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CYRIL E. MARSHALL, M.D RALPH J. KOVACH. M.D

July **26, 1999**

Mr. Thomas Dover
1501 Euclid Avenue
Cleveland, Ohio **44115-2108**

RE: George Criss, Jr.
Your File No. **1510-100754**

Dear Mr. Dover:

George Criss was examined by me at your request. He was accompanied by his wife who was present throughout the history and physical examination which I conducted in my office on July 26, **1999**. This man was born on November 27, **1956**. He was employed as a trainman. When on June 26, **1996**, he stated that he injured his lower back while at work.

The mechanism of injury was that he was throwing a switch using a lifting motion when he experienced sharp pain in his lower back which progressed as far as his left buttock. He said that he was able to finish the shift, but the next day he began to experience more pain. The pain was located in the same area. He tried to get an appointment with his physician and he was able to do so after a few more days. After being examined, he said that a CAT scan was carried out on the lower back.

He said that MRI studies were carried out and they eventually were repeated. His treatment consisted of seeing an orthopedic surgeon, Dr. Krebs, seeing a neurosurgeon Dr. Dakters, he saw Dr. Levin who is a neurologist and a pain specialist where he was given three epidural injections; none of these were stated to have helped him. He states that these studies showed that the L2-3 disk was a "blown out" disk. When I asked him who told him so, he said that his treating doctor told him this. He was told that he would have to live with the complaints and he also stated that the neurologist at the Cleveland Clinic told him that he had nerve damage.

He also stated that the neurosurgeon whom he saw stated that nothing was to be done surgically.

At this time, he has complaints of pain in his lower back which on the pain drawing, he marked the left lower back region, and he made X's which were stated to be painful areas along the anterior thighs to the front of the knees and the front of his shins. Specifically, the pain does not radiate below the back of his knees. There is no sensory discrepancy in the lower extremities when questioned.

He complains of pain in the above locations and sometimes he states he has cramps in the back of the left leg.

When questioned as to what makes his condition worse, he states that he has pain at all times and it is worse at various times. When asked what makes it worse, he states that if he walks up to 15 minutes, he begins to experience stiffness and then pain increases and he tends to drag his left leg. If this is for longer than one hour or stands for more than half an hour, this is stated to increase his painful discomfort.

At this time, he is seeing an orthopedic surgeon approximately every two months for follow-up. The medication that he takes is Motrin 800 mg t.i.d.

In the past he has had physical therapy for various lengths of time, none of which seem to be for long periods of time. He had therapy at Lorain Hospital as well as at a rehab center. He states that he did not obtain any relief from the therapy.

At this time he is working approximately three days on an average per week. He works as an engineer for a short line railroad. He states that when he is able to physically go to work, he works approximately three times weekly.

Close questioning of this individual indicates that he denies ever having prior back symptomatology either due to injury or natural causes at any time in the past. He states he has had no new injuries since the date of injury.

My examination revealed that this is a well-developed, significantly overweight white male with a significant abdominal paunch. His walking was bizarre in that he walked with a rolling gait, holding his left knee stiffly. He did not appear to be in pain when he was doing this maneuver. His posture revealed normal cervical and thoracic curvatures with some slight diminution of normal lordosis, Muscle spasm was not palpated in his back while he was standing. He had normal fullness to the left and right paravertebral musculature in the thoracic and lumbar spine. Side bending was moderately restricted to either side, but he did have normal curvature to the spine wnen doing this maneuver.

Standing flexion test with palpation of the posterior/superior iliac spines revealed that the pelvis moved symmetrically with flexion and extension, as did the transverse processes of the lumbar vertebrae from L5-L1. He would flex forward only to 45 degrees from the erect position. He pointed to the left flank as being the site of his discomfort. He was able to stand on the left and alternately the right leg without drooping of the opposite pelvis. He was able to stand on his toes, as well as on his heels.

In the seated position, he had normal patellar and achilles reflexes. He had a negative straight leg raising test bilaterally and negative tripod test bilaterally.

In recumbency, I found no motor weakness on extension of the great toes. There was no sensory discrepancy found. Straight leg raising test while recumbent was negative bilaterally.

Examination in the prone position revealed no muscle spasm to be present although carefully searched for. Skin rolling was productive of pain in the left flank and was stated to be exquisitely tender in that area. Beneath this area there was one area of muscle tenderness in the left flank and this was not located in the paraspinal musculature. He did have some subjective complaint of pain upon touching the spinous process at L4. This was only minimal pressure and was not expected to produce any discomfort. The fascial planes were carefully examined and no abnormalities were found. Examination furthermore revealed he had normal circulation to the lower extremities given good pulses.

I have reviewed all of the submitted records and these included records of Dr. Krebs, as well as the MRI reports and a CAT scan report, records of Dr. Levin, Dr. Dakters, Dr. Taylor, Dr. Tamas, and the medical records from Allen Memorial hospital.

After review of these records and careful review of my examination and history and physical, it is my opinion that there is no evidence of any disk abnormality other than a pre-existing minimal dislocation of the L2-L3 disk which is not considered to be the cause of any of his symptomatology. He has no herniated disk. He has no nerve root impingement by clinical examination. These findings have always been within normal limits for absence of neuropathy.

The fact that this man states that the disk was "blown out", is not substantiated in the records. The fact that this man stated that Dr. Levin told him that he had nerve damage is not substantiated in the letter of Dr. Levin submitted and a copy of this document was sent to Mr. Criss.

On the basis of this examination, there is no objective evidence to substantiate his subjective complaints. In my opinion his prognosis should be good according to the type of injury that he sustained. The documentation which is present does not substantiate his complaints.

Yours very truly,

Ralph J. Kovach, M.D.

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