Highland
Musculo-Skeletal
Associates, Inc.

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Brian R. McGraw
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Playhouse Square
Cleveland, OH 44115

RE: Shirley E. Harris
Case No. 322547 (Cuyahoga Co)
File No. 500-59112

Dear Mr. McGraw:

I evaluated Shirley Harris in my office on October 1, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident, which occurred on or about July 15, 1996. She was the front seat restrained passenger in a vehicle described as a Honda Accord. She was on South Green Road in South Euclid, their vehicle being stationary at a red light. Their vehicle was rearended. At the moment of impact she was thrown backwards striking her head on the seat rest. She had immediate pain in her neck and upper back. She believes the seatbelt injured her right shoulder. I carefully questioned her on the mechanism of injury and she did not "have the time" to brace herself or was there any report of any torquing injury to the shoulder. It was difficult to elicit any mechanism that would have caused a rotator cuff tear.

She was conveyed by ambulance to the University Hospitals Emergency Room. There was no loss of consciousness. She had full spinal protection on her transport.

A detailed trauma evaluation was carried out including multiple x-rays of her neck. An orthopaedic consultation was obtained in the emergency room. She was placed in a cervical collar and ultimately discharged. There was absolutely **no** mention of a specific right shoulder injury. They were mostly concerned with a closed head injury and a soft tissue strain or sprain of the neck region.

She subsequently saw Dr. Gregory Carlson, a spinal orthopaedic surgeon affiliated with University Hospitals on or about July 18, 1996. He did review the x-rays and there was "quite a bit of cervical spondylosis" and a possible mild subluxation. Flexion and extension views did not show any significant movement and this was felt not to be a severe ligament injury. Physical examination was also suggestive of only diffuse cervical arthritis and a probable cervical strain. There was no evidence of any nerve root inflammation or compression. She suffered a "soft tissue contusion of the right shoulder". There was no suggestion of a rotator cuff injury.

Subsequently she was referred to two physicians, Dr. Bruce Cohn and Dr. Grant Heller. Dr. Heller saw her initially on or about August 6, 1996. Her complaints were primarily that of severe headache and neck pain. She had some dizzy spells at night with the sensation of the room spinning. She had been treated by a psychiatrist for depression related to a previous accident (non-MVA). Allegedly this was improving until this mid-July 1996 accident. He treated her for what appeared to be a closed head injury and a possible concussion, as well as a subjective aggravation of a pre-existing postural tremor. No distinct neurological lesion was ever noted. Physical therapy was suggested for her cervical spondylosis. This included heat followed with cervical traction, which was continued through the end of 1996 and into 1997. There was good subjective improvement of her neck symptoms with the traction.

In reference to her orthopaedic follow-up, she consulted with Dr. Bruce Cohn, on or about July 24, 1996. She presented with a history of arthritis, as well as a history of bilateral carpal tunnel syndrome in the past. At the time of Dr. Cohn's evaluation there was virtually no reference at all to a right shoulder injury. He felt this was degenerative arthritis of the cervical spine exacerbated by the accident. He saw her

on one additional occasion, July 31, 1996, and then not again until September 18, 1997. Physical therapy was suggested at the Menorah Park facility. Therapy was started on or about August 7, 1996 and went on for approximately six weeks, ending on September 20, 1996. It should be noted that throughout this entire period of time she was complaining of only right anterior shoulder pinpoint pain compatible with her contusing suspected injury, continuing numbness and intermittent tingling in the thumb and first two fingers of both hands, compatible with the bilateral carpal tunnel syndrome. There was no particular mention. of an isolated right shoulder injury throughout this entire time period.

As a matter of reference, there was absolutely no specific right shoulder pain noted from the time Dr. Carlson saw her in mid July of 1996 until October 14, 1996. She saw Dr. Cohn at that time and she was having some "problems" with her right shoulder. She did claim to have pain at that point in time since the time of the accident, but this was never mentioned prior in Dr. Cohn's records. There was some limitation of motion and x-rays revealed that the subacromial space was well maintained and the shoulder joint was norma . He felt there was impingement syndrome or possibly even a rotator cuff tear.

There was absolutely no follow-up care from October 14, 1996 until March 10, 1997. At thatpoint in time she was still complaining of pain in her right shoulder and a rotator cuff tear was suspected. Follow up approximately two months later in early May of 1997 lead to the performing of an ultrasound exam. This confirmed a "small full thickness" rotator cuff tear. This was never confirmed by any other study such as an MRI scan or an arthrogram. She has continued with a variety of care and treatment. Surgery was discussed, but from the discussion with the plaintiff, it will probably not occur.

CURRENT CONDITION: In general she claims that the tremors which she had prior to the accident have gradually subsided, having been aggravated for a period of time after the accident. She claims that the left carpal tunnel syndrome is essentially unchanged but the right hand seems to be getting worse. She attributes this to the car accident although no specific hand injury was noted. She still continues to complain

of diffuse neck and upper back pain related to the cervical spondylosis. She continues with some limitation of motion, which is painful at the extremes of motion.. This generally feels as if it is heavy. She did wear a cervical collar "for months" but doesn't use it anymore.

In reference to her right shoulder, she still continues to complain of pain at night. She does have some limitation of motion although it is much improved from the time she was first seen by Dr. Cohn for her shoulder in October of 1996. There is pain at the extremes of motion and when she repetitively uses her arm. When she dances the right shoulder also is somewhat painful.

CURRENT MEDICATIONS include an anti-anxiety medicine. She was on Prozac for quite some time but this was recently discontinued.

PAST MEDICAL HISTORY revealed a prior accident in which a door fell on her head and left side. She was "real nervous" after this incident and this precipitated the psychiatric care and medication Prozac being prescribed.

PHYSICAL EXAMINATION revealed a pleasant 74 year old female who appeared in no acute distress. She was noted to have a non-intention tremor, worse on the left side than the right side. She spoke in a somewhat tremulous voice. Her gait pattern was normal. She was observed walking in and out of the exam suite. Although she moved in a slow, somewhat deliberate fashion, no limping or dysfunction was noted.

Examination of her cervical spine revealed about a 20-25% restriction of motion in forward flexion, hyperextension, lateral bending and rotation. This was not associated with spasm, dysmetria, and muscular guarding or increased muscle tone. The pain was noted at the terminal portions of motion, which appeared to be limited by stiffness only. This is probably solely from her cervical spondylosis. There was no atrophy in the neck, upper back or periscapular muscles. The supraspinatus muscular region appeared to be normal in proportion comparing the left to the right. There was no obvious muscle atrophy that would confirm a long standing rotator cuff tear or significant right shoulder dysfunction. Range of motion of the right shoulder,

however, was somewhat limited to about 110 degrees of forward flexion, 95 degrees of abduction, with about 20 degrees more passive range of motion. The left arm had about 15% more motion in forward flexion and abduction, but rotational movements were about the same. She is normally right handed. The right arm musculature on circumferential measurements did not substantially differ. Both arms measured within 1/4 of an inch of each other at the axillary, midarm, forearm and wrist level. Neurological examination was highly suggestive of bilateral carpal tunnel syndrome. No distinct radicular abnormalities were detected.

IMPRESSION: Closed head injury, resolving; subjective aggravation of benign tremors, resolving; strain or sprain of the cervical spine, resolving. Diffuse cervical spondylosis (degenerative disc disease and degenerative arthritis). Right rotator cuff tear by ultrasound.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from University Hospitals of Cleveland, Menorah Aging Center, Dr. Jeffrey Ponsky, Dr. Bruce Cohn, Dr. Grant Heller, and Dr. Greg Carlson. Records were also reviewed from the physical therapist, Michael Suppler.

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.

In reference to her right shoulder, it is clear that there may have been a contusing injury. The injury as described would not have caused a rotator cuff tear to develop. There was some initial pain specifically in the region of her shoulder noted in mid-July of 1996 but it was not until many months later that specific attention was drawn to the right shoulder as a separate and distinct entity. I carefully questioned her in reference to any potential etiologies of the right rotator cuff abnormality. She believes that the injury occurred just from the seatbelt. I have never heard of this type of mechanism causing a rotator cuff tear.

The tear was only diagnosed by ultrasound. In my clinical practice I do not rely heavy on an ultrasound exam and -would, certainly before any surgery is contemplated, either had an arthrogram or an MRI scan to determine whether, in fact, the tear is complete. I have had a number of cases in which I relied on the ultrasound only to discover that there was no significant full thickness rotator cuff tear present at the time of surgery. In my opinion, the presence of a rotator cuff tear is **highly suggested,** but not definitively diagnostic. She does not examine as someone with a full thickness rotator cuff tear would examine. There have been some recent clinical studies indicating a fairly high incidence in this age group of non-traumatic rotator cuff tears. I am not convinced on the basis of this review whether, in fact, there is a tear or the exact etiology of the tear. She certainly is not a definite surgical candidate, as she feels there has been some improvement in her strength and range of motion. 'I am not sure of the precise significance of the ultrasound findings.

In reference to her cervical spine, in my opinion, there was no permanent aggravation or acceleration of her degenerative condition. Clearly this was a soft tissue strain or sprain, which necessitated the treatment as indicated. Certainly the cervical traction is beneficial for symptomatic osteoarthritis of the cervical spine. In my opinion, the treatment for the neck was medically appropriate.

The long-term prognosis, in my opinion, is favorable. *As* stated above, I am not sure of the significance of the ultrasound finding. I cannot say, within a reasonable degree of medical certainty, that the accident, with **the** mechanism described, was the source of the rotator cuff abnormality. Further diagnostic testing would certainly need to be performed prior to the performing of any surgical procedure. On the basis of this evaluation I would not recommend surgery for this patient.

The neurological symptom, that is the tremors and dizziness, seems to be resolving. There was no clear objective diagnosis of a intercranial bleed although a cerebral concussion was suspected.

On the basis of this evaluation, in my opinion, she should continue with her range of motion and stretching exercises for her neck and shoulder. On the bqis of this evaluation, surgery could not be recommended on the basis c f this review.

Sincerely,

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

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