Highland
Musculo-Skeletal
Associates, Inc.

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October 14, 1996

Molly A. Steiber
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633 The Leader Building
526 Superior Avenue, NE
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RE: Mildred Spadaro
Case No. 306548 (Cuyahoga County)
File No. CPP 500 59 14C

Dear Ms. Steiber:

I evaluated the above plaintiff in my office on October 10, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on April 12, 1994. Throughout the history and physical she was accompanied by her attorney, Thomas Brunn.

The plaintiff presented with a history of being the driver and solo occupant of a motor vehicle described as a Buick Regal. This occurred while heading west-bound on Rockside Road at the intersection of Warrensville Road in Bedford, Ohio. Apparently a truck was in front of her. She was in the right (curb lane) when a rear end collision occurred. She was stunned at the impact. She does not recall whether she hit the car in front of her. She was wearing a cervical collar at the time of the accident from her previous motor vehicular accident, as will be discussed below.

She was conveyed to the Bedford Community Hospital Medical Center where she was evaluated for acute neck, thoracic and lumbosacral strain or sprain secondary to the motor vehicular accident. A thorough diagnostic workup showed rather significant

pre-existing degenerative disc disease at the C3-4 and C5-6 levels, as well as diffuse osteoporosis. There was also degenerative changes in the lumbar spine at the L2-3 level, as well as osteoporotic changes. There were no traumatic lesions noted.

She continued wearing her cervical collar and continued taking some medications. She subsequently returned to the care of her previous treating physician, Dr. David Thomas and the Thomas Pain Centers, Inc. She was evaluated approximately two weeks after the motor vehicular accident in question with headaches and generalized **pain** through her neck, upper and iower back region. She had difficulty sitting and breathing. She complained of diffuse stiffness in her neck and arms. Physical examination, according to his records; however, did not reveal any significant objective findings. There was no guarding, bracing or grimacing. There was minimal restriction of motion of less than 10 percent in all planes. Neurologic examination was normal. He began a series of treatments for essentially a soft tissue strain or sprain of the neck and back region.

He proceeded with a number of diagnostic studies, including EMG and nerve conduction studies done by one of his associates, Dr. Lee. These results were entirely within normal limits. She was also started with physical therapy at the Orthopaedic and Sports Physical Therapy with Mr. Tom Rodack. She also received treatments at Dr. Thomas' office. An MRI scan was performed at Regional Diagnostic Imaging in Bedford Heights, Ohio. The scan was done on **April** 26, 1994, and was compared to a scan done approximately one year earlier, on May 25, 1993. There was essentially no significant change. The bulging Qscs which were apparent in 1993 were unchanged-

As also noted, she had EMG and nerve conduction studies which failed to show a significant abnormality. These were done on two occasions. She had an attempt at epidural blocks done by Dr. Salib, another associate of Dr. Thomas'. These did not give her any substantial relief.

Because of a failure to improve, a number of consultations were requested. She was seen for a one-the visit by Dr. George Kellis on or about July 7, 1995; who discussed her degenerative disc disease of the cervical spine and lumbosacral spine, her alleged

soft tissue injury, as well as her persistent numbness in the lateral femoral cutaneous nerve distribution, He did no further testing. He also noted a hallux rigidus deformity of the left foot, which was unrelated to this accident. It is an arthritic condition.

The other physician involved in her care was Dr. A. Romeo Craciun, a neurologist. He felt her conditions were essentially a subjective strain or sprain with subjective left cervical radiculopathy, although no distinct neurological objective abnormality was ever noted. He has been treating her primarily for "my migraine headaches." This is primarily with a medication known as Midrin. She is convinced he described some nerve damage that she sustained. No further care or treatment was recommended other than some continuing therapy.

She continues with physical therapy currently through Western Reserve Therapy in Chagrin Falls, Ohio. She claims to have been in physical therapy for the past year. This includes heat treatments, ultrasound, massage and stretching exercises, and recently starting some machine therapy treatments. She continues to see Dr. Thomas about every other month.

CURRENT **MEDICATIONS** include a series of medications for high blood pressure, thyroid, as well as Motrin and Codeine.

EMPLOYMENT HISTORY: She was previously employed in real estate safes, She has not worked since 1993.

PAST **MEDICAL** HISTORY did reveal a prior motor vehicular accident which was a rear end collision that occurred in Las Vegas, Nevada. This was on April 14, 1993. She was a front seat passenger and sustained primarily a neck and upper back injury. As noted above, she had an MRI scan when she returned back to Cleveland which just showed degenerative disc disease. She claims to have concluded her treatments with Dr. Thomas about a month before this motor vehicular accident in question. As was noted, she was wearing her cervical collar from the previous accident at the time of this accident.

CURRENT SYMPTOMS: 'At the time of this evaluation she continued to complain of pain in the upper back and chest area. There was no true neck pain, it was really below the C7 vertebral level. This seemed to be mostly in the trapezius muscle area which was ""constant." She had diffise aching pain in the neck, upper back and periscapular area. She also claimed to have weakness in both of her arms due to an aching pain. This seemed to be constant and no particular activity made it better or made it worse. Heat seemed to help it as well as ice.

She also complains of numbness in all of her fingertips. She also claimed that she had decreased motion of her shoulders and couldn't close her hands to make a tight fist. As was noted in the physical examination, when I asked her to do a number of activities, she clearly had full motion which went against her claims of physical impairment.

In reference to her lumbar spine, she complains of pain in the paraspinal region, both above and below her belt line. The pain seemed to be diffuse. She also claims to have numbness on her left thigh and in the area relating to the lateral cutaneous nerve. This is a superficial skin nerve and not related to any lumbosacral disc problems. She claims to have numbness in the same area of her left leg to a lesser intensity. There is an aching pain that she feels in both of her legs which did not follow any neurological pattern. She also has pain in her right great toe compatible with the hallux rigidus arthritic deformity.

PHYSICAL EXAMINATION revealed a pleasant 67 year old female who appeared in no acute distress. Her gait pattern was normal. She was observed walking in and out of the exam room in a normal fashion. She was able to heel and toe stand without difficulty. No gross atrophy was noted in her neck, upper back, upper or lower extremities on inspection.

Examination of her neck and upper back revealed no tenderness in the sternocleidomastoid, scalene, or upper trapezius muscle groups. There was no tenderness noted in the entire cervical spinal area. She did claim to have discomfort in

the trapezius muscle groups bilaterally. There was; however, no spasm, dysmetria or muscular guarding which would confirm any chronic inflammatory condition in these structures. Protraction, retraction, and elevation of the scapulae were performed normally. No atrophy was noted in the neck, upper back or periscapular musculature.

Examination of her shoulders was somewhat interesting to observe. There was a full range of motion of her right shoulder in forward flexion, extension, abduction, internal and external rotation. Initially she claimed to have absolutely no internal rotation and very poor rotational movements of the shoulder. However, when she was explaining to me where her back hurt, she was able to completely internally rotate her left shoulder. The elbows, wrists, and small joints of the hand examined normally. Despite the fact that she complains of diffuse weakness in her arms, no atrophy, and actually fairly good muscle tone and muscle development, was noted on examination. Circumferential measurements of both upper extremities at the axillary, midarm, forearm, and wrist level were equal and symmetrical. A detailed neurological examination including sensory, motor, and reflex testing of both upper extremities was normal. As noted in her history, she claimed to have incomplete motion of her finger joints but when I asked her to make a tight fist as part of the neurologic exam, she could easily comply, There was a negative Tinel and negative Phalen sign at the wrist joint.

Examination of her lumbar spine revealed minimal decreased range of motion, approximately 15 percent of predicted normal. There was no spasm, dysmetria or muscular guarding noted. Her straight leg raising in the sitting position was performed to 90 degrees bilaterally. However, in the supine position there was a limitation of approximately 30 to 40 degrees. Her leg lengths were equal. There was good rotational movement of her hips. Neurologic examination revealed a claim of decreased sensation in the lateral femoral cutaneous nerve distribution of the left thigh. This did not follow any radicular pattern, but merely this superficial skin nerve distribution. A detailed neurologic examination including sensory, motor, and reflex testing failed to reveal any objective abnormality.

IMPRESSION: Subjective residuals of a neck, mid and low back strain or sprain. Subjective arm and leg complaints which did not follow any neurological pattern other than the left thigh decreased sensation. MRI evidence of multiple level degenerative disc disease in the neck and low back region. Contradictory findings on physical examination.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment- These include records from the Community Hospital of Bedford, the Thomas Pain Center and the records from Dr. E, David Thomas, records from Dr. Romeo A. Cracian, Regional Diagnostic Center, Orthopaedics and Sports Physical Therapy, Orthopaedics and Neurosurgery, as well as the x-rays from Orthopaedics and Neurosurgery.

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 the plaintiff's ongoing level of physical impairment.

On the basis of this evaluation, in my opinion, she sustained, at worst, a soft tissue injury to her neck, upper and low back. No other documented entries were noted. This was a recurrent injury to her cervical spine which she alleges complete recovery after one year of treatment with Dr. Thomas and his associates. There was clearly no new objective traumatic lesions noted. Diffuse degenerative disc disease and arthritis was noted on the films from the Community Hospital of Bedford, Orthopaedics and Neurosurgery, as well as the repeat MRI scan. No new Iesions were noted.

The neurodiagnostic studies, that is the two EMGs and nerve conduction studies, clearly note improvement. It is, therefore, my opinion that any "nerve damage" to the sensory nerve is not permanent in nature.

As noted, there were a number of discrepancies during the time of the physical examination. These included the difference in the sitting and supine straight leg raising, the difference in rotation of the left shoulder, and the ability to make a tight fist

when other parts of the hand and upper extremity were tested. In my opinion, these contradictory findings are associated with malingering or at least an attempt by the patient to exaggerate her ongoing symptoms. It is clear that she has had a significant amount of physical therapy and conservative care with little or no long-term improvement. There was never a great deal of objective findings noted. She has had a substantial amount of care solely based on her subjective symptoms.

At the time of this evaluation, in my opinion, she has objectively recovered from any soft tissue injury sustained. There are no indications at the time of this evaluation of any necessity for ongoing physical therapy solely related to the 1994 injury. In my opinion, the bulk of this therapy and diagnostic workup has been solely on the basis of her symptoms and not on the basis of any significant ongoing musculoskeletal pathology. On the basis of this exam she has objectively records and the long-term prognosis is favorable.

Sincerely,

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

RCC/bn

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