Highland
Musculo-Skeletal
Associates, Inc.

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RE: Pearl M. Metz
Case No. 291300 (Cuyahoga County)
File No. 1111/13494-SF

Dear Mr. Curtin:

I evaluated the above plaintiff in my office **on April** 16, 1996 in reference to alleged residuals of a motor vehicular accident that occurred on September 10, 1993. "She was evaluated without friend, family or legal counsel present. The reason for the substantial delay between the completion of this report and the, date of the examination was the collection of the complex medical records that were involved in her care and treatment over the years for this and other problems.

ACCIDENT HISTORY: She was the driver and solo occupant in a motor vehicle described as a 1992 Mercury Grand Marquis. The accident occurred in the vicinity of Warrensville Center Road and South Woodland. She was rearended by a late model Volvo with a "hard impact". She insisted that the damage to her car was minimal and, in fact, she stated the estimates were from $60 to less than $300 to repair the car. Despite this low impact she felt her head "snap" back and forth and her left knee struck the dashboard. She was able to get out of the car, tried to get some information, from the defendant and then she went home. She did not seek any emergency room care. According to the Police and Accident Report, there was no

damage to the Volvo vehicle and only 'light damage to the rear driver's side of the plaintiff's vehicle.

Later that day she began having a variety of complaints which she claims to have had since that time. These included neck pain most prominently, groin and left knee pain. She stated that initially the bulk of the pain was solely neck in origin. Many months later she began having radicular arm pain. She was somewhat evasive as to whether she had any neck or shoulder complaints prior to the motor vehicular accident. As will be discussed below, review of the medical records indicated multiple somatic complaints, but no ongoing chronic complaints in reference to her neck.

As stated above she did not go to an emergency room, but the following day went to her family physician Dr. Richard Weinberger, with "my whole body hurting." According to her history, she had some physical therapy ultimately and then some scans. This, of course, did not occur until many months later. According to the doctor's records, he saw her the following day on September 11, 1993. She had only pain in the upper neck and low back, as well as a left knee contusion. There was absolutely no neurological abnormality and in fact, she had a normal range of motion of her neck with only pain at the extremes of motion. He did refer her to physical therapy which was essentially massotherapy. She did have some neck traction and electrical stimulation, but this created some was discontinued. He did not see her again until late September and then in early December of 1993. At the time of the last visit in 1993, there was pain on neck range of motion and back pain, but absolutely no reference to any radicular or even questionably neurological complaints.

In December of 1993 she also saw a number of dentists stated that "my bite was off". By her history, she felt this was due to the accident. Some dental records were reviewed from Dr. Burton Siegel, but this was not evaluated to any extent. Also during the later months of 1993 she was treated with home massotherapy by Leslie LaBoda. Physical therapy was tried for only two to three weeks in one of the NovaCare facilities.

As stated above there was no care and treatment for approximately two months. She was evaluated on February 14, 1994 by Dr. Weinberger with a significant difference in her pain pattern. She no longer had only neck pain but at that point in time was developing some radiating and radicular type of pain. Pain was radiating to the right arm and into her fingers, and she noted some tingling in her left leg. Physical therapy was then initiated and she was referred to the Meridia South Pointe Hospital for evaluation of this pain. She was seen by a number of physicians including Dr. Jerome Yokiel, who is an anesthesiologist. An MRI scan was ultimately conducted on February 26, 1994. This revealed spondylitic protrusions at C4-5 and C5-6 without evidence of disc herniation. The clinical impression was that of severe cervical spondylosis with bilateral foraminal narrowing indicating a chronic arthritic condition. X-rays two months lateral were also performed of her left knee which just showed arthritic changes. These actual x-rays were reviewed and I agree with this interpretation. There was no sign of disc herniation, only a rather significant disc disease.

During the latter months of 1994 she was seen by a number of physicians. These included Dr. Chad Deal, who saw her in mid September of 1994, approximately one year after the motor vehicular accident in question. He felt she had a C7 or C8 sensory radiculopathy, as well as a C5-6 motor radiculopathy. She was having radiating pain at that point in time solely into her right upper extremity. By the history she presented, this was solely related to the motor vehicle accident in question. It did not appear that Dr. Deal was aware that the radicular pain did not start until five months after the motor vehicle accident in question. She had EMG and nerve conduction studies performed on October 11, 1994 at the University Hospitals of Cleveland. This revealed a right C7 radicular abnormality. This is despite the fact that her ongoing arthritic and degenerative abnormalities were at the C4-5 and C5-6 levels.

She was then referred to Dr. Sanford Emory, a spinal orthopaedic surgeon affiliated with University Hospitals. He saw her initially on October 31, 1994, over 13 months after the motor vehicle accident in question. He agreed that there was significant spondylosis at the C4-5 level, as well as the C5-6 level. He saw her on one additional

occasion, November 24, 1994. He suggested that a surgical procedure be performed in the form of a spinal fusion if her symptom did not improve.

On December 5, 1994, she consulted with Dr. Teresa Ruch, a neurosurgeon associated with the Northeastern Ohio Neurosurgical Associates. At that time, Dr. Ruch recommended, because of her ongoing symptoms, that she had a cervical spinal procedure in the form of a C5 corpectomy with strut graft and screws, essentially fusing C4-5 and C5-6 together. Again this did not correspond with the EMG abnormalities at the C7 level.

Ultimately she was evaluated by a second neurosurgeon, Dr. Benedict Columbi, who evaluated her approximately one week after Dr. Ruch. His initial evaluation, 10 months after the motor vehicle accident, was on December 12, 1994. He reviewed the studies done in February of 1994 and again agreed with all the physicians that this is where the pathology was. He recommended a surgical procedure. This was ultimately performed on December 20, 1994 at the Mt. Sinai Medical Center. The surgery performed was an *anterior* cervical discectomy, osteophytectomy (removal of arthritis spurs), and a fusion with iliac bone graft at the C4-5 and C5-6 levels. This operation was essentially a "cure" for her arthritic conditions. Despite this she still has ongoing symptoms. She was still under Dr. Shafron's care when evaluated by me in mid April of 1996. According to the medical records she was followed by Dr. Columbi until May of 1996. Because of ongoing symptoms a second MRI scan was done on May 8, 1996. Essentially this showed no evidence of spinal canal stenosis, no disc herniation, and no real reason for her ongoing symptomatology on the basis of neurological compromise. Additional medical records from the University Hospitals of Cleveland revealed the oral surgical problems that she has had in recent months. These are, of course, unrelated to the motor vehicular accident.

In reference to her left knee, there is clearly problems with her left knee for quite some time as noted in the records of Dr. Weinberger. She claims that physicians have aspirated her knee on three occasions. She had some home physical therapy after her neck surgery. She wore a brace or splint on her right hand for a period of time.

PAST MEDICAL HISTORY did reveal a history of cervical arthritis. She was not terribly precise. Clearly **the** abnormalities noted on the initial x-rays would have **taken** years, if not decades, to develop.

EMPLOYMENT HISTORY: She was unemployed at the time **of** the accident.

CURRENT CONDITION: At the time of this evaluation she was taking only over-the-counter aspirin or Tylenol, as well as an occasional Valium. Dr. Columbi recommended some over-the-door neck traction, but because of an old herpes neuralgia on her face and these residuals, she was unable to use the traction.

CURRENT SYMPTOMS: The primary areas of complaints were diffuse left and right sided neck pain, right shoulder, and recently, left shoulder pain. Within the past few weeks prior to this evaluation, she developed some left arm pain. This **was** intermittent in nature. Apparently this was one of the reasons that **Dr.** Columbi subsequently had the MRI scan performed about a month after I saw her. "She claimed that all of these above discomforts were intermittent in nature.. The surgery helped the numbness, but she could no recall exactly when the numbness started, (This actually was five months after **the** motor vehicular accident.) **She** also complained of difficulty traveling because of the pain. Most of the neck and arm pain had always has been on **the** right side and sometimes **the left.** The right arm pain was diffuse in the arm, elbow and forearm. She was wearing an elastic wrist splint but I wasn't quiet sure what this was for.

In reference to her left knee, she claims it swelling intermittently, and as noted above, was drained on three occasions. She did have a prior injury while visiting her grandchild attending the Laurel School, when she was "clipped," falling and striking her knee. She had the same type of pain after the accident which she claims was due to blunt trauma hitting part of the interior of the car.

PHYSICAL EXAMINATION revealed a pleasant 76 year old female who, despite all of her complaints and lengthy medical explanations, appeared in no acute distress. She was able to sit, stand, and move about the examining room normally. She was

able to walk without difficulty. She could stand on her heels and toes without difficulty. Arising from a sitting position was done normally, as was ascending and descending the exam table.

Examination of her cervical spine revealed a well healed scar in the anterior region, as well as a right hip scar, both well healed and almost invisible. The range of motion of her cervical spine was limited by approximately 25% in forward flexion, extension, side bending and rotation. This was not associated with any signs of muscle irritation or inflammation. No spasm, dysmetria, muscular guarding or increased muscle tone was noted. The stiffness was appropriate for her two-level spinal fusion. There was slight kyphosis of her thoracic spine compatible with her age. Protraction, retraction and elevation of the scapulae were performed normally. There was no detectable atrophy noted in the neck, upper back or periscapular musculature.

Examination of both shoulders failed to show any gross atrophy. There was a symmetrical range of motion in forward flexion, extension, abduction, internal and external rotation. The muscle development of her extremity appeared grossly normal and on circumferential measurements with a tape measure, it was within 1/2 cm at the axillary, midarm, forearm and wrist level. There was no significant atrophy, either on the basis of disuse or neurological compromise noted. Her reflexes were symmetrically diminished in both upper and lower extremities. She claimed to have tenderness in the thumb, as well as some arthritic symptoms compatible with arthritis of the right carpometacarpal joint. On examination there was a positive "grind" test indicating probable CMC arthritis.

Examination of her left knee revealed a mild boggy type of effusion. There was full extension to about 95 degrees of flexion. Her medial and lateral, as well as anterior and posterior ligamental complexes were intact. She appeared to have a chronic synovitis of her left knee.

IMPRESSION: Probable cervical soft tissue strain or sprain related to the accident. Subjective aggravation of her cervical disc disease and arthritis. No radicular

symptoms for five months. In my opinion, the care and treatment for her radicular symptoms were **unrelated** the motor vehicular accident in question.

DISCUSSION: I have had the opportunity to review a significant amount of medical records associated with her care and treatment. These included records from the Meridia **South** Pointe Hospital, the Mt. Sinai Medical Center and University Hospitals. The review included physician records from Drs. Richard Weinberger, Chad Deal, Sanford Emory; Teresa Ruch, Benedict Columbi, **as** well as a packet of x-rays including the initial MRI scan of her cervical spine and knee x-rays.

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.

The review of the records clearly indicate a low velocity motor vehicular accident. **The** injury, at worst, that she sustained **was** a *strain* or sprain of her cervical spine. She has a great deal of medical records which clearly document absolutely no radicular symptoms for five months after the accident in question. She complained only of right sided neck, upper back and shoulder pain. This would certainly be compatible with a **transient** subjective aggravation of her arthritic condition.

Once the symptoms changed she saw **the** appropriate physicians over the course of approximately 10 months. This included Dr. Chad Deal and later in 1994, **within** a very short period of time, Drs. Emory, Ruch and Columbi. In my opinion, the surgery performed was indeed appropriate for the severe arthritic condition in her mid cervical spine. In my opinion, the surgery was not related to the motor vehicular accident. The reason the surgery was performed was solely because of her radicular type symptoms and the failure to improve over that 10 month period of time. She appears to have had an excellent objective result. At the time of my evaluation she still had ongoing symptoms.

I am not aware of her current condition. I understand after reading through the records from University Hospitals that she has had some complicating oral cancer and

treatment. In my opinion, these are unrelated to the motor vehicular-accident in question.

On the basis of this evaluation she had objectively recovered from any soft tissue injury sustained. She had an excellent result from her surgical procedure of the mid cervical spine. In my opinion, in relation to her spinal injuries, the long-term prognosis was favorable. She had objectively recovered.

Sincerely,

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

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