Mt. Sinai
HEALTH CARE SYSTEM
EXCELLENCE. IT'S OUR HERITAGE.

Department of Medicine
Division of Neurology

Michael W. Devereaux, M.D.
Krishan Chandar, M.D.
Gerald E. Grossman, M.D.
David E. Riley, M.D.
Herman C. Sullivan, M.D.
Laurence J. Kinsella, M.D.

August 20, 1995

Martin J. Fallon, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114-1192

Re: Ivan Zavasnik, et. al. v. Mednet Euclid Clinic, et. al.
Your File No: 73028

Dear Mr. Fallon:

At your request, I reviewed a series of records, reports and depositions pertaining to the patient, Ivan Zavasnik. Those reports are outlined in your July 27, 1995 letter to me, and I will, therefore, not repeat the list of materials in this letter to you.

Ivan Zavasnik is presently a 52-year-old gentleman who was seen by James Napier, M.D. between November, 1987 and July, 1992.

Briefly stated, the patient injured his right shoulder on November 2, 1987, in a work-related activity. He evidently tried to open the hood of a truck and noted severe pain in his right neck and shoulder as well as a warm feeling behind his right ear and right facial numbness. After initial evaluations which included neck x-rays and referral to physical therapy, he was seen by James Napier, M.D. (neurologist) on November 10, 1987. His initial evaluation revealed restricted range of motion of the cervical spine, severe spasm of the paracervical muscles, and weakness of muscle groups in the rignt upper extremity, which Dr. Napier interpreted as being secondary to pain (guarding). He also had weakness in the right 'lowerextremity which Dr. Napier also thought might be secondary to pain. In several subsequent examinations, there was some improvement. However, because of continued weakness and tingling in the right arm, a diagnostic workup was instigated in January, 1988. An MRI of the cervical spine revealed a partial congenital fusion at the C4-5 level, a small disc herniation at G3-4, with additional moderate-sized disc herniations at C5-6 and C6-7. Additional tests obtained in January, 1988, included a cervical myelogram which revealed multiple ventral extradural defects at C3-4, C5-6, C6-7 and C7-T1. There was also impingement on the root sleeve at C3-4 on the right. The patient was seen by Henry Bohlman, M.D. (orthopedic surgeon) on January 21, 1988. His diagnosis was cervical radiculopathy. He was also seen by Michael J. Bolesta, M.D. (orthopedic surgeon) on January 22, 1988. It appears that all of the physicians caring for him at that time felt that he had one or more cervical radiculopathies on the right

producing his right arm symptomatology which included pain in the neck and right arm, paresthesias in the right arm, and varying degrees of weakness in the right arm.

He was followed on a regular basis by Dr. Napier following the January, 1988 neurodiagnostic workup. Reviewing his notes, it is apparent that the examination was somewhat variable. Dr. Bohlman noted in his April 25, 1988 examination that there was a significant amount of functional overlay in the examination. I suspect that this was part of the reason why conservative medical therapy was continued. Dr. Napier noted in his June 7, 1988 follow-up examination that the patient had chronic discomfort in the neck, but no arm pain or numbness. The motor examination was normal, and he continued conservative medical therapy.

The patient was seen in follow-up on July 7, 1988, because of new onset severe pain in the neck as well as right foot symptomatology. He had a sense of heaviness in his arms and legs. Once again, on examination there was a tendency for giving away in all muscle groups tested in the right upper extremity. The patient reported that his symptoms developed following using a sledge hammer on July 7, 1988. Dr. Napier saw the patient several more times in late 1988 for various symptoms, including complaints of episodes of lightheadedness and imbalance.

In the first several months of 1989, he had increased symptomatology with increased pain in the right neck, right shoulder, right arm and right hand. Dr. Napier thought that he might have increased radiculopathy. An **EMG** of the right upper extremity in February showed some mild disturbances most compatible with a C7 radiculopathy. He continued to follow the patient through the winter, treating him with various medical therapies. In a 5/25/89 examination, Dr. Napier noted that there was no discomfort in the right arm and only mild neck pain. On a follow-up examination on May 6, 1989, the patient reported only mild left shoulder discomfort. He discharged the patient with instructions to return if necessary.

Approximately 2-1/2 years later, the patient returned to Dr. Napier on 11/5/91 with recurrent pain in the right neck, right shoulder, right arm and right scapular region with low back pain radiating into the right lower extremity. He also had complaints of memory problems. Examination revealed giving away in virtually all muscle groups of the pight upper extremity to individual muscle group testing as well as decreased pinprick over the entire surface of the right upper extremity. He began with conservative management. A follow-up examination several weeks later on November 19, 1991 showed minimal weakness of the proximal muscles of the right upper extremity with intact strength of the distal muscles of the right upper extremity. There was also some pain in the right shoulder. An **EMG** in December, 1991 revealed chronic denervation in C5-C7 myotomes on the right. There were no acute changes. He had a repeat MRI of the cervical spine which revealed changes that were essentially the same as on the cervical MRI done in 1988. Dr. Napier continued to follow the patient into early 1992. Because of complaints of memory problems, he obtained a CT head scan and psychometric tests. Additional **EMG** tests were done in early 1992, which failed to reveal any evidence of acute denervation. He was seen by Dr. William Mast (orthopedic surgeon) and Dr. Michael Bolesta (orthopedic surgeon) in the first months of 1992. He was referred to Dr. Warren Selman (neurosurgeon) for

evaluation. Conservative therapy was continued. He continued to be followed by Dr. Napier, Dr. Selman and Dr. Bolesta in the first months of 1992. It was felt by Dr. Mast that he might have adhesive capsulitis of the right shoulder and he had a series of cortisone injections. An MRI of the right shoulder done on June 11, 1992 revealed evidence of a large right rotator cuff tear. It appears that he was last seen by Dr. Napier on July 6, 1992 prior to rotator cuff surgery. The patient was ultimately seen by John Brems, M.D., an orthopedic surgeon, on August 12, 1992, who confirmed a large rotator cuff tear.

On September 29, 1992, he was seen by June Rees, M.C., who diagnosed the patient as having a schizoaffective disorder with elements of depression and severe paranoia along with his physical problems.

He underwent right shoulder surgery by Dr. Brems on December 14, 1992. He had anterior chromioplasty, division of the coracoacromial ligament, bursectomy and debridement of the rotator cuff tear. The tear could not be closed completely.

The patient did well afterwards, and according to the March 1, 1993 report by Dr. Brems, the patient had had marked improvement.

As I understand it, it is being conjectured that the patient had two injuries, the first on 11/2/87 and the second on 7/7/88, which in combination produced a right rotator cuff tear with subsequent symptoms and signs that were missed by Dr. James Napier. It is quite clear that the patient was ultimately diagnosed as having a right rotator cuff tear in 1992 as described above. It is also quite clear from the series of evaluations by Dr. Napier and other physicians that the patient had cervical pathology, and it seems very likelythat the cervical pathologywas contributingto his right upper extremity symptoms. It must also be remembered that he was very difficult to examine with much variation in his symptoms and signs which led one physician (Henry Bohlman, M.D.) to opine that there was a significant functional component.

The main difficulty I have in the conjecture being offered about the above-described injuries producing a rotator cuff tear that was subsequently missed is that the patient made considerable improvement with conservative therapy in the early months of 1989. It must be remembered that when Dr. Napier saw the patient on 3/25/89, approximately eight months after the second injury on July 7, 1988, the patient reported no discomfort in his right arm and only mild neck pain. When he saw the patient on 5/6/89, there was only mild pain in the left shoulder. The patient was discharged to return only as needed. It is my further understanding that the patient returned to work for a period of time before losing his job as a result of his company going out of business. The patient then returns to see Dr. Napier on November 5, 1991 with more symptoms in the right upper extremity. In the subsequent months following Dr. Napier's November, 1991 evaluation, a diagnosis of rotator cuff tear, in addition to the cervical pathology, was made and Mr. Zavasnik subsequently underwent surgery followed by improvement.

Given the above scenario, I cannot accept the construct that the 11/2/87 and 7/7/88 accidents produced a rotator cuff tear, given the fact that the patient made a virtually complete recovery and was able to return to work following a 2-1/2 year hiatus in visits to Dr. Napier between 5/6/89 and 11/5/91. It seems perfectly reasonable to me that the rotator cuff tear occurred during that 2-1/2 year period. As Dr. Richard Rubinstein, expert for the Plaintiff, indicates in his report, the "diagnosis of massive right rotator cuff injury 3-6 months before Dr. Mast obtained the scan on June 11, 1992 would not have manifestly affected the outcome of Mr. Zavasnik's clinical course. I agree with Dr. Rubinstein on this point.

In summary, I do not think Dr. Napier can be held accountable for missing a rotator cuff tear during his period of care between 11/10/87 and 5/6/89 for the reasons outlined above.

Thank you very much.

Respectfully,

Michael W. Devereaux, M.D.
Chief, Division of Neurology
Mount Sinai Medical Center

Associate Professor of Neurology
Case Western Reserve University

MWD:mke 08/23/95