September 7, 1996

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Orthopaedic Surgeons

Terrence J. Kenneally
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595 West Broad Street
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RE: Marcus Justice
Case No. 94-CV-320 (Erie County)
DOI: 8/20/92

Dear Mr. Kenneally:

I evaluated.the above plaintiff in my office on September 5, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on the above date. Throughout the history and physical he was accompanied by Mr. John Ash, a paralegal with the plaintiff's law firm.

He presented with the history of being involved in a two-vehicle motor vehicular accident at approximately two o'clock in the morning on August 20, 1992. He was driving a 1986 Mercury Cougar vehicle in Vermilion, Ohio, with a front seat passenger. In the vicinity of Darrow and Frayley Roads, lie was involved in a collision. He was heading east-bound on Darrow and a car heading south-bound on Frayley struck his vehicle. Apparently the car "ran a stop sip." He was not wearing a seat belt. The impact was on the driver's side. He was thrown to the left and his head apparently went through the driver's window. He was tossed about the interior of the car.

He attempted to extricate himself from the car by leaning to the right and then trying to slam the door open with his left side, and had immediate pain in the left shoulder and

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rib area. He had difficulty breathing. According to the history presented the passenger dragged him out of the car.

He was taken by ambulance to the Lorain Community Hospital Emergency Room where he had the appropriate evaluation, including multiple x-rays. One of the chief complaints was severe pain in his left side. There was also a prominent facial laceration along the left lower chin area. Multiple x-rays were performed and these failed to reveal any significant skeletal trauma. He was essentially treated and released.

He had a follow-up visit with his family physician, Dr. Daniel Holden, who saw him for a short period of time after this accident. He believes some anti-inflammatory medications were prescribed. At the same time, he also followed with Dr. V. M. Fusilero, a plastic surgeon, who followed him solely for his facial laceration. Ultimately a dermabrasion was performed with a good cosmetic result.

After Dr. Holden left town, he was followed by Dr. Jonesco of Oberlin, Ohio. This initial visit was approximately a month after the accident on September 25, 1992. It was felt that he had a soft tissue injury to the neck and low back. No disc abnormality was suspected. Physical therapy was recommended and there was a good resolution of all of his pain, including his back pain. By December of 1992, after the therapy had been completed, the pain did reoccur.

He was seen by a number of physicians, including Dr. Victor Nemeth who he saw on one occasion, September 8, 1992. The neck complaints were most prominent at that time. A normal physical examination was noted. He was also evaluated by Dr. Dennis Carson at the Tri-City Family. Practice. There was complaints of severe mid and upper back pain at that time with objective signs of muscle spasm. He was started on a muscle relaxant at that time. He was only seen on two occasions by this office. It should be noted that he currently is employed by this company as an x-ray technician.

An evaluation was carried out by another orthopaedic specialist, Dr. Vernon Patterson. Initial evaluation was not until over **a** year after the accident on October 18, 1993. It was felt at that time that he had a "resolved cervical and thoracic strain or sprain, resolved left shoulder contusion, and a resolved left anterior chest wall contusion."

An MRI scan was done on February 23, 1994. This was of the lumbar spine and was interpreted as normal. The last visit with Dr. Patterson was September 16, 1994, with complaints primarily of mid back pain. Another round of physical therapy was recommended with more strenuous muscular rehabilitation.

The balance of his medical care has been provided by Dr. *Gary* Mellick and the American Pain Specialists, Inc. Dr. Mellick is a neurologist who specializes in the management of pain. He has provided conservative care which consisted of a great deal of physical therapy, as well as multiple soft tissue injections. These injections provided him with only temporary relief. The plaintiff believes that the benefits of the shots lasted no more than a few days, but according to Dr. Mellick's records, he had about a week of relief from these. He continued with this treatment and had one caudal block, also with a very short term relief. An MRI scan performed of the thoracic spine on May 23, 1996, revealed a "small central and slight eccentric disc herniation at the T7-8 level without cord compression." His current medications include Ultram 50 mg, two tablets every three or four hours as necessary.

EMPLOYMENT **HISTORY:** At the time of the accident he was in school **as** radiology technician, working at a gas station part-time. He did state that he lost some time from work, When his school had been completed he started working as an x-ray tech and has been working 111-time since then.

PAST **MEDICAL** HISTORY failed to reveal previous or subsequent injuries to his neck or upper back or spine.

CURRENT SYMPTOMS: At the time of this evaluation, as noted in the pain drawing, he has numerous areas of complaints of dull aching pain. The "epicenter"

seems to be along the medial border of the left scapular and described as a dull aching and occasionally stabbing **pain.** The pain seems to be relieved to some extent by rolling his shoulder blades forward and backwards, and shrugging his shoulders attempting to stretch out these tissues. This area is approximately the T10 to T12 region of the spine, and along the medial border of the scapula. There is also *an* occasional numbness along the ulnar nerve distribution of his left upper extremity only when he keeps his arm flexed for a long period of time. He usually only notices this after falling asleep with his elbow flexed. This rarely occurs at other times.

There is a dull aching pain in both of his shoulders which is poorly localized, as there is in the low lumbar area. This is described as an aching **pain.** When he is sitting for long periods of time, he feels numbness which seems to start in his left foot and then radiates **up** his leg into the buttock area. **A** separate type of discomfort was felt, approximately 12 times in the past four years which occur on an intermittent basis with standing. He gets a hot sensation in his legs and then the feeling of "cold water trickling down my legs." There are no true focal neurological complaints.

PHYSICAL EXAMINATION revealed a pleasant 24 year old male who appeared in no acute distress. His gait pattern was normal. He **was** observed to sit, stand, and move about the examining room in a normal fashion. He was able to heel and toe ***walk*** without difficulty.

Examination of his cervical spine revealed **a** full range of motion in forward flexion, extension, side bending and rotation. There was no spasm, dysmetria or muscular guarding noted. **A** full range of motion of both shoulders was noted in forward flexion, extension, abduction, internal and external rotation. There was a full range of motion of both scapulae in protraction, retraction, and elevation. No atrophy was noted in the neck, upper back, or periscapular musculature.

Examination of both upper extremities revealed a full range of motion of the elbows, wrists, and small joints of the hand. There was a subjective Tinel's sign along the left ulnar nerve at the elbow. No atrophy was noted in his forearm on observation or

circumferential measurements. A detailed neurological examination including sensory, motor, and reflex testing of both upper extremities was normal.

Examination of his thoracolumbar spine revealed a very minimal subjective restriction in forward flexion being able to bend forward to touch just above the ankle level. There was good reversal of his lumbar lordosis with this maneuver. Excellent paraspinal musculature was noted and asymmetrical muscle development was observed. Hyperextension, side bending and rotation of his lumbar spine was normal. His straight leg raising both in the sitting and supine positions was performed to 90 degrees bilaterally with only the complaints of tight hamstrings. A negative Lasegue's sign was noted. His leg lengths were equal. A full range of motion of the hips, knees and ankle joints were noted. Neurologic examination of both lower extremities including sensory, motor and reflex testing was normal. No atrophy was noted on circumferential measurements at the upper and lower thigh and upper or lower calf level.

IMPRESSION: Subjective residuals of a soft tissue injury to the mid and low back region. No objective clinical findings. MRI evidence of a minor disc abnormality at the T7-8 level. Normal MRI of the lumbar spine.

DISCUSSION: I have had the opportunity of reviewing a number of medical records associated with his care and treatment. These include records from the Lorain Community Hospital, City of Vermilion Emergency Ambulance Service, Drs. Daniel Holden, V. M. Fusilero, Victor Nemeth, Dennis Carson, Jone[illegible] and Vernon Patterson. Records were also reviewed from Dr. Mellick and the Pain Management Program. I had the opportunity of reviewing the x-rays of the cervical spine from the emergency room. I have not reviewed the MRI scans.

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.

The left chin Iaceration is an isolated diagnosis which has been adequately treatment. In my opinion, the care and treatment rendered for this was appropriate.

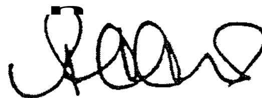
However, the care and treatment for his thoracolumbar spine, has been solely based on his ongoing subjective symptoms. This includes the multiple physical therapy visits, as well as the numerous doctors that have seen him as noted above. He has been treated extensively by the Pain Management Center run by Dr. Mellick, solely based on his subjective symptoms. It was not until May of this year that any objective abnormality was noted. This was a minor disc abnormality that is common in the general uninjured population and is of no clinical significance.

As stated above, despite his ongoing subjective symptoms and his ongoing need for these multiple injections, there is a paucity of objective findings noted by any of the physicians. At worst, there was muscle "spasm" noted with very little in the way of decreased range of motion or objective neurological abnormalities. The bulk of his symptoms have been solely based on his ongoing complaints which he causally relates solely to the motor vehicular accident in question. At the time of this evaluation there were no objective abnormalities that would be consistent with a four year old injury. There was a full range of motion of the major skeletal joints, as well as proportional muscle development with no signs of muscular atrophy. This usually denotes normal usage.

At the time of this evaluation he has objectively recovered from any soft tissue injuries sustained. On the basis of this evaluation, in my opinion, he has had excessive "pain management." Clearly the multiple injections were of no long-term benefit. I do believe this type of care and treatment is excessive as it is invasive and based solely on subjective symptoms and not on objectivity. The other care and treatment rendered by his previous physicians, in my opinion, was appropriate. The physical therapy is the appropriate method of management for soft tissue injuries, not multiple injection therapy.

The long-term prognosis is favorable. There still remains a lack of objective findings to support his ongoing subjective complaints. He has objectively recovered from any soft tissue injury sustained. The long-term prognosis is good. No further care or treatment is necessary or appropriate based on the lack of objective findings. If the MRI scans become available I will be glad to review those in the future.

Sincerely,



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

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