Highland
Musculo-Skeletal
Associates, Inc.

December 12,1996

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

Walter H. Krohngold
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Ethel Pataki
File No. 13676-AF

Dear Mr. Krohngold:

I evaluated the above plaintiff in my office on October 8, 1996, in the presence of both her husband and Tracy Carpenter, a paralegal from the plaintiff attorney's firm. This evaluation was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on September 21, 1993.

She reported as a somewhat unusual accident in which her husband was the driver and she was a belted front seat passenger in an Olds Delta 4-door 1982 vehicle. They were in the vicinity of State Road and Akins Road in North Royalton, Ohio. They had stopped just short of the intersection seeing an accident developing. A van, with the right of way, coming in the opposition direction toward them, was struck by a car. The van flipped and rolled, and essentially came directly on the plaintiffs vehicle's front hood. This was the second impact that the van had. At the moment of impact the plaintiffs were allegedly thrown forward and backwards. I was able to observe pictures of the motor vehicle that the patient brought with her, as well as some initial photographs which showed the damage to their vehicle.

She was conveyed to the Parma General Hospital Emergency Room by emergency squad. A thorough trauma examination was performed with complaints of pain in the

left upper anterior chest, **left knee,** as well as multiple bruises. There was no head injury and no neck pains. Some bruising was noted on the anterior aspect of the **right** leg. Physical examination did reveal these multiple contusions. There was a rather large ecchymosis along the lateral aspect of the left leg and from the mid-thigh down to the mid tib-fib level. The **left knee** was the most tender area. No specific reference of right knee injury was noted in the emergency room records. The appropriate x-rays were performed which included only the left knee. There was generalized degenerative arthritis noted. A chest x-ray was performed. There was no care or treatment rendered for her right knee, and she was discharged with a diagnosis of multiple contusions.

She subsequently came under the care of Dr. Lopez, her family doctor. The initial visit after the accident was on September 27, 1993, approximately three days later. Multiple contusions were noted along the left breast and chest area with tenderness. Contusions of both knees and thighs were also noted. He followed her on a regular basis, gave her a muscle relaxant and some **pain** medication. There was complaints also noted of her left shoulder and low back pain. She was referred to Dr. James Andrews, who had previously treated her from an orthopaedic standpoint. Reviewing the records from the time of the accident through November of 1993, indication only left-sided lower extremity pain with absolutely mention of any right knee injury or problem.

It was not until the office records of 1994 that she began having documented discomfort in her right knee.

According to the additional medical records at St. Alexis Hospital, she underwent x-rays of her left knee. Films were done of both knees; however, which revealed bilateral degenerative arthritis. She was referred to physical therapy with complaints of **pain** along the medial aspect of the **right** knee and the lateral aspect of the left knee. There was also tenderness in the left upper back, neck and left shoulder region as well. Electrical treatments were given on both knees at that time. The therapy went on for a few weeks, indicating the fact of some arthritis in both of her knees. Therapy seemed to end by October 20, 1993.

The only other care or treatment given by Dr. Lopez was in reference to the multiple glass fragments that were embedded as a result of the accident. She had two areas along her anterior left thigh which she underwent outpatient surgery for on February 24, 1994. She has recovered from those foreign bodies.

As alluded to above, she ultimately came under the care of Dr. Edward Andrews, an orthopaedic surgeon. She had previously been treated by this physician who did arthroscopic surgery on her left knee. The date of the initial evaluation was on November 23, 1993. She described the history and complained solely of the left knee. There were no documented problems with her right knee during this initial phase of his visits. Review of his prior records clearly indicate that she had known degenerative arthritis in her right knee as far back as 1990. Dr. Andrews continued to follow her left knee symptoms on a very intermittent basis. Follow-up examination was not carried out until May 24, 1994, approximately six months after the previous accident. Again, there was absolutely no mention of right knee discomfort. There was ongoing complaints in reference to the left shoulder. His diagnosis, care and treatment, was solely for "degenerative joint disease of the left knee.''

It was not until February 7, 1995, approximately one year and five months after the accident, that she began "a week and a half ago started with posterior aspect pain in the right knee." According to the medical records that were reviewed there was some mention of some medial right knee pain with the physical therapist's treatments at St. Alexis Hospital in October of 1993, but no further mention in any record of pain until February of 1995. X-rays at that time revealed narrowed joint space compatible with later stage degenerative arthritis of the right side with lipping, also end stages of arthritis. His impression was degenerative arthritis of the right knee and a probable meniscal tear.

She underwent her first surgery on February 9,1995, in the form of a right arthroscopy at the Meridia South Pointe Hospital. Accordmg to the operative record there was rather extensive degenerative arthritis of the right knee with a tear of the meniscus. The x-rays that were done revealed "moderate degenerative arthritis in the knee with medial joint space narrowing." At the time of the surgery there was noted to be a

moderate extent of arthritis involving the patellofemoral joint and medial jointline, and to a lesser extent the lateral jointline. An arthroscopic surgical procedure was performed in the form of a meniscectomy and chondroplasty. A laser was used to remove the abnormal cartilage along the medial condyle and upper tibial plateau. This was clearly a surgery for arthritis and a secondary meniscal tear.

After the surgery, she continued to have a fair amount of pain in the knee. She was followed on a regular basis by both Dr. Andrews and Dr. Krahe, on of his associates. There was fluid accumulation in the knee and the knee was aspirated and injected with Cortisone in early March of 1995. She was sent for further rehabilitation that improved her muscle strength. She had -10 degrees of full extension to 105 degrees of flexion. There were ongoing complaints of stiffness and pain. The last record of treatment with this physician was on July 18, 1995. At that time there was -20 degrees of full extension with flexion to 110 degrees. They discussed dynamic splinting and second orthopaedic opinion.

By November of 1995, her right knee continued to deteriorate. Her husband contacted University Hospitals Orthopaedics and they were referred to Dr. Petersilg. (His records were unavailable for review.) She underwent a right total knee replacement in November of 1995, and did not do well after that. There may have been a fracture sustained during a closed manipulation. She was casted for a prolonged period of time. She also recently underwent a revision of the right total knee replacement by Dr. Kim Stems at the St. Alexis Hospital. No records were available for review from those institutions.

She is currently in physical therapy recovering from her revision right total knee replacement. She goes three times a week to physical therapy.

CURRENT MEDICATIONS include only Darvocet. She takes one to two tablets per day.

PAST MEDICAL HISTORY failed to reveal any precious injuries to her right knee. There was the history of the arthroscopic surgery on the left knee for a loose body.

She claimed, and her husband claimed throughout this entire evaluation, that her right knee was the major source of complaints from the time of the accident on. This, of course, was not confirmed by review of the medical records.

CURRENT SYMPTOMS: At the time of this evaluation, her left knee, left shoulder, upper and lower back symptoms have totally resolved. All of her problems concerning her right knee for which she has had a somewhat poor result from her reconstructive surgery. She complains of pain, stiffness and inability to put full weight on the right knee. She doesn't trust the knee. There is incomplete motion. At the time of this evaluation she was three months status post revision arthroplasty of the right knee.

PHYSICAL EXAMINATION revealed a somewhat angry 73 year old female who appeared in no acute distress. She was observed to sit comfortably through the examination. She had difficulty walking showing a marked right antalgic gait favoring her recently operated right knee. She was unable to heel or toe walk due to insecurity in reference to this knee.

Examination of her right knee revealed a well-healed anterior scar compatible with her arthroplasty and revisional knee arthroplasty. I was unable to find the arthroscopic incisions. Range of motion was from -10 to 75 degrees of flexion. There was excellent medial lateral stability. There was no anterior posterior instability. No measurable atrophy was noted on circumferential measurements of the upper and lower thigh, or upper and lower calf level. Neurologic examination was normal.

IMPRESSION: Related to the motor vehicular accident, multiple contusions with foreign body (glass). Degenerative arthritis of the right knee. Transient medial right knee pain noted in early October of 1993. No further documentation of right knee problems until February of 1995. Status post right knee arthroscopy, total 'knee replacement, and revision total knee replacement.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from Parma Community General Hospital, Meridia South Pointe Hospital, Dr. James Andrews, St. Alexis

Hospital and Dr. Lopez. The x-rays were reviewed from Dr. Andrews office, as well as the arthroscopic pictures. Records were also reviewed from Ohio City Orthopaedics and Dr. Kim Stems. Dr. Petersilg's records were unavailable.

DISCUSSION: Although the patient and her husband vehemently explained that the right knee was the primary source of the problem since the immediate post accident period, this clearly is not reflected in the medical records. There was no indication of an initial severe trauma to her right knee. The **left knee** was the primary source of complaints. The referral to physical therapy within a month after the accident was primarily for her left knee. The right knee was also mentioned, but no significant follow up was specified in her medical records until February of 1995. This was approximately 15 months later. There was no documentation when she saw Dr. Andrew of any ongoing problems with her **right knee.**

It is my opinion that her current condition is due to the failure of her total knee replacement. It is difficulty to establish exactly what the care and treatment was with Dr. Petersilg. Ultimately there was a failure of the right total knee replacement which necessitated Dr. Stems involvement and the revision total knee. In my medical opinion, the knee arthroplasties and the care and treatment to her right knee was not related to the motor vehicular accident in question. There was a substantial time delay before the significant symptoms in her right knee started. Once the significant arthritis was noted in the right knee at the time of the arthroscopy, the knee progressively deteriorated.

In *summary,* in my medical opinion, within a reasonable degree of medical certainty, the primary injuries were multiple contusions, mostly to the left knee. There was very little documentation of any ongoing problems with her right knee other than one mentioned in the physical therapy record. The bulk of her right knee complaints did not start until approximately 15 months after the motor vehicular accident in question. There seemed to be a discrepancy between the history presented by the plaintiff and her husband, and the facts generated in the medical records. Her current condition is unrelated to the motor vehicular accident and due to failure of her reconstructive surgery for endstage arthritis of the knee. In the care and treatment provided to her

right knee, after the initial four to six weeks, in my opinion, is related **solely** to her underlying progressive arthritic condition. The necessity for the two knee replacements is unrelated to the motor vehicular accident in question.

Sincerely,

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

RCC/bn

cc: File

December 12,1996

Gregory H. Collins
Attorney at Law
800 Key Building
159 South Main Street
Akron, OH **44308**

RE: Larry Daniel Neumeyer
DOI: 5/12/95

Dear Mr. Collins:

I initially evaluated Larry Neumeyer in my office on December 6, 1996, in the presence of his mother who was present through the history portion of the evaluation. This examination was carried out in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on May 12,1995.

As you are aware, at the time of this evaluation, he was approximately one month post surgery on his lumbar spine. It was the initial intention to evaluate him prior to surgery, which was originally scheduled in February of 1997. At the time of this first evaluation, only the history **was** carried out. An appointment for a physical examination was made for mid-March of 1997.

MEDICAL HISTORY: On May 12,1995, he was the driver and solo occupant of **a** late model Firebird vehicle. He was in a stationary position on Ghent Road **waiting** for oncoming traffic to make a left turn. He did not recall to me whether he had his turn signals on. This was a four lane highway.

Apparently two cars were behind him and driving in close proximity to each other. The first car swerved to the right to avoid hitting Mr. Neumeyer's car, but the second car struck the vehicle. It is estimated that the force of the impact was greater than 40 miles per hour. Mr. Neumeyer's impact was from "55 to 60" miles per hour. He was not wearing a seat belt. We was thrown forward with impact and struck his forehead, in fact lacerated the forehead on the T-top. He hit his chest on the steering wheel. "hen he came backwards, his seat belt broke and he felt himself lying flat on his back. Accordmg to the plaintiff, he had immediate pain in his low back. As was noted in the medical records, no back was actually noted in the records for a number of months after the accident.

He was conveyed by ambulance, with full spinal protection, to the Akron General Medical Center Emergency Room. A careful history and physical examination was performed. At that time he estimated the speed of the impact at approximately 40 miles per hour. He struck his head on part of the interior of the car and there was a 1-1/2 cm laceration in the midline. This was repaired. He only complained of neck pain. There was absolutely no mention of low back pain at that time. No x-rays were taken as this was apparently just felt to be a forehead laceration. Mr. Neumeyer believes that because he had no health insurance his back was not mentioned nor were x-rays taken. He was essentially treated and released. He was referred back to the outpatient clinic for suture removal.

He complained the day after the accident his "whole body hurt." He ended up not seeing a doctor immediately and attempted to return to his previous occupation as a cement finisher about two weeks afterwards. He had been doing this work for a while and tried to return to it. He was living with his mother at that time and she stated that he had great difficulty. She even claimed to have him try to go to a doctor but he refused. He did clearly state that he did not see a doctor until after he had attempted to return to work.

That does not correspond with the medical records. He apparently was evaluated on May 16, 1995 by Dr. Jackson, a family practice physician. This was specifically in reference to a motor vehicular accident which had occurred only four days before. The history was presented with a history of a 55 mile an hour rear end impact. The only

pain that he complained of was in the anterior abdominal region near the ribcage, as well as anterior neck pain. There was no posterior neck pain nor was there any complaint of back discomfort. There was some tenderness over the anterior sternocleidomastoid muscles. His chest exam was normal. At the time of the first evaluation, there was absolutely no mention of his back.

He was seen approximately three days later for suture removal. He report his neck pain was feeling better. He still had some abdominal discomfort. He was told to follow up with his doctor in about two weeks if he had any complaints.

There is no documentation of any problem with his low back until he recontacted his doctor on July 5; 1995. Accordmg to the nurse's intake, "still having trouble with his low back." He was then evaluated on July 6, 1995, with the first documented symptoms of "continued pain in the lower lumbar area radiating to upper buttocks." There was no clear mention about the precise onset. There was clearly no mention of his low back until July 5, 1995, approximately two months after the motor vehicular accident. It was initially felt to be a lumbar strain and x-rays were recommended, In mid-July of 1995, Dr. Jackson wrote a letter to Dr. Brower, his subsequent treating orthopaedic surgeon, in reference to "some persistent back pain ever since the motor vehicular accident on 5/12/95." Dr. Jackson stated at that time there was nonspecific back pain in May of 1995, even though there was absolutely no chart reference to that nor were any x-rays taken. The back pain did not start with the radiating pain to the point that this was documented in any medical records until July of 1995.

He was subsequently elevated by Dr. Brower who remains his treating physician. Apparently the initial evaluation was on August 3, 1995 after he had been out of work for about a month. The history presented was that the pain existed since the time of the accident. Plain x-rays revealed a Grade I spondylolisthesis at the L5-S1 level. There was some motion at the L5-S1 interspace on x-ray studies as well.

An MRI scan was subsequently performed of his low back on September 7, 1995, and this revealed no herniated Qsc. He was started on an exercise program which did not help him. He was started with a brace which again was of no benefit. He had

tremendous relief of his symptoms with bilateral low back injections into the pars region.

The patient was treated conservatively for a period of time. The medical records have not been reviewed and the plaintiff was not a great historian. Apparently he did go back to work after these spinal injections and started working for another contractor, Ohio Concrete, in May of 1996. He worked all through the summer of 1996 as a cement finisher. He stopped work on November 4, 1996, and had his surgery which he described as an L4-5 fusion with a right side bone graft. He is only four weeks postop at the time of this evaluation.

The actual physical examination was scheduled for mid-March of 1997. Will complete this report at that time.

Records to date have been from the Physical Rehabilitation PRO Therapy, South Central Family Physicians, Inc. (David Jackson, MD), and his MRI scan.

My general feeling, unless this is a little bit better documented in the medical records, is it's basically the history he presents to the spinal surgeon is different than what was apparent in the medical records. He clearly had a pre-existing slippage. Hopefully if this fuses adequately and he goes through the appropriate therapy he can get back to where he was, Hopefully there will not be any permanency. Will complete the evaluation after the exam in mid-March of 1994. (RCC/bn)