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PRACTICE LIMITED TO NEUROSURGERY

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Thomas Mester, Attorney
7th Floor, Engineers Bldg.
Cleveland, Ohio 44114-1357

Re: James D. Helper Your File T-40117

DOC. 395

Dear Mr. Mester:

As you probably know, I saw this gentleman in my office on 1-11-84, with a history of left arm pain. He complained of pain in the neck as well as in the upper shoulder which radiated down the arm to the wrist and hand. He also complained *of* shooting pains into the small ring finger on an intermittent basis. This was *of* a less severe nature than it had been, although he did complain of pain in various parts of the arm. He had been under the care of a rheumatologist for these complaints.

At the time I saw him, there was a painful range of motion of the left arm at the shoulder girdle. There was some questionable atrophy of the left infraspinatus muscle. He had no distinct focal weakness. There was hypalgesia to pin with hyperpathia on the pad of the left small finger and the medial aspect of the ring finger, and this was associated with a positive Tinel's sign of the left ulnar nerve at the elbow. It was my feeling at that time that his clinical picture was confusing, and I thought that he could possibly have an ulnar neuropathy or remotely a nerve root compression.

I saw him again on 2-7-84. I had discussed the problems with his attending physician, Dr. Burg. He complained of pain in and about the left shoulder girdle and he stated that all movements of the left arm tended to give out. It was difficult for me to decide that this gentleman had any focal weakness with this type of motor examination, and again, my examination revealed no focal neurological disturbance.

The records which you provided indicate that he was in an accident on 6-29-82. Apparently the car he was in was struck from behind by another, and when he was at the emergency room at Hillcrest Hospital, x-rays of the chest, cervical spine, and dorsal spine were within the limits of normal. He was seen by a medical neurologist at the Euclid Clinic Foundation, who saw this patient on several occasions, and felt that he had perhaps a bilateral carpal tunnel syndrome or bilateral ulnar neuropathy. There is a letter from a rheumatology specialist who saw him in June of 1983. At that time the patient complained *of* pain in the left paracervical spinal region as well as pain which radiated into the left arm. Again, he complained of pain into the left fifth digit which I would note at this time is unusual for a nerve root compression at C6-7. According to the letter of his attending physician, the patient had a flare-up of his pain in January of 1984, at the time he was referred to me. While he was under the care again of Dr. Burg, repeat nerve studies were performed, and these studies seemed to show clear-cut changes strongly

suggestive of a C7 radiculopathy.

In April of 1984, he was admitted for an intensive period of physical therapy at Mt. Sinai Medical Center, and during the course of this hospitalization, diagnostic studies were performed, and these revealed clear-cut evidence of a herniated cervical disc. He was re-admitted to the hospital at which time I performed an operation which removed a herniated cervical disc. The patient had a totally benign post-operative course and has had total relief of his pain.

I think that it is within the realm of reasonable medical probability that this patient's development of a herniated cervical disc is related to the accident which occurred in June of 1982. Although his symptoms which began immediately or shortly after the accident in question were somewhat atypical particularly with respect to some of the findings, the distribution of pain which persisted during the course of his illness prior to his surgery suggest that this patient had cervical nerve root compression. I do note this in spite of the fact that this patient had equal and symmetrical reflexes just before I operated on him, in light of my own physical findings which showed the presence of all reflexes in both upper extremities. This is unusual but certainly impossible on medical grounds.

In summary then, this patient who had been involved in several previous accidents, was again involved in an accident in June of 1982. Following this accident, he developed persistent left arm pain which was finally diagnosed as being due to a herniated cervical disc. Surgery was successful in relieving his symptoms. Since this patient's symptoms began soon after the accident in question, I believe that it is medically probable that the recurrent symptoms of left arm pain which began after the accident in question, are due to the accident in question, and I believe that the accident in question was the initiating factor in the development of a herniated cervical disc.

If you have any questions after reading this report, please do not hesitate to call.

Very sincerely,

Melvin Shafron, M.D.

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enc.