Highland
Musculo·Skeletal
Associates, Inc.

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September 20, 1996

Margaret M. Gardner
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The 113th St. Clair Building
Suite 525
Cleveland, OH 44114-1214

RE: Raymond Tancredi
Case No. 298188
DOI: 11/24/93

Dear Ms. Gardner:

I evaluated the above plaintiff in my office on August 16, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 24, 1993. Throughout the history and physical he was accompanied by a second year Cleveland Marshall law student, Mr. George Carr.

The history presented in reference to the accident was that he was the driver of a 1992 ranger pickup truck, which was empty, with his wife as a front seat passenger. They were heading north-bound on 1-71just north of the entrance ramp of West 14th Street. The weather condition was described as "drizzly." He was slowing, at almost a complete stop or possibly even stationary when a rear-end collision occurred. He was wearing a seat belt. His body was "jarred forward." His seat belt locked. He did not stnke any portion of the interior of the car. The car that hit him was actually wedged underneath his vehicle. The cars were subsequently separated and he proceeded to drive to the Second District Police Precinct on Fulton Road. He made the appropriate police reports and then drove to the hospital.

He was initially evaluated at the Kaiser Foundation facility on Snow Road on the day of the accident complaining of neck and low back pains. He was discharged with a diagnosis of cervical strain. It does not appear that x-rays were taken initially. He was subsequently evaluated in the emergency room on December 4, 1993, still having pain. At that point, x-rays were performed which failed to reveal any traumatic lesions. Previous x-rays done at Kaiser and these showed "cervical spondylosis" indicating an arthritic condition which preexisted this motor vehicular accident. He followed-up with Kaiser for a short period of time. Physical therapy was recommended but, according to the patient, was not prescribed for too long a period of time. He sought medical attention with another physician.

He was subsequently followed for approximately a year by Dr. George Smirnoff, a family practice physician, initially being evaluated on December 13, 1993, about two to three weeks after the accident. There was complaints of neck and back pain with tingling at that time. Dr. Smirnoff treated him for a rather extended period of time with therapy in his office and a variety of medications. There did not seem to be any significant Improvement. Despite this lack of improvement, he continued with Dr. Smirnoff on an intermittent basis through December 6, 1994.

Also under his care an MRI scan was done at the Regional MRI in Bedford Heights on September 12, 1994. This was done of both the neck and low back. The only abnormalities noted were some degenerative changes at the C4-5 and C5-6 level, as well as at the lower lumbar level. This was not felt to be traumatic and his treating physician agreed these probably existed prior to the motor vehicular accident. There was no mention in Dr. Smirnoff s records of previous complaints, as will be discussed below, concerning his neck and back pain.

The last treatments that he had for this injury was at the Parma Hospital for physical therapy. This was in October of 1994. The therapy prescribed was somewhat more aggressive and active, adding exercises with Theraband, as well as cycling and a more aerobic type of conditioning program. He has not had any care or treatment since late 1994. The home exercises are continuing with stretching, isometric, as well as joining a health club and doing exercises.

CURRENT MEDICATIONS are only for "headaches" which is really an aching pain in the back of his neck.

EMPLOYMENT HISTORY: He is employed as a warehouse supervisor. At the time of the injury he was employed by Crest Industries. There was absolutely no loss of time from work. He has since switched job; however, doing the same type of job. There was no wage loss as far as the patient was aware.

PAST MEDICAL HISTORY, according to the plaintiff, involved only a 1965 back injury while playing basketball. He claimed to have not had any care or treatment, or any problems, since that time.

However, careful review of the Kaiser records indicate a number of visits for recurrent neck and back pain. There were numerous x-rays taken in the early 1990's of his chest and low back area, as well as his cervical spine. As far back as June of 1992, there were degenerative changes with disc space narrowing at the L4-5 and L5-S1 level. Cervical spinal x-rays on July 18, 1992, indicated cervical spondylolysis, most severe at C6-7 level. This was a chronic condition which was clearly present for years prior to this motor vehicular accident. He either denied or could not recall these previous problems.

CURRENT SYMPTOMS: At the time of this exam he continued to have intermittent pains in a variety of areas. The most consistent was this "headache" which is essentially mid cervical spinal pain. This would occur on an intermittent basis. This is probably related to his multiple level degenerative disc disease and arthritis which has been present for many years.

Another area of discomfort is the right shoulder blade area which, again, is intermittent in nature. This occurs when he is sitting for two to three hours, standing or doing any lifting. This is mostly an aching pain, but occasionally "zings, like you hit a ball wrong with a baseball bat." He tends to avoid doing heavy lifting.

Initially there was pain in his low back but he is asymptomatic in recent months. There was some tingling in his legs initially after the accident, but none has been noted for years.

PHYSICAL EXAMINATION revealed a somewhat robust appearing, 45 year old male who appeared in no acute distress. His gait pattern was normal. He was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally. He was able to heel and toe walk without difficulty.

Examination of his cervical spine revealed the claim of tenderness which was mild in the neck paraspinal muscles. There was a very minimal limitation of motion which was due to "stiffness" at the extremes of forward flexion, extension, side bending, and rotation. No spasm, dysmetria or muscular guarding was noted. Protraction, retraction, and elevation of the scapulae were performed normally. No atrophy was noted in the neck paraspinal muscles, upper back, shoulder or periscapular musculature. A full range of motion of both shoulders, elbows, wrists and small joints of the hand was noted. A detailed neurological exam 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 were equal and symmetrical bilaterally.

Examination of his lumbar spine revealed good flexibility, being able to bend to just above the ankle level. Hyperextension, side bending and rotation were performed without limitations. No spasm, dysmetria, or muscular guarding was noted. His straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. Neurologic examination of both lower extremities was normal.

IMPRESSION: Subjective residuals of a cervical strain or sprain. Long-standing degenerative arthritis and disc disease of the neck and low back.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his cafe and treatment. These include records from the Kaiser Permanente, Parma Community General Hospital and records and a report from Dr. George Smirnoff. The MRI scan results were reviewed but the films have not 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 evaluation, he has objectively recovered from any soft tissue injury sustained. At worst, in my opinion, he sustained a minor soft tissue strain or sprain of the neck and low back. This may have transiently aggravated a previously symptomatic neck and back degenerative condition. There is; however, no objective clinical or radiological permanent aggravation or acceleration of these conditions.

I have no explanation for his continuing treatments with Dr. Smirnoff over this rather long period of time. There is clearly not any great improvement in his symptoms with the physical therapy prescribed. On this review, it seems that this type of treatment was somewhat excessive in that ultimately formal physical therapy was requested. This in my opinion, was the appropriate treatment and should have been prescribed earlier in the clinical course.

Review of the MRI scan results indicate very minor bulging of 2.6 mm of the C4 and 4 mm bulge at the C5-6 disc. This was bulging discs and not felt to be "herniated." The study OR the lumbar spine showed a similar finding at the L3-4 and L4-5 level. There was no evidence of disc herniation or free fragment on any of the study. These were felt to be primarily degenerative disc bulges.

On the basis of this evaluation, he has objectively recovered from any soft tissue injury sustained. There is clear evidence of a previous neck and back condition which was not discussed by the plaintiff at the time of this examination. He clearly stated he never had any previous neck or back problems other than this 1985 injury. He

neglected to discuss these previous problems that were well documented in the Kaiser records, including arthritis and disc disease as far back as 1992. This disc abnormality, in my opinion, is solely related to his degenerative condition and not related to any trauma sustained.

On the basis of this evaluation he has objectively recovered from any soft tissue injuries. There is no aggravation of his preexisting condition. He has not had any medical care in over 18 months. No further care or treatment is necessary or appropriate for his soft tissue complaints.

Sincerely,

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

RCC/bn

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