Highland
Musculo-Skeletal
Associates, Inc.

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Cleveland, OH 44115-1901

RE: Jeffrey S. Nathanson
Case No. 326622
File No. 1138/15258-V

Dear **Mr.** Coughlin:

I evaluated the above plaintiff in my office on September 30, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident, which occurred on July 20, 1996. At that time he recalls that he was the driver and solo occupant of a Mitsubishi Montero **4x4** vehicle on his way to return the vehicle due to his lease on the vehicle ending. He was heading on SOM Center Road, heading in a northbound direction, around the vicinity of Cannon Road in Moreland Hills, Ohio. He was, at the time of the accident, stationary behind a vehicle making a left turn. He was wearing a seatbelt.

He noted through his rearview mirror that a vehicle was approaching from the rear. He was rearended and thrown forward and backwards. He had braced himself on the steering wheel. There was no immediate complaints of pain. He stated that he began feeling some upper back pain and stiffness shortly after the accident,

He consulted with his family physician, Dr. Terence Isakov, on or about July 22, 1996. At that time his complaints were primarily that of headache, upper back pain and a general feeling of tiredness. Physical examination was essentially normal with

a full range of motion and no point tenderness. There was no specific neurological complaints 48 hours after the accident. It was felt that he had a strain of the cervical region. Physical therapy was recommended for the upper back, neck and shoulder, including massage and electrical stimulation.

He was re-evaluated in early September of 1996, about six weeks post injury. His neck was supple and a full range of motion was noted with some discomfort in the left neck and left trapezius muscle, There was no spinal tenderness at that time. Again, absolutely no neurological complaints were registered. Seven more physical therapy sessions were performed. According to the plaintiff there was absolutely no relief with the therapy but according to Dr. Isakov who evaluated him around Thanksgiving of 1996, he stated that the therapy had, in fact, helped. Some tenderness was noted at that time. Examination of his neck revealed some diminished range of motion, approximately 50% in extension with normal flexion, and a 30% diminished right rotation. Left rotation was normal. On January 28, 1997, which I believe is the last time he saw Dr. Isakov specifically for this problem, a series of x-rays were performed. There was osteoporosis and diffuse degenerative disease, primarily in the mid portion of his cervical spine. Foraminal encroachment was noted. This was felt to be degenerative in nature.

He subsequently came under the care of Dr. Bruce Cohn, an orthopaedic surgeon, who saw him in early February of 1997. There was some confusion in Dr. Cohn's office notes, which indicates the initial exam was February 21, 1997, and his letter on February 22, 1996. The assessment at that time was of bursitis or tendonitis of the left and right shoulder. Some diffuse discomfort in the neck region was noted as well. X-rays of the cervical spine were ultimately reviewed within the next few weeks, which demonstrated degenerative changes in the lower end of the spine. There was also some narrowing of the acromioclavicular joints bilaterally. The impressions were that of cervical arthritis. His medication was switched and a MRI scan was discussed. This scan was ultimately performed on April 16, 1997. It showed moderate impingement upon the neural foramina at the left C5, right and left C7, and left C8 due primarily to a disc osteophyte formation. There was no true disc herniation noted. These were all felt to be degenerative chronic changes. These

degenerative changes were diffusely localized throughout the lower half of the cervical spine. Dr. Cohn followed him intermittently and performed cortisone injections of his shoulders. He still follows with Dr. Cohn on an intermittent basis. He believes the last evaluation was during the summer of 1997.

One additional physician saw the patient and that was Dr. Ben Columbi, a neurosurgeon. Dr. Columbi evaluated him on or about May 8, 1997. MRI scan was felt to show a disc osteophyte complex. Neurologic examination was entirely within normal limits. It was felt that his primary disorder was cervical spondylosis without evidence of nerve root impingement. A home traction unit was recommended.

There was a series of physical therapy treatment sessions from early March to early April of 1997. This was carried out at the Ohio Physical Therapy Unit. There was no long-term benefit from this according to the plaintiff.

CURRENT MEDICATIONS: He takes no prescription medications for his musculoskeletal symptoms. He can take anywhere from 0 to 8 Advil per day. He continues on a variety of other medications including medicine for hypertension, high cholesterol, and he takes Prozac also for what he is claiming to be a personality change due to residuals of injury.

EMPLOYMENT HISTORY: He is employed as a stockbroker. He claims he may have lost some clients due to the "personality" changes.

PAST MEDICAL HISTORY failed to reveal any previous treatable injury. He claims to have had "off and on neck problems". He did have some treatment for a "pinched nerve" due to the way he was holding a telephone between his left ear and left shoulder.

PRESENT STATUS: He currently uses an over-door neck traction unit. He claims to have some ongoing pain in the neck, upper back and penscapular muscles.

In general, he feels he has pain every day and every night. It "never goes away". The pain is primarily in the neck paraspinal muscles from the base of his skull down to the base of his neck. This is associated with varying degrees of stiffness. Intermittently, the left hand "gets numb." This does not follow any particular neurological pattern although it is mostly in the left middle finger. Generally he feels his pain is due to ''sore muscles". There is also some soreness around both shoulder areas near the AC joints and generalized "sore muscles".

I neglected to mention above that he has been seeing a chiropractor, Dr. Bondra. The chiropractic manipulations seem to help the neck and upper back stiffness.

PHYSICAL EXAMINATION revealed a pleasant 54-year-old male who appeared his stated age. His ability to walk was normal. He was able to arise from a sitting position without difficulty. Ascending and descending the exam table was performed normally.

Examination of his cervical spine revealed some diffuse deep muscular tenderness in the neck paraspinal muscles. There was no spasm, dysmetria, muscular guarding or increased muscle tone noted. The muscle development in the neck, upper back and penscapular areas appeared to be normal and symmetrical. No gross atrophy in any one particular nerve distribution was noted. He also claimed to have some deep tenderness about the right upper scapular region.

Range of motion the cervical spine was performed without limitation in forward flexion and extension. Right and left rotation showed approximately 15-20% limitation. This limitation was due to "stiffness" not **pain.** The endpoints of range of motion were not associated with any obvious muscular guarding. Protraction, retraction and elevation of the scapulae were performed normally.

Examination of both upper extremities revealed normal shoulder movement in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. There was excellent proportional muscle development with a slight dysmmetry, his dominant right hand

side being slightly larger than his left. A detailed neurological examination including sensory, motor and reflex testing failed to reveal any precise anatomic neurological deficits. There was a mildly positive left Phalen sign noted compatible with left carpal tunnel syndrome.

IMPRESSION: Cervical strain or sprain. X-ray and MRI evidence of diffuse cervical spondylosis. No evidence of traumatically induced disc herniations. Multiple level degenerative disc disease and arthritis of the cervical spine.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included records from Drs. Isakov, Cohn, and Columbi. Records were also reviewed from the Ohio Physical. Therapy and the Brainard MRI.

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, in my opinion, at worst, he sustained a strain or sprain of the cervical spine. He has complaints of pain which have been present since the time of the injury. There seems to be some discrepancy in his description or memory of his symptoms and those recorded in the medical records. There was clearly a fairly rapid resolution of his acute symptoms, as noted in Dr. Isakov's records. These; however, had recurred and are mostly "arthritis" in nature. He also claims to have substantial diminished ability to do sporting activities such as workouts and aerobic condition. These limitations are strictly voluntary. He has never had any specific recommendations from his physicians to decrease this activity. In fact, this type of activity would probably be of benefit in maintaining his strength and muscle tone. It would certainly take the stress off of the diffuse degenerative disc disease and arthritis of his cervical spine.

Review of the medical records failed to show any direct evidence or opinions that the accident in question caused cervical disc herniations. At worst, it was felt by his

history that his arthritic and degenerative conditions were subjectively aggravated. Cervical traction and exercise were recommended.

The long-term prognosis is good for his soft tissue injuries. The bulk of his ongoing symptoms are arthritic or degenerative in nature. There are no objective findings of ongoing soft tissue inflammation. The prognosis for his degenerative condition is only fair. This condition clearly worsens with age. There is; however, no objective evidence of any permanent aggravation or acceleration of these preexisting conditions.

On the basis of this evaluation, there is no contraindication to resume an increase in physical activity. This would include flexibility and strengthening exercises that he can do unsupervised. He does have a health club membership. He should be encouraged to be as active as possible. There is no surgery that is indicated on the basis of this evaluation, He has recovered from the soft tissue injuries sustained. The bulk of his symptoms are subjective and arthritic in nature.

Sincerely,

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

RCC/bn

cc: File