Highland
Musculo-Skeletal
Associates, Inc.

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September 10, 1997

Jeffrey **A.** Schenk
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526 Superior Avenue, East
Cleveland, OH 441 14-1460

RE: Gayle **A.** Ryba
Case No. 327709 (Cuyahoga County)
DOI: 11/13/95

Dear Mr. Schenk:

I evaluated the above plaintiff, Gayle Ryba, in my office on July 8, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 13, 1995. She was evaluated without friend, family or legal counsel present.

She described the incident as being a passenger in an RTA bus, described as the #35 Flyer, leaving from the Broadview area in Independence to Downtown Cleveland. The bus was on I-77, headed in a north bound direction, at approximately 7:30 in the morning. She described the conditions as heavy traffic, having recently snowed and the road was wet. The bus had slowed down and stopped, and was rear ended by a semi-truck. She was in a front facing seat on the driver's side, sitting next to the aisle.

At the moment of impact she stated she was thrown forward and backwards, her neck being forced into those positions. The passengers were asked whether anyone needed. to be conveyed to an emergency room. She then transferred to another bus and

continued on to work. At that time she was employed as an administrative assistant for the MCI Company in Downtown Cleveland. She was starting to have some pain and stiffness in the neck and left work early that day. She called her family physician and he would not see her as this was due to an accident.

Her initial care was with Dr. Brian Hassinger, a chiropractor. She saw this individual approximately 20 years ago, this was after a slip and fall down some stairs. She claims not to have seen this doctor for at least two decades. The following day she was evaluated and he started some modalities, as well as some gentle manipulation. There was not much improvement in her symptoms. Initially there was some radiating and radicular type of arm pain. This did ultimately resolve itself over the first few weeks. She has been left essentially with midline, mid-cervical pain, as well as some left upper trapezius area pain.

Subsequently she was referred to Dr. Daniel Leizman, a physiatrist associated with Beachwood Orthopaedics. His initial evaluation was on December 12, 1995. There was neck pain at that time with left shoulder pain, and episodic numbness and tingling in the left arm. Cervical spinal exam revealed some restriction of motion, approximately 25% of predicted normal, especially in rotation to the left. There was some voluntary muscle guarding also. There was some decreased sensation over the left middle finger (C7 dermatome) and an absent triceps reflex on the left. This lead this physician to be suspicious for a C7 radiculopathy and a number of diagnostic tests were performed.

The testing included x-rays and an MRI scan. The MRI showed severe degenerative disc disease at the C5-6 level with some minor subluxation at the C4-5 level. There was also a disc osteophyte formation and a spur near the left C7 nerve root. EMG and nerve conduction studies were done on December 13, 1995, and were entirely within normal limits.

She was started on a series of physical therapy treatments, and was last seen by Dr. Leizman for this treatment in late February of 1996. She was on Ibuprofen, an

anti-inflammatory, and Cyclobenzaprine, a muscle relaxant. The final diagnosis was that there was a sprain of the neck and a symptomatic aggravation of a pre-existing large cervical disc osteophyte complex at the C5-6 level. This is despite the fact that there was a C7 sensory subjective change.

She has had absolutely no medical care since that time. She continues with a home traction unit provided by Beachwood Orthopaedics, which she uses about every other day. There was only one additional follow-up visit on July 7, 1997. On review of the records sent from Dr. Leizman's office, records of that visit were not included. A CT myelogram was discussed. She never had any consultations with a surgeon, nor have any other diagnostic studies been recommended. She still continues with Ibuprofen, usually 0 to 4 per day. These are the over-the-counter 400 mg strength. Dr. Leizman believes that this accident caused a cervical "radiculopathy." This is purely a sensory phenomenon. His EMG and nerve conduction studies were normal indicating no objective radiculopathy.

EMPLOYMENT HISTORY: At the time of the accident, as discussed above, she was employed as an administrative assistant for MCI. There was no time loss. She would schedule her physical therapy sessions around vacation time and/or hours. She is currently a staff administrator doing training and hiring for MCI in their Independence office.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries to her neck region. She did described this fall down the steps about 20 years ago. She was not under active care at the time of the bus accident.

CURRENT SYMPTOMS: At the time of this evaluation her major ongoing complaints were midline cervical spine pain, described as a deep "toothache". This would limit her neck movement due to pain. The evenings were usually more painful and she has had difficulty sleeping. Rotation to the left still was somewhat noted. There was also pain in the left upper back and trapezius area, described as an aching and/or stabbing pain. She has limited sitting ability due to progressive neck stiffness. She also claims that her left shoulder is somewhat stiff and she has difficulty with

overhead activities, including doing her hair. She continues with home traction. She has given up tennis and golf, as this pain seems to worsen with activity.

Specifically, there were absolutely no radicular symptoms whatsoever. The only pain she has is in her neck and left trapezius muscle area, There is no numbness, tingling or weakness noted in her upper extremities.

PHYSICAL EXAMINATION revealed a pleasant 51 year old female who appeared in no acute distress. Her gait pattern was normal. She was observed walking in and out of the exam suite without difficulty. Ascending and descending the exam table was performed without difficulty.

Examination of her cervical spine revealed the claim of tenderness in the mid cervical area. There was; however, very minimal restriction of motion in forward flexion, extension and side bending. There was, at most, 10% restriction without any objective findings in the form of spasm, dysmetria, muscular guarding or increased muscle tone. Protraction, retraction, and elevation of the scapulae were performed normally. This however, did cause some discomfort in the left trapezius muscle region. There was some diminished range of motion in rotation to the left, also a 10 to 15% restriction of motion without objective findings.

Examination of both shoulders revealed pain at the extremes of motion in forward flexion and internal rotation of the left shoulder. No atrophy was noted. There was no specific injury noted. These type of movements tended to give her more pain in the left upper back and trapezius area. The elbows, wrists and small joints of the hand examined normally.

A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level failed to show any diminished muscle bulk or muscular atrophy. The right side was very slight larger than the left, compatible with her right side dominance.

IMPRESSION: Sprain of the cervical spine. Subjective aggravation of a degenerative arthritis and disc disease. No clinical, neuroradiological or neurodiagnostic evidence of disc herniation. No objective evidence of neuropathy.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her claim. This included records from Beachwood Orthopaedics including the most recent evaluation, as well as records from Dr. Brian Hassinger.

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 her ongoing level of physical impairment.

On the basis of this evaluation, she had, at worst, a soft tissue strain or sprain of the neck. There is no evidence of any permanent neurological dysfunction, although she did have some numbness and tingling. This did not, by her history, precisely match the MRI abnormalities which showed C4-5 and C5-6 disease. There was some significant arthritic spurring and degenerative disc disease noted at the C5-6 level with almost complete obliteration of her disc space. There was minor changes at the C4-5 level, but not significant disease at the C6-7 level. There subjective neurological complaints may have been due to a transiently aggravation of these degenerative conditions in the form of a cervical strain or sprain. Her neurological symptoms resolved quite early in her post injury period and have been nonexistent for over a year and one-half.

She does; however, continue to have neck symptoms, difficulty sleeping, and pain after exercise. This is compatible with mild degenerative disc disease at the neck region. She is not doing any ongoing physical therapy for stretching and flexibility. The only therapy she really does is using her pneumatic cervical traction unit.

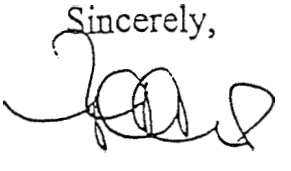
Individuals with these types of ongoing complaints and objective radiological findings would most benefit by an ongoing exercise program. This should be encouraged in the future. The residual stiffness in her cervical spinal region is objectively minimal. She still has ongoing soft tissue complaints without any objective clinical orthopaedic abnormalities. There is rather significant degenerative disc disease and arthritis in the mid portion of her cervical spine which, in my opinion, was unrelated to any traumatic

incident. By the history presented there may have been a **subjective** aggravation of her pre-existing arthritic and degenerative spinal condition which gave her the early neurological symptomatologies. These have since resolved.

The long term prognosis is favorable. There is no objective evidence of any permanent aggravation or acceleration of her previous disc disease. She is somewhat symptomatic at this point in time. Her increase in symptoms is not associated with any objective clinical abnormalities. Without the neurological symptoms her condition is not surgical in nature. She should be encouraged to continue her exercise program. The prognosis is favorable for the soft tissue component of her injury. Undoubtedly the degenerative condition will continue to worsen with age. This worsening, in my opinion, is not related to any singular traumatic incident but to the natural history of this phenomena. She has not sought medical care or treatment for quite some time. On the basis of this evaluation, this is appropriate.

There is no clinical indications for a CT myelogram on the basis of her current condition . There is certainly no indication for cervical disc surgery. The long-term prognosis is favorable for the resolution of her soft tissue complaints. Her arthritic condition undoubtedly will worsen with time. This is the natural history of this medical condition. The progression is unrelenting and, in my opinion, unaffected by the motor vehicular accident in question. There was no objective evidence of any permanent aggravation or acceleration of this condition. She still continues with subjective complaints without any objective clinical, radiological or neurological impairment or impingement. Any future care or treatments specifically addressed to this disc, in my opinion, is related to the pre-existing condition and not related to the motor vehicular accident in question.

Sincerely,



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

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