend forward to touch her mid thigh level. However, in the supine position she could be to touch just above her ankle level.

Hyperextension, side bending and rotation failed to show any significant limitations. There was at least 90% of her preserved range of motion present.

The second discrepancy was noted on her straight leg raising. In the sitting position she could clearly have her legs elevated passively to 90 degrees with a negative Lesague's maneuver. However, in the supine position I could barely lift either leg off the table because of severe back and leg pain. She seemed to "writhe" in discomfort when I did this maneuver. This contradictory finding is not physiologically based. The type of discrepancy usually indicates a degree of malingering or at least an attempt by the patient to exaggerate his or her symptomatology.

Her leg lengths were equal. There was a full range of motion of both hips and knees. No gross atrophy was detected. There was a slight diminution in size of her left calf as compared to her right calf. This difference was less than one-quarter of an inch. She is right side dominant.

IMPRESSION: By history, strain of the neck and low back. Degenerative disc disease at the L5-S1 level. Subsequent surgeries, times. two, on the L5-S1 disc. Chronic complaints of pain persistent in both the low back and left leg.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These records included records from the Meridia Huron Hospital, Dr. M. P. Patel, Dr. Zaas, and Dr. Heller, the MRI scan of May 2, 1994 on the neck and back, records from Grace Hospital and the EMG and nerve conduction study, complete records from University MedNet, records from the University Hospitals of Cleveland for the second *surgery*, and a report from Dr. Mavin. The complete records from the Cleveland Clinic, Carnegie Surgery Center, extensive records from the Kaiser Foundation facility, and the Social Security Administration records were also reviewed. A number of actual x-ray films were reviewed from University MedNet, Kaiser Foundation, University Hospitals of Cleveland, Meridia Huron Hospital, and Advanced Imaging x-ray films were reviewed.

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 her ongoing level of physical impairment.

The records from Meridia Huron Hospital and the initial consultants, clearly show only a soft tissue injury to her neck initially. There was some further documentation of an increase in soft tissue low back pain. It appears that none of these specialists or evaluators had any concept of her previous records from University MedNet or the Kaiser Foundation. She was seen by a number of qualified specialists, including Dr. Heller and Dr. Zaas. Neither of them could find any objective signs of a clinical disc abnormality other than the degenerative changes noted on the MRI scan of May of 1994. There was no documentation in any of their records of radiating pain until July of 1994 when she was evaluated by Dr. Raheja, the second neurologist. EMG and nerve conduction studies showed some irritation of the S1 nerve root on the right side. One recalls the decision for the low back surgery was due to left leg symptoms. The findings up to July of 1994 (eight months after the accident) did not relate any radicular abnormalities in to the left lower extremity.

As noted above, the medical records from the Kaiser Foundation clearly show a history of radiating and radicular symptoms in both her left and right leg **prior** to the motor vehicular accident in question. One must consider her radicular symptoms chronic in nature and documented to be pre-existing. The diagnostic work-up through 1994, as noted, was not suspicious of this objective disc herniation.

The ultimate decision for the lumbar disc surgery was based on persistent left leg complaints and a failure to improve with the epidural blocks. There was, according to her physician, good relief of pain until a number of months afterwards. She then necessitated a re-operation for recurred disc herniation.

It is my opinion, within a reasonable degree of medical certainty, that there was a history of chronic soft tissue low back **pain** for many years. This may have been transiently aggravated, per the patient's history, by the motor vehicular accident in

question. Clearly there was no communication between her prior and subsequent treatment physicians, and the exact extent of her long standing back problems were not clearly recognized by the treating doctors. Dr. Itani's records clearly indicate no treatable disc herniation many months after the motor vehicular accident in question.

It is further my opinion that the surgery performed was for advancing degenerative disc disease. If there was a disc herniation directly and causally related to the motor vehicular accident there would have been a much clearer chronological relationship. Typically disc herniations resulting from a single traumatic episode become symptomatic in a relatively short period with radicular symptoms, both sensory and motor, within a 72 hour period. This was obviously not the case. The care and treatment rendered by Dr. Hlavin in the form of the two surgeries at University Hospitals, in my opinion, were unrelated to the motor vehicular accident in question.

The long term prognosis is guarded. She has clear documentation in the Cleveland Clinic record of a psychological component which affects her physical condition. She has objectively recovered at the time of this evaluation on the basis of the physical examination performed. There was a number of physiological contradictory findings which were noted above. There is no clear orthopaedic or neurological explanation for her ongoing level of symptomatology other than her chronic back complaints which have been present for over 12 years.

Sincerely,

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

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