Highland
Musculo-Skeletal
Associates, Inc.

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RE **Susan E, *Mandel***
CASE NO: **315377**
FILE NO: **737-97146**

Dear Mr. *Young:*

I evaluated the above plaintiff in my office on July 24, 1997. As you are aware, the case in my opinion is not tembly complicated, but the past medical history and the medical conditions of the plaintiff somewhat cloud the alleged traumatic issues. I will discuss her remote medical care and her medical care and treatment prior to the Continental Airlines incident and then discuss the appropriateness and the relationship of her subsequent medical care. Throughout the history and physical she was accompanied by one of her attorneys.

As you know, Mrs. Mandel has a number of complicated medical problems that have been treated at University Hospitals of Cleveland. These include a past history of migraine headaches, goiter, osteoarthritis, and degenerative disc disease of primarily the neck, spinal canal stenosis, esophageal reflux, eczema, and hypoparathyroidism. She has had a number of significant surgical procedures in the past. The appropriate orthopaedic procedures include: 9/81 - cervical discectomy and fusion, C6-7 (H. Bowman); 5/83 - cervical discectomy and fusion, C4-C5 (H. Bowman); 7/85 - lumbar foraminotomy, L4-5 and L5-S1 (H. Bowman); 9/88 and 11/88 - right and left knee arthroscopy (F. Zahrawi); 2/90 - cervical discectomy and fusion, C3-4 and spur removal C5-6 (H. Bowman); 6/92 - lumbar foraminotomy/fusion L5-S1 (H. Bowman); 1/94 - cervical posterior triple wire fusion, C5-6 (H. Bowman); 10/94 - left arthroscopic shoulder decompression (B. Victoroff).

All of the above procedures were outlined in a sheet that the plaintiff gave me and were confirmed by extensive review of the medical records.

Specifically in reference to her right shoulder, there was persistent problems throughout the latter months of 1994. She was seen by Dr. Michael Sheahan and Dr. Brian Victoroff, her medical and orthopaedic surgeon. It was felt that she had rotator cuff tendinitis and acromioclavicular arthritis. She did not improve with multiple injections in the shoulder region and surgical decompression was recommended. Ultimately this was performed as noted in mid-October of 1994 in the form of an arthroscopic subacromial decompression. This included a bony as well as soft tissue excision of the undersurface of the acromion and the distal end of the clavicle. She was seen in follow up on 10/29/94, 11/18/94 and on 1/5/95. At that time, she still had some subacromial crepitus but this was reduced. She had some persistent diminished range of motion but still had a strength deficit at that time. He continued to recommend ongoing treatment and therapy.

The first incident related occurred on February 8 of 1995. This was a somewhat frightening experience in which she was on a Continental Airlines Flight from Cleveland to Tampa, seated in an aisle seat in the rear right side of the aircraft. She noted her ears were popping and difficultyequalizing that sensation and felt dizzy. Apparently the cabin was physically losing pressure as one of the doors used for the catering service was not completely closed. The pilot informed the passengers, turned the plane around. She was sitting "tense and still". I carefully questioned her and there was absolutely no significant turbulence nor was the shoulder area injured in any way, shape or form. No incident of trauma was noted. They came back to Cleveland. The door was fixed and she went on her way to Tampa, Florida to visit her mother. She claimed to have some difficulty raising her left ann after this, but on review of the records there was some restriction prior to this incident.

On her return, she saw Dr. Victoroff on or about 2/24/95. There was an "exacerbation in her shoulder pain". It was the "pressure difference" which seemed to bother her shoulder. X-rays were essentially normal and Dr. Victoroff gave her a diagnosis of rotator cuff tendinitis which he was suspicious of in the past. He felt there was a "muscle strain associated with the stress" surrounding the airline incident, but did not feel any particular injury was incurred. He continued to follow her throughout the spring of 1995. Dr. Victoroff reinjected the shoulder on or about 4/7/97. She continued to have subacromial pain. An MRI scan was performed in May of 1995 and additional fluid had accumulated in the subacromial bursa. The rotator cuff appeared to be intact. Further surgery was discussed.

This second surgery of the shoulder was performed on 6/6/95. This was for the excision of a bursal cyst of the left shoulder. Post-operatively she seemed to do well and was making slow progress throughout the summer months of 1995. Throughout this entire period of time, there was absolutely no mention of posterior shoulder pain or periscapular pain. There was only continuing pain in and around the anterior aspect of the left shoulder. According to the medical records there was absolutely no mention of any rotator cuff trauma, tear or injury. Both surgical procedures were done to decompress the subacromial space. There was absolutely no mention of any problems in or around the posterior aspect of the left scapula until after the motor vehicular accident in question.

The car accident occurred in October of 1995. She described this accident as being the operator of a late-model Accura vehicle. The weather was raining. She was wearing her seatbelt. She was heading northbound ,on Park East and a vehicle pulled out of a driveway from a hotel toward her right. She tried to avoid the collision and turned her vehicle hard to the right. There was an impact on the driver's side. She stayed in the car and was attended by the police. She was not taken by ambulance.

She went on to her scheduled physical therapy sessions with Michael Lepp. IT was felt she had an injury to her neck, upper back and low back region. Rest was recommended. From this point on there was a general change in the complexion of her complaints in that a fair amount of her symptoms were now in the posterior aspect of her neck and back. This was aggravated with certain activities including swimming. There was noted to be a questionable scapular winging and she was evaluated by a neurologist. The neurological evaluation was essentially normal. An MR scan of her cervical spine was performed which was essentially normal. An MRI arthrogram of the shoulder showed a possible rotator cuff abnormality, but no tear visible on MR scan. It was elected to proceed with a conservative approach including follow up care and treatment with Dr. Tom Anderson at the Cleveland Clinic. She has been obtaining a number of periscapular injections to relieve this type of pain.

CURRENT SYMPTOMS: She still has an inconsistent aching pain in the anterior aspect of the left shoulder. This occasionally—is aching and stabbing, but this has diminished significantly over &e.

The bulk of her ongoing pain is about the left scapular region. With any repetitive motion, lifting or swimming, she develops a deep aching pain which is fairly constant in and around &e medial border. She also has some pain along the lower left ribs rotating I

from the inferior aspect of the scapula around her anterior chest area. This is not as consistent and at worst is aching and stabbing on an intermittent basis. There are no true neurological complaints that were registered.

She also complains of pain dong the lateral aspect of the ankle. She had previous injuries to this area. 'She is claiming to have some ongoing pain in this area as well.

EMPLOYMENT HISTORY: .She is employed as a music therapist. She has difficulty carrying sorne'of her'equipment and has difficulty playing the guitar. She is employed by the Lake Hospital System and the Montifiorre Hospice facility.

PHYSICAL EXAMINATION: Revealed a pleasant, 49 year old female who appeared in no acute distress. Her gait pattern was normal. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally.

Examination of her cervical spinal region revealed well-healed scars along the anterior aspect, both left and right and a long posterior aspect scar compatible with her previous surgical history. There was a longitudinal scar on her low back as well. Arthroscopic incisions were not evaluated in her knees and no-complaints were in this area.

Examination of hdr cervical spine revealed about a 25% restriction of motion on forward flexion, extension, side bending and rotation. This would certainly be compatible with her multiple surgical procedures as outlined. -There was no soft tissue objective abnormalities in the form of spasm, dysmetria, muscular guarding or increased muscle tone.

Specific examination of her left shoulder revealed the scar from the open incision and previous arthroscopic incisions. There was minimal crepitance noted on range of motion.. There was no significant objective muscular abnormality noted in the form of atrophy. The bulk of her discomfort was posteriorly in and around the scapula. Protraction, retraction and elevation were performed but with complaints of diffuse aching pain. Neurologic examination in both upper lower extremities was normal.

Examination of the right ankle was normal. No atrophy was noted in the thigh or calf region.

IMPRESSION: Cervical thoracic myositis, subjectively caused by the motor vehicular accident of October 1995. No objective injury sustained in relation to the airline incident. No permanent objective orthopaedic injuries sustained.

DISCUSSION: I have had the opportunity of reviewing a significant amount of medical records associated with her care and treatment. These include the records from the Cleveland Clinic, University Hospitals of Cleveland, University Suburban Health Center, Beachwood Orthopaedics, Dr. Michael Keith, Mr. Michael **Lepp** (physical therapist), medical records from University Hospitals Drs. Bashar, Katirji, Dr. Michael Sheahan and Dr. Brian Victoroff.

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

Specifically in reference to the Continental Airline incident, in my opinion no injury was sustained. There is no question that she had complained of increasing pain specifically related to the incident and the "stress" which is somewhat understandable. Her own treating physicians, however, cannot account for her subsequent surgery being directly related to this airline incident, nor any distinct injury sustained. Careful review of the records indicate that prior to the motor vehicular accident most of her ,ongoing discomfort was in reference to the **anterior** aspect of the left shoulder. This had been previously operated on and she had developed a "cyst" which needed open surgery on in mid-1995. This second surgery in my opinion was unrelated to the airline incident. Specific medical care involving the Continental incident would have just been the physician's visit. No further care or treatment **was** necessary from this incident.

In reference to the motor vehicular accident, in my opinion at worst she sustained a cervical thoracic strain or sprain. The bulk of her ongoing symptoms demanding medical care from mid-October 1995 on were specifically in reference to this thoracic pain. She had an extensive diagnostic work up to **rule** out any neurological or any other cause for the pain. This work up, in my opinion, was related to the motor vehicular accident residuals. Fortunately no significant objective abnormality was noted and she still continues to have discomfort strictly related to a soft-tissue injury.

On the basis of this evaluation, there is minimal objective findings to support her ongoing subjective complaints. At worst in my opinion, she sustained a soft-tissue strain or sprain as a result of the motor vehicular accident and no physical injury as a result of the airline incident. There is no question that this type of scenario would cause emotional stress.

In my medical experience, emotional stress never creates physical musculoskeletal injury. In my opinion it was only her ongoing anterior shoulder complaints that were slightly subjectively worsened. No injury was sustained.

Despite her rather complex medical history, the ongoing prognosis is favorable. I do believe she should continue to be managed conservatively. Exercise and the use of anti-inflammatory medications including an occasional injectable medication is appropriate. No surgical intervention is necessary or appropriate solely on the basis of either of these two incidents. She has objective recovered from the motor vehicular trauma.

Sincerely,

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

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