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ORTHOPAEDIC SURGERY

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Regional Transit Authority
Oscar Trivers
615 Superior Avenue, N.W.
Cleveland, Ohio 44113-1877

RE: [redacted]
RTA File No. [redacted]

Dear Mr. Trivers:

I examined [redacted] in my office on October 25, 1993. He is a 33 year-old male who was involved in a motor vehicle accident on March 7, 1992. According to the patient, he was seated as a passenger on a bus that struck a parked car. He was jerked forward and his left shoulder struck a bar on the bus. He then jerked backward into his seat. He immediately had pain in the neck, lower back, the entire aspect of both legs down to the feet, numbness of the feet, and pain in the right arm down to all the fingers.

He stated he had a previous history of lower back problems. He had an injury at work in October 1991 when moving a scrubber and doing maintenance work. After that injury, he had pain for seven days and then returned to work. He had no further problem with his lower back until the bus accident in March 1992. He has not worked since that accident and he continues to have pain. He went to Huron Road Hospital after the accident and was admitted overnight for observation and discharged the next day.

He then was treated intermittently with medications and has had no other treatment other than taking an occasional Tylenol with codeine #3 and Darvocet-N 100 mgs. for pain. He stated the lower back pains were much worse than the leg pain. The pains still radiate from the lower back down both legs. He also still has pain in the back of the neck. The symptoms have been persistent in nature and present most of the time. Be has gotten no relief with any treatments to date. As I mentioned, he has not returned to work since the bus accident. He states he falls at times and is unable to walk more than one and one-half blocks at a time because of pain. He cannot grocery shop, fish, or hunt and is unable to play any sports, mop, or clean the house. He is unable to bend over.

In reviewing medical records from the emergency room on the day of the accident, he was seen at Huron Road Hospital. The physician's notes stated he had mild right trapezius discomfort and mild tenderness in the lower back. They made no mention of any major injury and there were no neurological findings. Straight-leg raising test was normal and he had good grip. There were absolutely no objective findings and no mention of bruises or swelling or any sign of external injury or contusion. Their diagnosis was a cervical sprain, lower back injury. The diagnosis

was made by the patient's history as there were no objective findings. There was no mention made that the patient was hospitalized overnight as he stated to me. He was given a soft cervical collar and some medications.

He went back to the emergency room two days later, March 9, 1992 and they mentioned his neck was better and the back was more sore. He complains that his feet were getting numb intermittently. There was no record made of any problem with the left shoulder or the extremity pain that he gave in his history to me. Again, there examination was negative and they stated the patient moved about comfortably. There were no objective findings and their diagnosis was cervical and lumbosacral strain.

He went back to the hospital on March 19, 1992, or twelve days after the injury and they stated he had lower back pain on that visit. On March 25, he had an MRI of the lumbar spine which was reported to show mild degenerative disc narrowing at L3,L4, and L5 with some retrolisthesis of L3-L4 and L4-L5. There was disc bulging, but no apparent disc herniation. They mentioned there was a question of some herniation of a disc fragment at *L4*. These type of findings on an MRI are of no particular clinical significance and are commonly found in asymptomatic patients and are not related to this accident in March 1992.

He was then seen at the Orthopaedic Clinic on April 16, 1992 and at that time, they mentioned he complained of neck pain, diffuse tingling of the foot, "non-anatomic distributions". Again, there were no objective findings on the record.

He was seen at Mt. Sinai Hospital Medical Center on April 19, 1992, about six weeks after the accident. He complained then of lower back pain but no complaints of his neck at that time. There were no objective findings and the diagnosis was lower back pain, herniated nucleus pulposis. Another note from Mt. Sinai Hospital on the same day also mentioned the patient had pain on the right side of the neck, right arm, and the lower back. They did not say anything about the left shoulder. Furthermore, the notes from Mt. Sinai and Huron Road Hospital emergency rooms made no comment on preexisting lower back injury. He complained of numbness of the legs and feet while at Mt. Sinai Hospital. He was given some medications, admitted overnight, and discharged on April 20, 1992. They stated he was admitted because of bilateral leg weakness, difficulty walking, and falling. He had pain in the lower back and both legs to the feet, numbness of the legs. He was wearing a neck brace which helped to decrease the pain in the back. He stated he had pain in the neck which was improving.

An extensive examination while at Mt. Sinai Hospital revealed no objective findings and they recommended medications.

When I saw the patient, the examination of the neck revealed him to have about 10" motion in all directions. He complained of pain with minimal tenderness around the neck. There was no evidence of spasm, swelling, masses, or deformity. He had normal motion of the shoulders and the Adson Test was negative bilaterally. There were no neurological findings in the arms and no muscle atrophy.

The patient had a normal station and gait. He had pain on motion of the lumbar spine of about 10° in any direction. There was mild tenderness over the lower back

with no muscle spasm, list, or leg length discrepancy. There was no deformity and lumbar lordosis was normal. Straight-leg raising test was negative bilaterally. He had good motion of the hips and no contractures. Deep tendon reflexes of the legs were normal and there was no motor or sensory loss in the lower extremities. There was no atrophy and no sign of nerve root compression.

Essentially, examination of the neck, lower back, and extremities in this patient is completely normal and there are no objective findings. At this time, I feel he has no disability involving the cervical or lumbar spine and the extremities in this patient which would be related to the accident as described above on March 7, 1992.

As far as these areas are concerned, I feel he would be able to work and requires no treatment or tests. The patient did have preexisting lower back problems secondary to the injury at work which was not mentioned in his medical records. Furthermore, it was not mentioned in the records of his complaints of striking the left shoulder up against the pole or of pain in the left shoulder as far as I could see from the medical records. Examinations from Mt. Sinai Hospital and Huron Road Hospital revealed no objective findings involving his neck or lower back. The MRI findings are unrelated to the March 1992 accident. His diagnosis and treatment was based only on symptomatic complaints or subjective complaints.

Yours truly,

GARY I. KATZ, M.D.

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