Highland
Musculo·Skeletal
Associates, Inc.

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John A. Neville
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The 113th St. Clair Building
Cleveland, OH 44114

RE: Teny Lee Rather
Case No. 310770 (Cuyahoga County)
File No. 2800-05-27517-95

Dear Mr. Neville:

I evaluated the above plaintiff in my office on May 2, 1997, in reference to alleged residuals of injury sustained in two motor vehicular accidents. He was evaluated without friend, family or legal representative present.

The first accident was on September 23, 1993. At that time he was driving his girlfriend's car, described a Toyota. He was on Snow Road heading in an east bound direction in the left hand lane, waiting for a car to make a left turn in front of him. He believes he was stationary for about eight to ten seconds when a rear end collision occurred. The impact was such that the seat back broke backwards. The impact forced his vehicle into the car in front of him. The driver's front bumper of his car struck the car in front. He was wearing a seat belt. His vehicle was towed. His father came on the scene to pick him up and took him home.

He was seen at the MedCenter near his home in an urgent care type of set-up on the same day of the injury, The primary complaint at that time was to his neck region. X-rays were taken and these were interpreted as being normal. It was then

The second motor vehicular accident occurred on June 22, 1994. He was the driver of a cab that was moving through an intersection. He was slowly moving when he was rear ended. The force of the impact was such that he was unable to continue working. That evening he was evaluated at the Southwest General Hospital where he received his first emergency room care.

There were absolutely no medical records available from the Southwest General Hospital visit through the time he was referred to Beachwood Orthopaedics on October 22, 1994. At that point he was evaluated by Dr. Jeffrey Moms and had a number of diagnostic tests that were performed. This initial evaluation was 13 months after the first motor vehicular accident and approximately four months after the second accident. The initial impressions were that he had a sprain of the neck, mid and low back, with some ongoing headaches. There was also some suspicion about the right elbow, He did not see Dr. Morris again until December 13, 1994, approximately two months later, after which time Dr. Morris had had time to review the other medical records. It was felt that this was, at worst, a soft tissue injury. In order to make sure, other diagnostic testing was performed.

He underwent a series of MRI examinations in Dr. Morris' office. These included a study of the right elbow on November 18, 1994 which was normal and the cervical spine which was normal on November 23, 1994. He then went through a series of physical therapy treatments geared toward increasing flexibility. He was also prescribed some traction.

Because of a failure to improve he was evaluated at the Meridia South Pointe Hospital Pain Management Center. He was seen by Dr. Ross and he believes there was only two cervical blocks performed. There was never any neurological deficit or deficiency. These blocks were to control his "myofascial pain" according to the records. He had a severe reaction which necessitated another emergency room evaluation on February 14, 1995. He did not have any further care with Meridia South Pointe Hospital or with Dr. Jeffrey Morris.

The most recent physician seen by the patient was Dr. John Nickles. The initial consultation was on or about September 18, 1996. He prescribed a number of medications including anti-inflammatories, pain pills, as well as muscle relaxants. The final visit with Dr. Nickles was in early April of 1997. There appeared to be a fairly substantial period of time between February of 1995 and September of 1996 where I could not document any medical care. The last therapy he received at Beachwood Orthopaedics was in late 1994 or early 1995.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries.

EMPLOYMENT HISTORY: At the time of the initial accident he was employed as a disc jockey working essentially just weekends. He was out of work for a period of time, the exact dates could not be recalled. He subsequently got a job working as a cab driver, the exact dates of employment could not be recalled. He was not employed at the time of this evaluation. In January of 1997, he had been working in a local service station.

CURRENT SYMPTOMS: At the time of this evaluation he continued to have complaints, essentially of myofascial subjective pain. These included diffuse pain in the neck, upper back with a radiating pain down to the low back region. This vaguely followed the trapezius, mid rhomboid, and lumbar paraspinals. There was also some discomfort about the iliac crest. The pain was described as moderate to moderately severe, the best being a level "5" and the greatest being a level "10". A level "10" was a pain that no human on earth could stand for more than five seconds. He claimed to be at a level "7" pain at the time of this evaluation.

In addition to the posterior head pain, which is deep, dull and aching in nature, he complains of a pain that runs essentially from the base of his skull, down on either side of his neck, staying mostly in the trapezius muscle, from the occipital insertion laterally toward the shoulders and then back in a v-type fashion toward the low back. This feels tight, stiff and with an intermittent burning pain. The burning sensation seemed

to run up and down his spine. He also complains of a deep, crampy hot **pain.** The type of **pain** is essentially the same quality and the same location. The intensity seems to vary with activity, changes in weather or "on its own".

He continues to complain of pain in the right elbow region as well, in the posterior medial aspect. This occasionally worsens when he lifts greater than five or six pounds. The pain is described as deep sharp **pain,** with occasional numbness radiating to the little finger of the right hand. He also complains of diffuse cramping.

PHYSICAL EXAMINATION revealed a pleasant 40 year old male who despite his level "7" **pain,** did not appear in any significant distress. He was noted to sit comfortably through the bulk of the examination. He did not shift or move about in an uncomfortable fashion while seated. He was able to arise from a sitting position' without difficulty. He was able to walk on his heels and toes without any observable difficulty. He was able to ascend and descend the examining table in a normal fashion.

Examination of his cervical spine revealed minimal decreased range of motion without spasm, dysmetria, muscular guarding or increased muscle tone. There was less than 10% of restriction of motion in forward flexion, extension, side bending, and rotation. Right rotation seemed to be more uncomfortable for him, although there was no objective correlation. There was diffuse tenderness in the neck, upper back and periscapular muscles, but this was not associated with increased muscle tone or muscular guarding. Protraction, retraction, and elevation of the scapulae were performed without difficulty. No muscular atrophy was noted in the neck, upper back or periscapular muscles.

There was a full range of motion of both shoulders in forward flexion, extension, abduction, internal and external rotation. Both elbows examined normally with the exception of some tenderness along the medial,epicondyle of the right,elbow: There were no objective abnormalities noted in either upper extremity With good muscular

development. Circumferential measurements of both upper extremities at the *axillary,* midarm, forearm and wrist level showed no abnormalities and they were equal and symmetrical bilaterally. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

Examination of his thoracolumbar spine failed to reveal any significant reduction in motion. The only finding was the subjective complaint of tenderness. There was no objective abnormality in the musculature. Both hips examined normally. The knees and ankles examined normally as well. There was excellent muscular development in both lower extremities. No atrophy was noted on circumferential measurements at the upper and lower thigh or upper and lower calf level. 'Neurologic examination of both lower extremities was normal.

IMPRESSION: By history, cervical, thoracic and lumbosacral strain or sprain. This is a **recurrent** injury. Ongoing subjective symptoms without objective abnormalities. No objective clinical findings and no objective x-ray or neurodiagnostic findings.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the MedCenter Group, Dr. Cynthia Taylor, Parma Community Hospital, the two massotherapists, as well as the CT scan results from November 16, 1993. Records were reviewed from Mark J. Friedman, Beachwood Orthopaedics, Advanced Imaging MRI, Meridia South Pointe Pain Management program. I have also reviewed the records from Dr. John Nickels but have not seen the Southwest General Hospital medical records.

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 that the injuries sustained 'in both collisions were to virtually the identical area. The plaintiff; however, claims 'that the bulk of his ongoing symptoms

were from the September 1993 accident. At worst, the complaints of **pain** are myofascial in origin, that is stemming from the soft tissue. They are not associated with any objective soft tissue abnormality. **A** thorough examination looking for any abnormalities in muscle tone, abnormal contracture, or decreased motion, failed to show any abnormality. Review of all of the neurodiagnostic testing, including the multiple MRI scans, as well as the EMG and nerve conduction studies, also proved to be normal.

In essence, this gentleman still complains of ongoing subjective symptoms without any objective findings. I have no clear orthopaedic explanation for his ongoing complaints without any observable objective signs of injury or ongoing disease. Review of the scans did not show any pre-existing conditions that were significant aggravated or accelerated. All studies to date have been within normal limits. Despite all of the doctors that this gentleman has seen and all of the testing, no precise anatomical injury was ever identified. He still continues to have treatment based on his subjective **pain** only. He is not being treatment in reference to any objective signs of injury or degenerative changes.

Typically soft tissue injuries of this variety heal within a six to eight week period **of** time. The bulk of the ongoing subjective symptoms usually dissipate by three to four months, especially with appropriate physical therapy. I have no explanation for the prolonged nature of his complaints. Clearly the same areas that were initially injured in September of 1993 were re-injured in June of 1994. I have no explanation for the large gaps in his medical treatment from the time of the second accident until October of 1994, and again after the conclusion of the blocks until he started seeing Dr. Nickles in mid to late 1996.'

On the basis of this evaluation, he has objectively recovered from any soft tissue injury sustained.. 'On the basis of this evaluation, there are no clear objective orthopaedic

abnormalities that would necessitate further care or treatment. He has objectively recovered from any injury sustained. The prognosis usually favorable in these types of situations. No further care of treatment is necessary or appropriate.

Sincerely,

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

RCC/bn

cc: File