Highland
Musculo-Skeletal
Associates, Inc.

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Orthopaedic Surgeons

August 11, 1997

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

RE: William H. Oldfield
Case No. 316306 (Cuyahoga County)
File No. 1111/14450-SF
PRELIMINARY REPORT

Dear Mr. Curtin:

I evaluated the above plaintiff in my office on March 4, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on August 18, 1995. He was evaluated without legal counsel or representation present.

He recalls that on Friday, August 18, 1995, he was the driver and solo occupant of a Nissan Sentra vehicle, heading south bound on I-44 in Auburn, Ohio, near Washington Street, cross street intersection. He was traveling approximately 45 miles per hour when a car coming in the opposite direction turned suddenly in front of him, making a left turn. He was wearing a seat belt. He tried to turn his vehicle to avoid this, but the left front aspect of his vehicle struck the other car.

He was twisted slightly to the right and the left portion of his body hit the steering wheel. He felt that his head "twisted and snapped" back and forth. He did not complain of any acute head injury and there were no bruises. He was car towed.

He notified his employer who picked him up. There was some discomfort at the scene but it was not severe. He was driven back to his office where he actually, in fact, slept there overnight: This was in Newbury, Ohio. He then notified a friend who came from Akron, Ohio, picked him up, and drove him home. He had no other care or treatment initially.

He finally sought medical attention at the Geauga Community Hospital Emergency Room where he was evaluated on August 23, 1995. At that point he complained of pain in his neck with radicular symptoms radiating down his left upper extremity. There was numbness at that time of the left middle and ring, and somewhat less, to the little finger. The reflexes were essentially normal. It was felt that he had a cervical strain with left radicular symptoms. He was given a prescription for Medrol, an oral cortisone, as well as Flexed, a muscle relaxant. X-rays at that time revealed some minimal degenerative changes at the C6-7 level. Review of the records and the patient's history did not note any injury to the medial aspect of his left elbow.

He has had minimal medical care, as you are aware, since that time. He followed up with Dr. Wayne Risius, an orthopaedic surgeon, who saw him initially on or about August 28, 1995. Physical therapy was recommended by never continued. The only other care or treatment he had was an MRI scan which was performed at the Geauga Hospital on September 2, 1995. The working diagnosis was cervical spondylosis with strain. The scan revealed a "moderate left paramedial disc herniation of the C6-7 disc," approximately 4 mm in depth. There was also anterior and posterior osteophyte formation indicating the chronicity of this abnormality. There was no spinal cord impingement.

Since that time he has had absolutely no further care or treatment. He stopped all sports, running approximately once a week. He no longer does any bicycling or swimming. He never had any further diagnostic studies and, in fact, only saw Dr. Risius on one additional occasion, March 29, 1996. He continues with a variety of intermittent complaints of numbness and tingling, primarily stemming from around the left elbow. No neurodiagnostic studies have been performed in order to more clearly evaluate the source of his neurological symptomatology.

CURRENT SYMPTOMS: Over the past year and one-half, his neck and left upper extremity symptoms have not been as severe. He still complaints of discomfort in the left side of his neck and intrascapular area. It seems to be worse when he is doing repetitive work. Recently, while painting his home, he had difficulty holding a brush in his left hand. This was due to some weakness and tingling in the right and little finger only. There is absolutely no numbness in his middle finger. He also does some furniture restoring. He has difficulty holding a brush and doing repetitive types of movement and motion.

The neck, back, and shoulder area is primarily on the left side. It seems to start below the C7 vertebral process. Repetitively lifting, such as lifting groceries and with certain neck movements, he has episodes of subjective numbness and tingling in his left elbow and in the left ring and little finger only.

EMPLOYMENT HISTORY: He is employed as a consultant and does primarily office work. He has not lost any time from work due to his residuals of injury.

PHYSICAL EXAMINATION revealed a pleasant **34** year old male who appeared in no acute distress. He was noted to sit, stand, and move around the examining room in a normal fashion. He was able to heel and toe walk without difficulty.

Examination of his cervical spine revealed unrestricted motion in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation' of the scapulae were performed normally. The sternocleidomastoid, scalene and trapezius muscle groups were all palpated and noted to be within normal limits. There was no tenderness noted. No increased muscle tone was noted. No spasm, dysmetria, muscular guarding or increased muscle tone was noted throughout the exam. Despite his claim of difficulty usage, there was no atrophy in his neck, upper back or periscapular musculature.

Range of motion of the cervical spine was full in forward flexion, extension, side bending, and rotation. At the extreme of right lateral bend, left rotation,

hyperextension, and hyperflexion, he complained of burning and tingling along the medial left elbow region, as well as tingling in the right and little finger only.

Examination of both shoulders showed no muscular atrophy. There was a full range of motion in forward flexion, extension, abduction, internal and external rotation. The left elbow, however, showed a great deal of soreness and tenderness about the left ulnar nerve. Lightly tapping or massaging the nerve above the level of the elbow reproduced his symptoms precisely. This caused the same degree of tingling in the ring and little finger. There was no other abnormalities noted objectively. The elbows, wrists and small joints of the hand, other than this sensation, were within normal limits. No atrophy of the intrinsic musculature or any of the C7, C8 or T1 muscles appeared to be abnormally involved. A detailed neurologic examination, other than the claim of numbness and tingling, was within normal limits.

PRELIMINARY IMPRESSION: By history, cervical strain or sprain. Subjective neuropraxia, left ulnar nerve distribution (C8 and T1 nerve root distribution).

DISCUSSION: I have had the opportunity to review a number of medical records involving his care and treatment. These included the records from Geauga Community Hospital, Dr. Wayne Risius, and the actual x-ray films from Geauga Community Hospital. The complete office records from Dr. Risius were requested but have not yet been 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 his ongoing level of physical impairment.

On the basis of this examination, there are no objective abnormalities detected. Despite the face that he has ongoing neurological symptoms, in the ring and little finger, there is no objective abnomality that would show any peripheral neuropathy or central neuropathy that corresponds with his symptoms. His muscular development appears to be normal and proportional on circumferential measurements, and there appears to be no changes in his neurological reflexes. It is only the symptoms that are

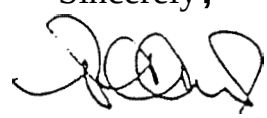
referred to the left ring and little finger, that correspond to any neurological abnormality.

Review of the actual MRI scan reveals a degenerative type of C6-7 disc bulge. This is not only posteriorly, but anteriorly osteophyte formation indicating the long term nature of this abnormality. It is my opinion that the nerve root that would be affected by this would be the C6 nerve root. This specifically innervates the thumb side of the forearm, index finger, and thumb, not the ulnar border of the hand. It is my medical opinion, within a reasonable degree of medical certainty, that there is no true cervical radiculopathy symptoms that correspond with the abnormal MRI scan.

At the time of this evaluation, he has objectively recovered from any soft tissue injury sustained. On the basis of this evaluation, no further care or treatment is necessary or appropriate. If neurodiagnostic studies were performed these would include an EMG and nerve conduction study which would more clearly delineate the level of abnormality, whether this was, in fact, left ulnar nerve, neuropraxia, or stemming from a nerve root involvement in the cervical spinal region.

The long term prognosis for the soft tissue component of his injury is favorable. Undoubtedly the degenerative disc disease will worsen with time. He has objectively recovered from any injuries sustained as a result of his motor vehicular accident. No further care or treatment is necessary or appropriate on the basis of this evaluation. I would be glad to review any additional medical records, specifically those from his treating orthopaedic surgeon, Dr. Risius, when these become available.

Sincerely,



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

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