Highland
Musculo-Skeletal
Associates, Inc.

August 8, 1997

Robert C. Corn, M.D., F.A.C.S.
Timothy L. Gordon, M.D.
Orthopaedic Surgeons

G. Michael Curtin, Esq.
330 Hanna Building
1422 Euclid Avenue
Cleveland, Ohio 44115-1901

RE: *Eileen Loftus*
CASE NO: *322219 (Cuyahoga County)*
FILE NO: *1064/15130-M*

Dear Mr. Curtin:

I evaluated the above plaintiff in my office on August 4, 1997 in reference to alleged residuals of injuries sustained in a motor vehicular accident which occurred on 2/1/96. Throughout the history and physical, she was accompanied by a paralegal from the plaintiff's law firm, Karen Manning-Farroni.

The history presented was that she was the driver and solo occupant of a' 1992 Oldsmobile Cutlass Vehicle that was involved in a re&-end collision at approximately 8 o'clock in the morning. The accident occurred at 11850 Edgewater Drive in Lakewood. She was exiting her condo complex driveway in an eastbound direction when the impact occurred. The impact was in the driver's rear aspect; She was wearing her seatbelt. She saw the accident developing and "braced myself". At the moment of impact, she was thrown forwards and backwards. Her car was drivable and she went back to her home.

Later that day she was seen at the' Lakewood Hospital Emergency Room being driven by a friend. She complained of virtual immediate right side neck pain radiating from the neck into the shoulder region. They provided her with a cervical collar and took a series of x-rays. The x-rays'revealed essentially degenerative changes at the C5-6 as 'well as some subluxation at C7-T1. No evidence of instability was ,noted on subsequent views. She was discharged with a diagnosis of a cervical strain or 'sprain.

Subsequently she was referred back to Dr. Rondd Garcia, her family medical doctor. His initial evaluation was on 2/9/96. Complaints at that time were primarily: that of pain. He gave her prescriptions 'for Ibuprofen and Flexeril, a 'muscle relaxant. Physical

therapy was started at Lakewood Hospital. She underwent massage, ultrasound, heat treatments and some exercise. When followed up later that month, she still had no neurological deficits and the working diagnosis was cervical strain or sprain. She continued with this physical therapy, completing the first and then a second round which lasted into Late August of 1996.

Because of her ongoing symptoms, she was initially evaluated by Dr. Jeffrey Shall, associated with 'Precision Orthopaedics on or about June 24, 1996. He re-x-rayed her cervical spine. There was noted to be C5-6 space involvement with spurring as well as to a lesser extent at the C6-7 level. It was felt at that time that she had degenerative changes and acute strain or sprain. An MRI scan of her cervical spine was suggested. The MRI scan was reviewed by this physician on her return to the office on June 28, 1996. She had some herniation at the C4-5 disc. Although there was some "significant herniation with neurologic compression", no precise neurological deficits were noted. Facet joint blocks were discussed and ultimately carried out by Dr. Shall's associate, Dr. Gregory Sarkisian. This physician assumed her Care as of July of 1996. Although a series of blocks were discussed, the first block gave her absolutely no relief. The working diagnosis was degenerative disc disease with facet arthropathy. She was continued with medication in the form of Naprosyn, a nonsteroidal, anti-inflammatory drug as well as a Tens unit.

She continues to use Lodine and another anti-inflammatory medication and an occasional Darvocet. She uses the Tens unit on an every day basis. She continues to follow with Dr. Sarkisian every three months. The last visit was approximately one week ago. Recently she was sent back to physical therapy for more manipulation and stretching and massage. An EMG and nerve conduction studies were performed and these were essentially within normal limits. There was never any **objective** radiculopathy noted. She still continues to have pain on a regular and routine basis.

PAST MEDICAL HISTORY: Failed to reveal any previous symptomatic neck condition.

EMPLOYMENT HISTORY: She is employed by the Cuyahoga County Treasurer's office, working in the cashier/accounting division. She works at the main county offices in downtown Cleveland. There was no significant loss of time out of work. She has lost a series of days "here and there".

CURRENT SYMPTOMS: At the time of this evaluation, she still had continuing pain that was primarily soft tissue in nature. The bulk of the pain was in the trapezius muscle, from the mid-cervical region radiating laterally toward the posterior aspect of both

shoulders. The quality of the **pain** was essentially dull, deep and aching in nature, but seemed to *vary* in intensity as well as on laterality, that is sometimes right, sometimes left and sometimes bilateral. She has this discomfort virtually on a daily basis. In the mid-thoracic and lower scapular region, she develops a "burning sensation". This again is usually on both sides. With lifting, driving or reading for periods of time her neck and upper back **pain** seems to be worse. She occasionally has a radiating aching **pain** into the lateral aspect of the arm. She described this is a "duller **pain**". When she uses her right upper extremity more, the right upper back seems to bother her more. When carefully questioned, there is no true radicular symptoms. Most of the symptoms are muscular in origin and are not specifically, by symptoms, related to her degenerative disc disease.

PHYSICAL EXAMINATION: Revealed a pleasant, 53 year old female who appeared in no acute distress. She was able to sit, stand and move about the examining room normally. 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.

Specific examination of her cervical spine revealed no tenderness in the anterior or lateral sternocleidomastoid or scalene muscle area. The bulk of her **palpable discomfort** was in the trapezius muscle. There was no objective signs of ongoing muscle irritation or inflammation in the form of spasm, dysmetria, muscular guarding or increased muscle tone. She did demonstrate tenderness, mostly in the trapezius muscle at the base of the neck and the mid shoulder region posteriorly. There' was full mobility of her scapulae in protraction, retraction and elevation. There was a minor restriction of motion in forward flexion, extension, side bending and rotation with at least 85% of her predicted range of motion present. There was no significant abnormality noted on physical examination involving her musculature. There was no atrophy noted in the neck, upper back or periscapular muscles.

Examination of her shoulders revealed full range of motion in forward flexion, extension, abduction, internal and external rotation. ..The elbows, wrists and small joints of ,the hands examined normally. Circumferential measurements of both upper extremities at the axillary, mid-arb, forearm and wrist level were equal and symmetrical bilaterally. There was no' deficits noted neurologically or in her muscle strength. Neurologic including sensory, motor and reflex testing of both upper extremities was normal.

IMPRESSION: By history, cervical strain' or sprain. Ongoing symptoms 'related primarily to the muscular elements. Degenerative disc disease noted by x-ray and MRI scan. This is not the source of her ongoing pain.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include the records from the Lakewood Hospital including emergency room and physical therpay, Precision Orthopaedics, including Dr. Shall, Dr. Sarkisian, Parma Regional MRI, the EMG and nerve conduction study as well as records from her family physician, Dr. Ronald Garcia.

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,

On the basis of this evaluation, in my opinion, her symptoms are not stemming from her degenerative disc disease. There was no objective evidence of any permanent aggravation or acceleration of her previous degenerative condition. The failure of the facet blocks to work to any degree indicates the source of her pain is probably not from her degenerative spondylosis. There is a minor disc herniation which in my opinion is asymptomatic. In my opinion, her symptoms are unrelated to these minor disc abnormalities. There is no signs of radiculopathy, either clinically, radiologically or by electroconductive testing.

It is my opinion that her symptoms are "soft tissue" in nature. There is no objective signs of any ongoing muscle irritation or abnormality. Despite the lack of objective clinical symptoms, she still complains of a fair amount of neck, upper back and shoulder discomfort. She continues to have subjective symptoms without any objective clinical, radiological or neurodiagnostic findings.

The long-term prognosis, in my opinion, is good. As noted above, there is no objective evidence of any permanent aggravation or acceleration of her pre-existing degenerative condition. She still has ongoing subjective soft tissue pain without any objective abnormality. In my opinion the care and treatment to date has been appropriate. She still continues to have complaints of pain despite excellent orthopaedic management. Her subjective symptoms continue, but her objective abnormalities have resolved. The prognosis for soft tissue injury is good. She has objectively recovered.

Sincerely,

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

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