Highland Musculo-Skeletal Associates, Inc.

Robert C. Corn, **M.D.**, F.A.C.S.
Timothy L. Gordon. M.D.
Orthopaedic Surgeons

November 22, 1997

William T. Neubert
Attorney at Law
Suite 616 - The Arcade
401 Euclid Avenue
Cleveland, OH 44114

RE: Robert F. Mamrak
Case No. 97 CV 118518 (Lorain Co.)
DOI: 7/13/95

Dear Mr. Neubert:

I evaluated the above plaintiff in my office on November 20, 1997 in reference to alleged residuals **of** injury sustained in a motor vehicular accident which occurred on July 13, 1995. The history presented was that he was the driver of a Honda Accord vehicle on Route 60 in Vermilion, Ohio. He was the driver and a friend of his was in the front seat. He described this road as a "interstate". He was in the passing lane traveling approximately 55 to 60 miles per hour." **A** motor vehicle came **on** the entrance ramp and suddenly pulled in front of him. He couldn't stop & this happened "too suddenly". **A** front end occurred. He was wearing a seatbelt. There was immediate soreness in his neck. No paramedics were summoned and he "just dealt with" the sore neck that he had which increased over the next three-week period of time.

He began having much more discomfort and severe left arm pain within the next three weeks. He had multiple visits to the Allen Memorial Hospital complaining of severe posterior neck pain, as well as numbness and burning pain radiating into his left lower extremity. This was not relieved with ongoing injections. Ultimately an MRI scan was performed at the Northern Ohio Imaging on August 16, 1995 which

showed a herniated cervical disc at the C5-6 level. There was rather significant degenerative disc disease at that level as well.

The patient subsequent was referred to a neurosurgeon, Dr. Mario M. Sertich, who initial saw him on or about August 17,1995. He recommended immediate surgery on his neck and this was carried out at the Lorain Community St. Joe's Medical Center on August 21, 1995. This consisted of a cervical discectomy at the C5-6 level with an arthrodesis. He as not in the hospital for more than a 23-hour time period and then was discharged.

There was almost immediate relief of his neck and arm pain. The numbness and weakness of his left arm took about a year to resolve. He wore a neck brace for approximately 14 weeks. The right anterior neck incision healed beautifully. He continued to follow with Dr. Sertich on a fairly routine basis, the last visit he believes was in late 1995 or at the latest, 1996. He has not had any care or treatment since that time for his neck symptoms.

EMPLOYMENT HISTORY: At the time of the accident he was employed in the Lorain Ford Assembly Plant. He was laid off during the time of his accident and surgery. He then went back to work in approximately mid-November of 1995 until he was furloughed to Louisville, Kentucky. He currently lives in Louisville, Kentucky; and works at the truck assembly plant having moved there is September of 1997. He has not sought any care or treatment for his neck since his move out of Westside Cleveland.

PAST MEDICAL HISTORY failed to reveal specific problems with his neck or left arm. Records were reviewed from the Bureau of Workers' Compensation which essentially dealt with a right shoulder injury, a left wrist sprain, a fractured left clavicle, and a right subscapular bursitis. He also developed a chronic tennis elbow. None of these were related to a neck condition.

CURRENT SYMPTOMS: He has recovered nicely from his post injury residuals. Initially there was increasing neck pain followed by worsening left arm pain. This was totally relieved with the surgery.

He now complains of an intermittent neck discomfort. This is a dull, achy pain, primarily on the left side of his neck near the occipital region of the skull. Cold and rainy weather bothers it. The pain, at worst, is "mild" and this does not prevent him from working.

In reference to his left arm, the only residual symptom is that intermittently the left middle finger "gets ice cold". He occasionally has a cramping sensation in the anterior aspect of his elbow in the biceps region with forced flexion of the elbow. These are his only residual symptoms.

PHYSICAL EXAMINATION revealed a pleasant 44 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 exam table was performed in a normal fashion.

Examination of his cervical spine revealed a well-healed anterior scar compatible with his surgical history. There were no signs of ongoing muscular irritation in the form of spasm, dysmetria, and muscular guarding or increased muscle tone. Despite the single level fusion he had a full and complete range of motion of his cervical spine in forward flexion, extension, side bending and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. No atrophy was noted in the neck, upper back, or periscapular muscles. There was full range of motion of both shoulders noted in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. No neurological deficits were noted specifically in the C5-6 nerve distribution. The right arm was slightly larger than the left by less than one-quarter inch. He is right handed.

IMPRESSION: Probable acute cervical sprain with aggravation of preexisting C5-C6 cervical disc disease. Probable cervical disc herniation related to the motor vehicular accident. This was essentially an aggravation of a preexisting condition. Complete resolution of his symptoms postoperatively.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included records from the Lorain Community St. Joe's Medical Center, Dr. Sertich, Allen Memorial Hospital, Tri-City Family Practice, and records from the Bureau of Workers' Compensation.

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.

It is my medical opinion, within a reasonable degree of medical certainty, the primary injury was a severe cervical sprain. This, in my opinion, aggravated a preexisting C5-C6 disc disease and either caused or aggravated a cervical disc protrusion: There was immediate pain after the accident with increasing discomfort, initially radiating pain, and then true radicular pain with burning within two to three weeks after the motor vehicular accident. This was appropriately diagnosed and treated surgically. There was almost complete resolution of his symptoms immediately after the surgery. It is, therefore, my opinion, there is a fairly consistent cause and effect relationship between the accident, the onset of the symptoms, and the necessity for the surgical procedure.

He has, as is well noted in the medical records, recovered from this injury. There is no significant permanent objective injury that is noted. The only permanency is the scar and the fusion at the C5-6 level. This has not left him with any functional loss of movement or motion. There is no permanent soft tissue injury sustained nor was there any permanent neurological injury. He has only mild subjective symptom that have persisted. These do not necessitate any medical care or treatment."

The long-term prognosis is favorable. On the basis of this evaluation he has objectively recovered. No treatable permanent injury was sustained. On the basis of this evaluation, no further care or treatment is necessary or appropriate. He has recovered. The prognosis is good.

Sincerely,

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

RCC/bn

cc: File

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Associates, Inc.

Robert C. Corn, M.D., F.A.C.S.
Timothy L. Gordon, M.D.
Orthopaedic Surgeons

November 22, 1997

William F. Gibson
Attorney at Law
The Bulkley Building
Seventh Floor
1501 Euclid Avenue
Cleveland, OH 44115

RE: Edward Poirrier
Case No. 97-01-0338 (Summit County)
File No. 93474-97599

Dear Mr. Gibson:

I evaluated the above plaintiff in my office on July 28, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident that occurred approximately two years earlier on July 31, 1995. He appeared alone for this evaluation without a friend, family, or legal counsel present.

The history presented was that he was the driver and solo occupant of a full-sized, 3/4-ton van heading westbound on 1-76 in the Akron, Ohio vicinity. The weather was described as clear and dry. The accident occurred in the early afternoon. There was a fair amount of construction heading in the westbound direction and the traffic was funneling into one lane. He stated he was at a complete stop but some records indicate that he may have been moving slowly when his van was struck in the right rear by a tractor-trailer. According to the records, the police estimated the speed of the tractor-trailer at about 25 miles per hour. The plaintiff, as will be discussed below, conveyed a somewhat different history to Dr. Barry Greenberg: a subsequent treating orthopaedic surgeon. The force of this impact pushed him into a concrete

median wall causing damage to the left front comer of his vehicle as well. He stated the van was "totaled". He was wearing a seatbelt and shoulder harness.

After the impact he stated he was thrown forward and backwards. He does not believe he injured his head and there was no loss of consciousness. He was conveyed by ambulance to the St. Thomas Hospital in Akron, Ohio, where he had his initial evaluation. Because of a diagnosis of spondylolisthesis at the L5-S1 level and the thought that this may have been an acute injury, he was admitted on an observational status. While hospitalized he initially saw Dr. Barry Greenberg: a referring orthopaedic surgeon. It was felt that the spondylolisthesis was chronic and no acutely related to accident. He was discharged the following day with a diagnosis of a low back strain.

During that hospitalization a CT scan was performed of the low back and no other abnormalities were noted. He then followed up with Dr. Greenberg who recommended physical therapy for the low back. There was some reported soft tissue injury in the form of a strain or sprain to this neck but this had resolved to a great extent in the immediate post injury period. Physical therapy was initiated in January of 1996 for the chronic low lumbar slippage. At that time there was a significant amount of paraspinal muscle guarding indicating a benign soft tissue injury. There was a good response to physical therapy with the bulk of his residual pain gradually diminishing.

In reference to the history, Dr. Greenberg recalls the injury as a semi-truck hitting him at "full speed". As noted, this was not the history that was presented in the balance of the medical records. Additional diagnostic work-up, including flexion extension films, failed to show any significant instability in the lumbar region. There was some confusion in the initial records reviewed as to which level the spondylolisthesis was. This was felt to be the lowest mobile lumbar segment which may have been the L4-5 level. A bone scan was ultimately recommended and did not show any acute fracture.

As noted above, the neck pain resolved by early November of 1995. He continued to follow with Dr. Greenberg through the balance of 1995. The next follow-up was in mid-July of 1996. It was Dr. Greenburg's opinion at that time that there was a subjective aggravation of his spondylolisthesis. Surgery was discussed by never seriously considered. He continues to see Dr. Greenberg on an every six-month basis.

EMPLOYMENT HISTORY: He is self-employed, designing and selling custom baskets that are manufactured by the Amish population. He stated that he was out of work for approximately three weeks. He lost some time attending a few local trade shows in the immediate post injury period. He has essentially resumed his normal work and responsibilities.

CURRENT STATUS: He is currently not on any prescription medications. He still has some ongoing residua1 symptoms which he relates to the motor vehicular accident. At the time of this exam, he continued to complain of pain in the cervical spine region. This bothers him only with extreme rotatory positioning of the neck, that is, when the neck is turned maximally to the right or the left, he would develop a deep aching pain on the same side trapezius muscle group. This occasionally gives him some difficulty sleeping, but is not a significant ongoing source of discomfort. Other than with the extremes of rotation there is no pain or symptomatology in the neck region. There have never been any complaints referable to his upper extremity.

In reference to his lumbar spine, he has had a much more consistent type of discomfort. This is primarily on the right side, just below the iliac crest level. The pain is not particularly centered in the midline but more in the region of the sacroiliac articulation. He claims this constant, like a very low-level toothache type of pain. It is not throbbing, stabbing, or burning in nature. The pain seems to increase somewhat with prolonged standing and repetitive bending and lifting. He tends to avoid extreme strenuous activities. There is an intermittent inconsistent right leg discomfort. It has no particular activity origin, It does not bother him more when he is bending, lifting, or sitting for prolonged periods of time. It does not bother him more when his back is in the hyperextended position. Typically this discomfort

would be short lived and in the posterior thigh region. When the back is at its worst, the posterior thigh discomfort can increase and, in fact, give him some radiating pain below his knee. This is very unusual. He could not recall which particular leg had the most radiation of this discomfort.

PAST MEDICAL HISTORY is significant. He recalled that his initial low back injury was in 1966 while in the Marine Corps. He was loading boxes of rocket launchers when he sustained a low back injury. He has been treated intermittently at the Brecksville Veterans Administration Hospital. Review of these records clearly indicate that as recent as the summer of 1993, he had complaints of progressive worsening and difficulty walking, standing, or lifting, and morning stiffness, as well as working difficulty. Radiological evaluation in September of 1993 showed evidence of the anterior spondylolisthesis. This clearly was a preexisting diagnosed condition.

PHYSICAL EXAMINATION revealed a pleasant, somewhat soft spoken, 50 year old male who appeared in no acute distress. He was noted to sit, stand, and move about the exam room in a completely normal fashion. His gait pattern was normal. He was able to walk on his heels and toes without difficulty.

Examination of his cervical spine revealed a full range of motion in all directions of forward flexion, extension, side bending, and rotation. There were no objective signs of muscle irritation or residual injury noted. There was no spasm, dysmetria, and muscular guarding or increased muscle tone. No atrophy was noted in the neck, upper back, or periscapular muscles. He claimed to have some discomfort in the ipsilateral trapezius area on right and left full rotation. There were no objective findings associated with this complaint.

Examination of both shoulders revealed a full range of motion in forward flexion, extension, abduction, and internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. A detailed neurological evaluation 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 showed no demonstrable difference between his left and right sides.

Examination of his lumbar spine revealed a claim of tenderness to deep palpation just below (inferior) to the right iliac crest. This was not centered in the midline. There was no discomfort at the extremes of forward flexion or hyperextension. Even forced hyperextension was not significantly uncomfortable for him. There was very minimal restriction of motion with over 90% of his predicted range of motion present. This is considered to be essentially normal for his height, weight: and age.

His straight leg raising in both the sitting and supine positions were performed to 90 degrees bilaterally. A negative Lasegue's sign was noted. A negative Patrick's sign was also noted. His leg lengths were equal. A detailed neurological examination including sensory, motor and reflex testing of both lower extremities was normal. There was a very minor degree of right calf atrophy, approximately 1 cm as comparsd to the left. There was no additional physical correlation. The significance of this is unknown It may be developmental. There were no symptoms related to this finding.

IMPRESSION: Subjective intermittent residuals of a soft tissue strain of the neck. Probable lumbar strain. **Transient** subjective aggravation of his low lumbar spondylolisthesis.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included records from the St. Thomas Hospital and the 24-hour observation, records from physical therapy, as well as the Crystal Clinic, and Dr. Barry Greenberg. The results of the x-rays and bone scans were also reviewed. I had the opportunity to review some records from the Veterans Administration Hospital as well.

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 soft tissue strain or sprain of the neck and low back region. These injuries responded well to rest, anti-inflammatory medications, and appropriate physical therapy. He only missed approximately three weeks out of work and has gradually recovered subjectively. There is still some residual symptoms refers back to the motor vehicular accident in question. The most consistent is in the right lumbosacral region near the sacroiliac joint. No provocative testing on physical examination suggested any significant lumbosacral pathology other than the spondylolisthesis which was known for years prior to this accident. There was no objective abnormality other than the mild atrophy on physical examination.

Review of the x-rays and the scan reports indicate a Grade I (less that 25%) spondylolisthesis at the lowest mobile segment. Some of the records state this is at the L5-S1, but it may be at the L4-5 level. This differentiation is not critical from a clinical standpoint. On flexion/extension laterals there was no instability noted. Although this is a definite objectively normal finding: it is chronic in nature and relates to a remote back injury or developmental abnormality that occurred in his younger years. I disagree with Dr. Greenberg's interpretation of the bone scan. In that the scan is normal, this indicates a *non-acute* pathology. In my opinion, at worst, there was a transient subjective aggravation of his spondylolisthesis symptoms. The bulk of his symptoms were identical to those described in the previous Veterans Administration records.

In conclusion, it is my opinion that the plaintiff sustained: at worst, a minor soft tissue strain or sprain of the neck. This did not necessitate a great deal of treatment. The symptoms resolved by the fall of 1995. His low back injury was also a strain or sprain which he continues to have some subjective symptoms. No objective abnormalities were noted. There is no clear explanation for the right calf atrophy. There are no other specific signs that would be directly related to this minor muscular abnormality. This may be developmental in nature.

The long-term prognosis is favorable. I am not certain, within a reasonable degree of medical certainty, that his source of pain is his spondylolisthesis. I do believe that

this is chronic condition which has given him pain for years. He should continue with his flexibility and strengthening exercise program indefinitely due to the chronic nature of his low back abnormality. It is my opinion that he will continue to recover in the future.

Sincerely,

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

RCC/bn

cc: File

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November 22, 1997

Thomas M. Coughlin, Jr.
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Richard S. Feldtz
Case No. 309656 (Cuyahoga County)
File No. 1109/14395-SF

Dear **Mr.** Coughlin:

I evaluated the above plaintiff in my office on August 28, 1997, in reference to subjective residuals of injury from a motor vehicular accident which occurred on June 20, 1994. The plaintiff was evaluated without friend, family or legal counsel present.

He presented with the history of being a driver and solo occupant of a late model Pontiac Firebird vehicle in Lakewood, Ohio, on his way to work early in the morning at 6:25 AM. As he was proceeding through the intersection, through a flashing yellow light, a car came from a side street and "broadsided" the driver's side door area. His car was then forced to his right and the passenger side of the vehicle struck a nearby utility pole, There was immediate pain in the neck with some upper extremity numbness which shortly dissipated. The vehicle was totaled.

Police were on the scene and ultimately took him home. His wife then conveyed him to the University Hospitals of Cleveland Emergency Room where he had his first medical evaluation. Complaints at that time were compatible with a soft tissue strain or sprain of the cervical spine. X-rays did reveal his rather significant pre-existing bony abnormality. No new fractures were seen. An orthopaedic consultation was

obtained. It was felt that there was a "mild cervical strain" according to the records, a soft collar and Ibuprofen was prescribed.

The plaintiff then returned to his previous treating spinal orthopaedic surgeon, the late Dr. Geoffrey Wilber. Dr. Wilber was his treating physician for this neck abnormality prior to the motor vehicular accident. As will be discussed below, there has been ongoing follow up for his congenital abnormality. Dr. Wilber started him on some home exercises. Later that year, between late 1994 and 1995, he underwent formal physical therapy through Fairview Hospital. This was specifically for his Klippel-Fiel syndrome.

Early in the course of his recovery, his attorney sent him to the Cleveland Therapy Center where he was initially evaluated on October 1, 1994. It was felt at that time that he had an acute cervical strain. Some therapy was initiated but this was too painful and it was discontinued.

He is currently being followed by Dr. John Davis. He has seen this physician on a number of occasions. The initial evaluation was on or about May 1, 1996. The plaintiff most recently saw him on October 1, 1997, about a month after my evaluation. Dr. Davis was most concerned, as have all his physicians, with the nonfused vertebral segments of his cervical spine. No specific treatment was recommended unless this has further degeneration and instability develops. There was specifically no neurological abnormalities related to this condition. There was some degree of subluxation which had been present for many years. There was absolutely no mention of any residuals of the motor vehicular accident. There was no significant change in his clinical examination and follow-up examination was scheduled on a routine basis in six months, April 1998.

EMPLOYMENT HISTORY: He is employed by the General Motors plant at the General Motors Parma facility as an engineer and production support. His job involves a fair amount of walking. He lost the day from work and a few days after the accident. He has also lost occasional days for doctor's visits.

CURRENT SYMPTOMS: Initially after the accident there was diffuse pain in his neck and upper back region. There was also initially some bruising across his chest wall from the seat belt. He believes he may'havestruck his knees and there was some bruising there as well. He never had any particular treatment for his chest or knee complaints.

He continues to complain of a subjective degree of discomfort, primarily in the left trapezius muscle area. This bothers him every day at a "dull, low level". Walking distances and bouncing in a car sometimes aggravates the soft tissue symptoms. His neck was quite stiff prior to the accident and he does not claim to have any increased stiffness. Occasionally there is a severe, sharp pain which radiates from the upper back region into his left ann. This may "ache" for a period of time and then gradually dissipate. I specifically questioned him on neurological symptoms, that is numbness, burning or tingling, and he does not have any of these symptoms. He feels that he is generally "a little weaker" than he was in the past.

PAST MEDICAL HISTORY reveals the congenital Klippel-Fiel syndrome. He has been followed by Dr. Hernden at University Hospitals since he was in grade school. He had yearly visits with Dr. Hernden until he went off to college. In the early 1990's he was initially evaluated by Dr. Wilber. He explained that all of his physicians were concerned about the one mobile segment. It was felt, in general, that he had a C2-3 congenital fusion, as well as a C4-5-6 congenital fusion. The occiput C1-C2 levels were normal, as was the C6-7 level. The bulk of everyone's attention seemed to be on the C3-4 level or the mid cervical mobile level. This is the level that is obviousfy most under stress due to the fact that there is a dramatic reduction of the mobile cervical spinal segments. This has been the source of attention over the years.

PHYSICAL EXAMINATION revealed a pleasant 33 year old male who appeared in no acute distress. His gait pattern was normal. He was observed ambulating to and from the examining room, as well as in and out of the medical building. There was no gait disturbance. He was able to heel and toe walk without difficulty. He held his neck in a somewhat rigid fashion compatible with the short neck stature of the congenital abnormality. The general appearance was typical for individuals with this condition.

Specific range of motion of the cervical spine showed approximately 50% limitation in forward flexion, extension, side bending and rotation. This was a functional range of motion but still diminished. It was not associated with spasm, dysmetria, muscular guarding or increased muscle tone. There was some soreness in the left trapezius muscle on the left side. This was no accompanied with an gross measurable atrophy in the neck, upper back or periscapular muscles. A full range of motion of both shoulders was noted. Symmetrical development of the deltoid, biceps, and forearm muscles were noted. Circumferential measurements at the axillary, midarm, forearm and wrist level showed the left side was slightly larger than the right. He is left-handed. The balance of the neurologic examination was normal.

IMPRESSION: Probable cervicothoracic strain or sprain related to the motor vehicular accident. No **objective** worsening of his preexisting significant cervical spinal disease. No rapid deterioration of the mobile mid cervical segment.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These records included records from the University Hospitals of Cleveland and his treating orthopaedic surgeon, Dr. Geoffrey Wilber and **Dr.** John Davis. Records were also reviewed from the Fairview General Hospital for physical therapy. I have reviewed both the original and April 1997 x-rays from the Southwest General Hospital office of Dr. Davis. These clearly show no significant change in the bizarre appearance of the congenital cervical spinal abnormality.

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 plaintiffs ongoing level of physical impairment.

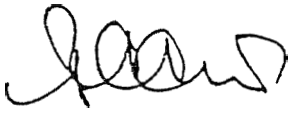
It is within a reasonable degree of medical certainty that the primary injury sustained as a result of this collision was a strain or sprain of the cervical spine. In that there are only a few mobile cervical spinal segments, this strain or sprain seemed to take longer to resolve than typically anticipated. With a normal spine, these fairly typical soft tissue injuries heal within a six-week to eight-week period of time, and with appropriate therapy, resolve within three to four months. The subjective symptoms,

as noted above, have persisted. It would not be unusual for there to be some persistent symptomatology due to the abnormality of the spine. This preexisting condition may have made the spine more vulnerable to injury.

However, there was no **objective** radiological injury sustained. There is no objective evidence of any worsening of his preexisting condition. Subjectively he notices no increased stiffness of his cervical spine from his baseline pre-injury status. He continues to have subjective symptoms in the left trapezius muscle without any objective findings. There is no objective evidence of any further deterioration or degeneration of the mid cervical movable cervical spinal segment. Review of the most recent x-rays show no substantial change from the original x-rays. There is no objective evidence that his pre-existing condition was influenced in any way.

It is my opinion that since this evaluation was done over three years post-injury that any future care or treatment related to that remaining movable segment is unrelated to the motor vehicular accident in question. There is no evidence of a permanent aggravation. Any care and treatment, including a cervical fusion in the future would be solely related to his pre-existing condition. The soft tissue injury sustained in this motor vehicle accident, objectively, has resolved. The long-term prognosis is therefore favorable. He should continue to follow with Dr. Davis for his congenital abnormality, This future care will be unrelated to the motor vehicular accident.

Sincerely,



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

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