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COPY

June 3, 2003

Law Offices of Craig S. Cobb
Attorney Barbara J. Moser Esq.
1605 Superior Building
815 Superior Avenue
Cleveland, OH 44114

Re: George C. Roush II v. Nita L. Terzic, et al.
Summit County Court of Common Pleas
Case #: 2002 05 2905
Your File #: 02-00100

Dear Ms. Moser:

At your request, I evaluated Mr. George C. Roush II in my office on May 13, 2003. He was examined for the purposes of independent medical review with regard to injuries allegedly sustained when he fell off a ladder on or about April 30, 2001 - just over 2 years earlier.

For the duration of this independent medical evaluation, Mr. Roush was accompanied by a Paralegal from the Law Offices of J. Thomas Henretta, Mr. Gerald Leb.

You requested that I obtain a history, perform a physical examination, review the records that were submitted and issue a report setting forth my opinions on the following issues:

- *Is there any medical support in plaintiff's history with the records relating to the fall from our roof to a medical / neurological event?*
- *What, if any injury, the plaintiff suffered as a result of the fall, discussing the treatment which might have been necessary for this injury, whether this injury is likely to be permanent and if future care of treatment would be expected.*

At the time of the incident of April 30, 2001 Mr. Roush was 50 years of age and was employed professionally building golf clubs in a workshop.

He was allegedly unable to work for about a year and a half following that incident but, in August 2002, he became gainfully employed as a representative for a line of professional golf equipment but had not returned to building golf clubs.

At the time of his evaluation in my office on May 13, 2003 Mr. Roush was 52 years of age and was still working as a representative for a line of professional golf equipment.

I discussed the events surrounding the incident of April 30, 2001 with Mr. Roush, as well as the injuries he allegedly sustained in that incident, the medical care he had received to date and the subjective symptoms that he still suffered.

I obtained a history, performed a physical examination and subsequently reviewed the records that were provided to me.

HISTORY

The history reported below reflects the detailed account of events surrounding that incident and the subjective symptoms, as described by Mr. Roush - both spontaneously and in response to specific questions from me:

Details of Incident

Mr. George C. Roush stated that on or about April 30, 2001 he stopped by to visit a friend who was building a deck on a roof. He was invited to view the deck and climbed up the ladder, which was standing against the side of the house, leaning against a gutter. He was standing on the ladder, about 15 to 20 feet up in the air, observing the deck that was 1-1/2 to 2 stories up. The gutter reportedly buckled and gave way, causing the ladder to veer to the left. Mr. Roush fell to the ground and landed on the flagstone patio.

Mr. Roush recalled that, when he landed, his **left shoulder** (he demonstrated the region of the acromioclavicular joint posteriorly) was the first point of impact. He also hit his **head** on the patio, causing a lump, and became somewhat dizzy.

His friend advised him not to move and called 911. Mr. Roush was transported, on a backboard and in neck restraints, to the Emergency Room at Akron City Hospital.

*[**Comment:** I asked Mr. Roush to describe the circumstances surrounding his fall from the ladder. I specifically asked Mr. Roush if there were any additional medical, physical or mechanical potential causes (such as dizziness, stroke, blackout or weather) that might have contributed to his fall from the ladder. He reassured me that there were no other medical or physical conditions that contributed to his fall and that it was entirely a mechanical issue related to the ladder slipping when the gutter gave way.]*

As indicated above, Mr. Roush was transported on a backboard with neck restraints to the Emergency Room at Akron City Hospital. He had complaints of a bump at the back of his **head**, some **dizziness** and pain in the **left shoulder**. He was x-rayed in the Emergency Room, a CAT scan of his head was performed and he was admitted for observation to the Intensive Care Unit. He did not recall that there were any significant findings on the CAT scan. Less than 24 hours after admission Mr. Roush was transferred to a Neurology floor, where he continued to be assessed and monitored. At some time during the next 3 days, as best as he could recall, he was assessed by an orthopedic surgeon as well as by the neurologist.

After 3 days in hospital, Mr. Roush was very dissatisfied with his care. He stated that he complained repeatedly of pain in his left shoulder but that this was ignored. He also felt that the care, both medically as well as "in-house" was substandard and that the bathroom and linens were dirty. He therefore signed himself out of the hospital.

Mr. Roush returned home but did not seek medical attention for his left shoulder for the next 45 to 60 days. He stated that he "rehab'd on my own" by taking over-the-counter medications, using rubs and doing exercises.

*[**Comment:** Mr. Roush was reportedly dissatisfied by the lack of attention paid to his left shoulder while he was in the hospital, especially in view of his significant shoulder symptoms. Yet, after he left the hospital on his own accord, he did not seek medical attention for these complaints and "rehab'd on my own" for the next 45 to 60 days.]*

About 45 to 60 days after this incident, on the advice of a friend, Mr. Roush consulted with Dr. Eugene Pogorelec, a primary care osteopathic physician. Dr. Pogorelec treated Mr. Roush's left shoulder with a single intra-articular cortisone injection, weekly massage-type physical therapy, iontophoresis treatments and medications such as Skelaxin and Vioxx. He also ordered an MRI of the left shoulder, which revealed some sort of a rotator cuff problem although Mr. Roush was not certain of the nature of this diagnosis.

Mr. Roush stated that he reluctantly took Vioxx while under the care of Dr. Pogorelec. One morning, he suffered a myocardial infarct and this resulted in his needing cardiac care.

*[**Comment:** Although Mr. Roush did not feel that there he had any factors predisposing for a myocardial infarct, he indicated that he was on Vioxx at that time. He did admit to smoking half-a-pack of cigarettes a day.]*

After 3 months of treatments with Dr. Pogorelec with no benefit derived, Mr. Roush consulted with Dr. Robert Bell at the Crystal Clinic. Dr. Bell told him that his left shoulder was "messed up" and that it would get worse with time. Mr. Roush told me that Dr. Bell advised him that his fall from the ladder had caused his shoulder problem. Dr. Bell could only offer him surgical treatment but did perform a single cortisone injection - this was of no benefit.

Dr. Bell was reportedly concerned about Mr. Roush's neck and therefore referred him to an associate at the Crystal Clinic, Dr. Scot Miller, for an assessment.

Dr. Scot Miller reportedly told Mr. Roush that he had degenerative disc disease in his neck that pre-existed the incident of April 30, 2001 but that it had been aggravated by that incident. However Dr. Miller did not suggest or offer him any treatment for his neck.

To date Mr. Roush has not availed himself of the surgical treatment offered for his left shoulder. He has also not yet decided whether he will elect to proceed with any surgical intervention in the future.

Previous Injuries

Mr. Roush specifically denied any significant prior injuries to or symptoms in his neck or left shoulder allegedly injured in the incident of April 30, 2001.

Subsequent Injuries

Mr. Roush denied any intervening injuries or accidents subsequent to the incident of April 30, 2001 that might have aggravated the symptoms in the areas allegedly injured in that incident.

Past Medical History

Mr. Roush was given a Past Medical History sheet to complete. The history reported by the examinee was not of additional significance with regard to the areas allegedly injured in the incident of April 30, 2001.

He had suffered a myocardial infarct and had a stent placed on September 20, 2001.

Work and Lifestyle History

At the time of the incident of April 30, 2001 Mr. Roush was 50 years of age and was employed professionally building golf clubs in a workshop.

He was allegedly unable to work for about a year and a half following that incident but, in August 2002, he became gainfully employed as a representative for a line of professional golf equipment and had not returned to building golf clubs.

At the time of his evaluation in my office on May 13, 2003 Mr. Roush was 52 years of age and was still working as a representative for a line of professional golf equipment.

Mr. Roush was of the opinion that his leisure activities had been adversely affected by the injuries he allegedly sustained when he fell on April 30, 2001. He was unable to play golf in the manner to which he had been accustomed in the past, due to decreased

strength and pain. However, reportedly on the advice of Dr. Bell, he had attempted to play golf fairly regularly. Recently he had been unable to complete even 3 holes on a par-3 course.

Symptoms on Evaluation in my Office

On evaluation in my office Mr. Roush reported the following residual symptoms:

- He reported no significant residual true **neck** complaints or discomfort. Mr. Roush did experience pain on the left side of his neck in the trapezial muscle, which he graded at approximately a 5/10.

- Mr. Roush was right-handed. His **left shoulder** pain had become worse over time, was constant in nature and radiated posteriorly down his left arm towards his hand. He also experienced increased discomfort with attempts at above-shoulder movements, lying or sleeping on the left side, extending his shoulder to reach (even at shoulder level) and attempting to golf. His shoulder discomfort was estimated as a constant 8/10. There were no specific relieving factors. He denied any obvious swelling but did indicate that he had constant weakness and grinding in the shoulder.

  He also reported a "burning" sensation and numbness in the upper part of his arm that occurred about 6 times a week, without any obvious precipitating cause. This numbness originated around the deltoid insertion and extended distally, completely circumferentially, like a long glove from the mid-arm all the way down to his fingers.

*[**Comment:** This non-segmental sensory distribution was not consistent with cervical radiculopathy or peripheral mononeuropathy, as best as I could tell.]*

PHYSICAL EXAMINATION

The physical examination reported below reflects the objective findings elicited by me during the course of my evaluation of Mr. George C. Roush:

Physical examination revealed a 52-year-old gentleman who was reportedly 5 feet and 11-1/2 inches tall and weighed approximately 200 pounds. He was in no distress and was cooperative. He did not seem to exaggerate his symptoms and moved about easily, demonstrating a normal gait.

- Examination of his **cervical spine** revealed it to be held in the midline position. There was no spasm in the paraspinal musculature however moderate tenderness was present in the trapezial trigger points on the left. Cervical spinal motion was normal in range, without pain, and screening neurologic examination of the upper limbs revealed no sensory, motor or reflex abnormalities. He

appeared to exhibit some pain-mediated weakness of abduction and external rotation.

- Examination of Mr. Roush's non-dominant **left shoulder** revealed some alteration in contour, with mild atrophy noted in the supraspinatus muscle and the pectoralis major and equivocal infraspinatus atrophy. There was no "step-off" at the acromioclavicular joint. Diffuse tenderness was evident throughout the left shoulder - over the coracoid process, the acromioclavicular joint, the subacromial bursa, the biceps tendon, the trapezial muscles and over the deltoid insertion. The range of motion examination revealed abduction and forward flexion to about 110 degrees, at which point pain seemed to block further active movement. Passive movement was also resisted beyond that range. Internal rotation was obtainable on the left side to just about the thoracolumbar level but not to the mid-dorsal spine. There was weakness of abduction and external rotation against resistance that appeared to be, at least in part, pain-mediated. The impingement test was positive in forward-flexion and the apprehension test was positive in abduction and external rotation.

REVIEW OF RECORDS

I reviewed the records that were provided to me regarding the evaluation and treatment of Mr. George Roush in the above-captioned matter.

The records that I reviewed are summarized below:

EMS Report - Akron Fire Department.

The EMS report indicated that they were dispatched at 19:59 on **April 30, 2001** to attend to Mr. George Roush who was reportedly on a roof "while working on deck" when he fell 12 feet and landed on his left shoulder. The patient stated that

> "he is unable to move left arm; + loss of consciousness, - neurovascular; + dizziness; + lightheaded; - short of breath; - chest pain. Patient also complains of pain in neck and back. Patient claims drinking 4 beers today. The patient denies any recreational drug use."

He was observed to have discomfort to palpation in the **neck** and on the left side of his cervical spine but no crepitus. There was some deformity in the **left shoulder** with intact vascular status and a good radial pulse and capillary refill. There were no neurological notations. However it was noted that there was a

> "+ smell of ETOH."

The EMS personnel suspected a possible dislocated shoulder with cervical spine injury and Mr. Roush was transported on a backboard with cervical spine and head immobilizer to Akron City Hospital.

*[**Comment:** It appears that there was, in fact, some alcohol intake related to the time of this fall from the roof or ladder. As will be seen from the subsequent hospital records, Mr. Roush's blood-alcohol level on admission was 0.212, which is more than twice the legal limit for driving. This certainly raises the question as to what extent this might have contributed to Mr. Roush's fall from the roof or ladder.*

It will be recalled that, despite being questioned extensively about the circumstances surrounding this fall, Mr. Roush specifically denied any additional medical, physical or mechanical potential causes that might have contributed to his fall from the ladder. He reassured me that this fall was entirely a mechanical issue related to the ladder slipping when the gutter gave way. Although he did not disclose to me any alcohol intake associated with this incident, his blood-alcohol level on admission to the hospital was 0.212 which, as noted above, is more than twice the legal limit for operating a motor vehicle.]

Emergency Department - Summa Health System

Mr. Roush was admitted to the Emergency Room at Akron City Hospital on **April 30, 2001** where he was attended by Dr. Hiram Brooks.

The **history** taken by Dr. Brooks indicated that Mr. Roush stated that

> "he had a few beers and up on a ladder that was 20 feet in height. He fell off landing on his left side. The patient is complaining of left shoulder pain. No other complaints."

On **examination** Dr. Brooks noted tenderness in the left arm, which had been splinted but the pulses were intact. He appeared to be unable to move his left lower extremity to command or eye movements spontaneously. He was rolled but there was no tenderness in the thoracic or lumbar spine. Trauma x-rays of the shoulder were pending, as was his disposition.

Dr. Brooks' initial **diagnosis** was that of the left shoulder pain and questionable neurological deficit after the fall.

The Trauma Team then attended to the patient.

Admission and ICU Record - Akron City Hospital

- The Trauma Team attended to Mr. Roush at Akron City Hospital on **April 30, 2001** at 20:30.

  On **history** it was noted that he had fallen approximately 12 feet from a ladder or roof, with history of positive loss of consciousness for less than a minute. They noted that

"the patient admits to + ETOH use today."

He was complaining of left flank and shoulder pain as well as neck pain and back pain. He also complained of numbness in the left upper and lower extremities.

It was noted that his blood alcohol level was 0.212. He admitted to drinking four 12-ounce beers in approximately 8 hours.

The Trauma Team assessed him as a 50-year-old white male

> "who had been drinking beer earlier and fell about 12 feet from a roof/ladder with positive loss of consciousness less than 1 minute."

He complained of left shoulder / upper extremity pain and was noted to have sensory deficits in the left upper and left lower extremities.

Consultations for Orthopedics and Neurology were ordered and steroids were started.

- Mr. Roush was admitted to the hospital and was first treated in the **Intensive Care Unit** (ICU). He was disoriented for year and time. He reported observing

> "a white light by the clock on the wall"

when there was no light. At this time, the nurses documented that he was

> "belligerent at times"

and that he stated

> "I'm trying to get out of here today, I'm going to get my lawyer today and get me out of here."

Physicians' & Nurses' Notes - Akron City Hospital

- At various times during the course of this admission, the nurses documented that Mr. Roush was uncooperative.

  The physician's notes indicate that Mr. Roush was admitted for observation of the left-sided sensory deficit and neurological and orthopedic consults were requested. There was concern about a possible disc herniation and MRIs and CT scans were also ordered.

- On **May 01, 2001** the documentation indicated an inability to move his left upper and lower extremities and concern was raised about a left hemiparesis. There was also concern about concussion. An MRI of the spine was ordered. The left-sided weakness and sensory deficit persisted.

- Early on **May 02, 2001** the nurses noted that Mr. Roush was

  "belligerent, cursing at staff."

- Later on **May 02, 2001** Mr. Roush was transferred from the ICU to the floor and was reportedly more cooperative after transfer from ICU. He was

  "behaving better, cooperative at this time."

  His left shoulder and left lower extremity continued to be painful but he did not have any neck pain or tenderness at that time. The left shoulder movements were less painful. His still had left-sided weakness.

- The, "CIP team" evaluated Mr. Roush for alcohol abuse on **May 02, 2001**. His blood alcohol was noted to have been 0.212 on admission and he reported drinking four 16-ounce beers prior to the fall. Mr. Roush indicated that he

  "did not feel more than slightly intoxicated."

  He denied that alcohol was a problem in his life and minimized concerns on this issue. He had not run into trouble with alcohol-related legal difficulties other than a DUI.

*[**Comment:** This was the first acknowledgement by Mr. Roush that he experienced any degree of intoxication whatsoever at the time of the incident of April 30, 2001. As noted above, although he did not disclose to me any alcohol intake associated with this incident, his blood-alcohol level on admission was 0.212.*

As this is more than twice the legal limit for operating a motor vehicle and as Mr. Roush subsequently admitted to some degree of intoxication, it is probable that this was at least a contributing factor to Mr. Roush's fall from the roof or ladder on April 30, 2001.]

- A physical therapy evaluation was performed on **May 03, 2001**.

- The MRIs reportedly showed no fracture or changes in the spinal cord but Mr. Roush still had persistent numbness on the left side. He was

  "very angry and agitated. He states he plans to leave AMA. Concern was expressed for the need for phenobarb or Librium given the patient's alcohol level on admission."

- On **May 04, 2001** he was ambulating without difficulty and had no residual neurological deficit and no objective numbness.

  The nursing notes indicated that

  "patient signing out AMA. Advised patient for risks for possible back injuries not seen and that he needs to stay for MRI. The patient became

belligerent and cursing. Sign obtained and consent form for AMA portion completed."

Imaging Studies - Akron City Hospital

- On **April 30, 2001** a **CT of the cervical spine** revealed no acute fractures, although it was suspicious for a broad-based disc bulge/herniation exactly to the left C5-C6 and C6-C7.

  The **dorsal spine CT** performed the same day was normal.

  CT of the brain did not reveal any acute intracranial process and an **abdominal and pelvic CT** likewise revealed no acute intra-abdominal or intrapelvic process.

- A **MRI of the brain** performed **May 01, 2001** revealed no acute intracranial pathology.

  A **cervical spine MRI** revealed

  > "spinal canal stenosis, which is severe at C4-C5, C5-C6 and C6-C7 and moderate at C2-C3 and C3-C4."

  No nerve root compression was specifically reported but foraminal narrowing was present bilaterally from C3 to C7 and there was moderate-to-severe central canal stenosis from C4 to C7.

- A left shoulder study x-ray on **May 03, 2001** was reported to be normal, without arthritic change, fracture or dislocation.

Discharge Summary - Akron City Hospital

The discharge summary from Akron City Hospital indicated an **April 30, 2001 admission** and a **discharge on May 04, 2001**.

Mr. Roush was admitted after a fall of 12 feet from the ladder, with a positive loss of consciousness - less than 1 hour. It was noted that

> "the patient was intoxicated at that time."

Mr. Roush experienced numbness in the left upper and lower extremities and pain in the left shoulder, arm, neck and back. During the course of his hospitalization, he was observed in the intensive care unit for concussion and a Neurology consult was obtained. An MRI of the brain was obtained which was negative. The MRI of the spine was also obtained which was negative and the patient's symptoms reportedly slowly resolved.

At discharge it noted that he had a diagnosis of concussion and he was advised to follow up with Orthopedics for a "possible left-sided AC joint separation." He was to take Vicodin for pain and follow-up with Dr. Donthi.

*[**Comment:** On more than one occasion during the course of the IME, I reviewed the circumstances surrounding Mr. Roush's fall with him. I was reassured that the fall was purely the result of the ladder slipping because of the gutter and that there were no other potential factors that contributed to his fall.*

These records reflect that Mr. Roush was intoxicated at the time of the fall. Although he did not disclose to me any alcohol intake associated with this incident, his blood-alcohol level on admission was 0.212. As this is more than twice the legal limit for operating a motor vehicle and as Mr. Roush subsequently himself admitted to some degree of intoxication, it is probable that this was at least a contributing factor to Mr. Roush's fall from the roof or ladder on April 30, 2001.

There were also varied descriptions of the actual fall - as to whether he was on a roof or on the ladder and whether he was 20 feet up or 12 feet up.

On admission Mr. Roush exhibited clinical neurological deficits that were associated with a left-sided hemiparesis. No cord contusion or spinal injury was identified and the MRIs of the brain and the CT of the brain appeared to be normal. This at least raises the concern as to whether there was some neurologic episode, such as a transient ischemic attack, that preceded the fall and might, in fact, have been a contributing factor to the fall. Furthermore, the "belligerent" behavior and "vision of white light" demonstrated by Mr. Roush while in hospital are potential signs of a neurologic condition or alcohol withdrawal. However, as this is beyond my scope of expertise, I would defer to a neurologist for an opinion on this matter.

Mr. Roush was diagnosed with a possible left acromioclavicular joint separation yet the x-rays of the shoulder were normal. However it does not appear that "weightbearing views" were done and it is therefore difficult to be certain whether an AC separation was present at that time or not. There was no clinical evidence of left acromioclavicular joint separation when Mr. Roush was evaluated by me at the time of the IME.]

Dr. Eugene Pogorelec

Dr. Pogorelec's notes were somewhat difficult to read as they were only handwritten.

- The first documentation regarding Mr. Roush appears to have been on July 11, 2001 – just over 2 months after his fall from the ladder on April 30, 2001.

  Mr. Roush again stated that he had fallen from a 15-20 foot ladder onto concrete and brick. He stated that he had no loss of consciousness but was dazed and confused and suffered posterior neck soreness as well as left shoulder pain.

*[**Comment:** This was inconsistent with the hospital record that was positive for loss of consciousness for less than an hour and a diagnosis of concussion.]*

Mr. Roush presented with acute pain in the left upper extremity.

He was **diagnosed** with an acute scapular sprain and strain and an acute left shoulder ligament sprain and strain with suspected tear of the supraspinatus tendon.

- Mr. Roush continued to follow with Dr. Pogorelec at fairly regular intervals and was treated with iontophoresis.
- At one point, Dr. Pogorelec felt that he should undergo an MRI of the left shoulder and this was scheduled for **August 17, 2001**. Concern was expressed about a rotator cuff tear. He was noted to have cervical spine central canal stenosis with degenerative disc disease. He was also diagnosed as having a frozen shoulder.
- The **MRI of the left shoulder** was performed at Akron General Medical Center on **August 24, 2001**. This study revealed an

  "extremely thickened and irregular tendon on the supraspinatus, consistent with a partial tear with tendinopathy. No full thickness tears identified."

  It was also noted that they were lesser but similar changes in the tendon of the infraspinatus and that the subscapularis was not well-imaged.

*[**Comment:** No full thickness rotator cuff tear was identified in Mr. Roush's left shoulder. Some degenerative tendinopathy was noted. It was not reported to be of traumatic origin.]*

- Mr. Roush continued to be treated with iontophoresis at Dr. Pogorelec and an appointment was made for him to see Dr. Robert Bell at the Crystal Clinic on **August 28, 2001**.
- The appointment that scheduled for Dr. Bell was rescheduled for **September 18, 2001**.
- On **September 05, 2001** he continued to complain of left shoulder pain. Dr. Pogorelec recommended orthopedic evaluation. Dr. Pogorelec's opined that he had a tear of the supraspinatus tendon of the left shoulder and cervical spinal stenosis.
- Mr. Roush's care at Dr. Pogorelec's office was completed at that time.

*[**Comment:** I have not been provided with records that reflect any intervening treatment after Mr. Roush was last seen by Dr. Pogorelec on **September 05, 2001** up until his evaluation with Dr. Shannon Wolfe on **November 20, 2001**. It does not appear that he was seen at the Crystal Clinic in the interim.]*

Dr. Shannon Wolfe

Dr. Shannon Wolfe evaluated Mr. Roush on **November 20, 2001.**

At that time, Mr. Roush gave a **history** of having fallen off the ladder onto cement, directly on April 30, 2001 some 7 months earlier. He stated that he was admitted to the intensive care at Akron City and kept for observation. Mr. Roush informed Dr. Wolfe that

> "he was discharged without any complications."

***[Comment:** As will be recalled, Mr. Roush left the hospital, absent medical advice (AMA).]*

He had been to physical therapy with Dr. Pogorelec and had a loss of motion, pain in the shoulder radiating down to the elbow but not below it and he was having trouble sleeping at night. He had been advised to take Vioxx and unfortunately had suffered a myocardial infarct and

> "he believes that the Vioxx caused an MI."

***[Comment:** I am not aware of literature that indicates that this would have been the most likely cause of his Mr. Roush's myocardial infarct. It should be recalled that Mr. Roush was a smoker. However, as this is beyond my scope of expertise, I would defer to a cardiologist for an opinion on this matter.]*

Physical **examination** by Dr. Wolfe did not reveal any asymmetry or atrophy.

> "His active range of motion is about 80 degrees of forward flexion and 90 degrees of lateral abduction. His external rotation is maintained and his internal rotation is to the midlumbar level and is comparable to the contralateral side. He has a negative lift-off test. Through range of motion, he is extremely sore. He has a positive Hawkins and a positive Neer's sign."

He had a good range of motion in his neck and a negative Spurling sign and upper extremity strength was comparable to the contralateral side.

***[Comment:** At this time, some 7 months after the fall from the ladder, Mr. Roush's neck examination was essentially normal.]*

X-rays reportedly showed the configuration of his acromion and the MRI showed signal changes in the supraspinatus and infraspinatus although Dr. Wolfe stated that

> "I don't see a frank rotator cuff tear."

Dr. Wolfe **diagnosed** an

"impingement tendinitis of his rotator cuff."

Mr. Roush's shoulder was **injected** with local anesthetic and steroid and was to start **physical therapy** to retrain and strengthen his rotator cuff muscles. He was to return in 4 to 6 weeks.

There were no available records to indicate that Mr. Roush subsequently returned to Dr. Wolfe's care.

Crystal Clinic Records

*[**Comment:** I was provided with what was reportedly "the entire files of Bell and Miller" as forwarded from the Law office of Mr. J. Thomas Henretta. These notes were fairly minimal - there was only one office note each from Dr. Miller and Dr. Bell.]*

- Dr. Robert Bell authored a report to Dr. Pogorelec on **February 19, 2002** indicating that he had evaluated Mr. George Roush with complaints of left shoulder pain. He stated that this all began in April 2001 when

  > "he fell off the building approximately 2 stories high. Since that time, he has complained of pain in the shoulder with some paresthesia down into the hand. He does have a component of night pain and difficulties with his activities of daily living."

  On **examination** Dr. Bell noted a positive Spurling's sign with some relief with distraction to the cervical spine in the office. He had difficulty with all motion of the shoulder.

  Although the **MRI** had been interpreted as negative, Dr. Bell suspected he might have a rotator cuff tear. The MRI of the cervical spine reportedly showed stenosis from degenerative change.

  Dr. Bell **injected** the subacromial space but this did not result in any significant improvement in his symptoms. He arranged for him to see Dr. Scot Miller in the office to evaluate the cervical spine but provided him a soft collar at that time. He indicated that he might need a trial of cervical traction and could see Dr. Miller the next week.

  It does not appear as if there was any follow-up appointment given by Dr. Bell at that time.

- An **MRI of the cervical spine** was performed at the Crystal Clinic on **May 22, 2002**. This revealed mild developmental stenosis of the central cervical spinal canal, multisegmental cervical disc degeneration and a small posterior right

paracentral disc protrusion, associated with end plate remodeling causing minimal spinal cord impingement at that level. There was also mild-to-moderate central canal and neural foraminal stenosis on the right side. No abnormal signal intensity was noted.

*[**Comment:** The only significant findings were degenerative changes with a right-sided posterior paracentral disc herniation at C5-C6. There was also some central canal stenosis and some right neuroforaminal stenosis. No compression of nerve roots was identified at any level.*

However it will be recalled that Mr. Roush's symptoms were left-sided in nature.]

- Mr. Roush had a scheduled appointment with Dr. Scot Miller on **May 30, 2002**. However he

  "left today without being seen."

*[**Comment:** The reason for Mr. Roush leaving before being seen was not documented. I would have to assume, given that this represents the entire file of Dr. Miller and Dr. Bell at the Crystal Clinic, that there were no prior visits.]*

- Dr. Scot Miller saw Mr. Roush on **June 11, 2002** at which time he was complaining of left-sided radiating arm pain and posterior shoulder discomfort. Dr. Miller indicated that he had

  "moderate stenosis at C5-C6, secondary to degenerative disc disease. He does have multilevel cervical disc disease which appears to be moderate as well."

  He **suggested** that he would be a candidate for all available conservative measures before surgical treatment was considered. He recommended a cervical epidural injection and referred him to Dr. Shin for consultation in this regard. He was to call if he had any acute changes or worsening.

*[**Comment:** As no additional notes were provided and I must therefore assume that Mr. Roush was not seen again by Dr. Miller and that he did not undergo any of the epidural blocks.*

When he was evaluated in my office on May 13, 2003 Mr. Roush indicated that he had not made any decisions regarding additional treatment.

Mr. Roush also advised me that Dr. Miller had told him that the pre-existent degenerative disc disease in his neck had been aggravated by the fall from the ladder and that Dr. Bell informed him that the fall caused his shoulder problem. However the records that were reviewed do not document any opinions to this effect.]

OPINIONS

The opinions rendered below are the opinions of this evaluator and are based upon the medical examination (history and physical examination) and review of the records and the documents that were provided. Furthermore these opinions are based on the assumption that these records are a true and accurate reflection of the events that transpired.

If additional information, records or documentation become available at a later date, a supplemental report may be warranted. Additional information, records or documentation may or may not change the opinions that I have rendered.

You requested that I obtain a history, perform a physical examination, review the records that were submitted and issue a report setting forth my opinions on the following issues:

- ***Is there any medical support in plaintiff's history with the records relating to the fall from our roof to a medical / neurological event?***

- ***What, if any injury, the plaintiff suffered as a result of the fall, discussing the treatment which might have been necessary for this injury, whether this injury is likely to be permanent and if future care of treatment would be expected?***

Based on the history, physical examination and my review of the records provided, may I offer the following opinions and responses to your specific questions, all expressed to a reasonable degree of medical certainty and probability:

Is there any medical support in plaintiff's history with the records relating to the fall from our roof to a medical / neurological event?

- These records reflect that Mr. Roush was intoxicated at the time of his fall from the roof or ladder on April 30, 2001. Although he did not disclose to me any alcohol intake associated with this incident, his blood-alcohol level on admission was 0.212. This is more than twice the legal limit for operating a motor vehicle and Mr. Roush himself subsequently admitted to some degree of intoxication.

  It is my opinion, to a reasonable degree of medical certainty and probability, that alcohol intoxication was, more likely than not, at least a contributing factor to Mr. Roush's fall from the roof or ladder on April 30, 2001.

- Mr. Roush's "belligerent" behavior and his vision of "a white light by the clock on the wall" during his hospital admission after the fall of April 30, 2001 were possible signs of a pre-existent organic condition, a post-traumatic neurologic condition or even an alcohol withdrawal syndrome. Accordingly I am unable to exclude some sort of pre-existent neurologic condition or episode, such as a transient ischemic attack, as an additional contributing factor to Mr. Roush's fall from the roof or ladder on April 30, 2001. However, as this discipline of medicine is beyond my scope of expertise, I would defer to a neurologist for an opinion on this matter.

What, if any injury, the plaintiff suffered as a result of the fall, discussing the treatment which might have been necessary for this injury, whether this injury is likely to be permanent and if future care of treatment would be expected?

- It is my opinion, to a reasonable degree of medical certainty and probability, that Mr. George C. Roush II suffered a closed head injury with concussion, a myofascial strain of his cervical spine and a sprain and contusion of his left shoulder as the direct and proximate result of the injuries he sustained in his fall from the roof or ladder on April 30, 2001.

- It is my opinion, to a reasonable degree of medical certainty and probability, that as a consequence of the injuries he sustained in the fall from the roof or ladder on April 30, 2001 Mr. Roush developed an impingement syndrome of his left shoulder and a transient exacerbation of pre-existent degenerative disc disease of his cervical spine.

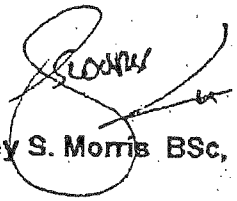
- It is my opinion, to a reasonable degree of medical certainty and probability, that Mr. Roush's concussion and transient exacerbation of the pre-existent degenerative disc disease of his cervical spine have been appropriately treated and that no additional treatment, conservative or surgical, is indicated for these conditions. Furthermore, it is my opinion that no additional treatment, conservative or surgical, is reasonably anticipated to be indicated for these conditions in the foreseeable future.

- It is my opinion, to a reasonable degree of medical certainty and probability, that any additional treatment for the degenerative disc disease in Mr. Roush's cervical spine, whether conservative or surgical, would not be causally connected to the injuries that he sustained in the fall from the roof or ladder on April 30, 2001.

- It is my opinion, to a reasonable degree of medical certainty and probability, that the impingement syndrome in Mr. Roush's left shoulder will probably require additional conservative treatment and possibly an arthroscopic surgical decompression and debridement with post-operative rehabilitation, in order to improve function and decrease discomfort.

I respectfully submit this evaluation for your consideration. I trust that this addresses your questions in a satisfactory manner. If clarification on any issue is required, please do not hesitate to contact me. I appreciated the opportunity to evaluate Mr. George C. Roush II and to provide you with this report.

Very truly yours



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