Drs. Wolkin, Shafron & Colombi, Inc.
26900 Cedar Road
Beachwood, Ohio 44122
(216) 831-6595

Julius Wolkin M D *(retired)*
Melvin Shafron, M D
Benedict J Colombi, M D

PRACTICE LIMITED TO
NEUROSURGERY

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Sheila A. McKeon, Attorney
7th Floor-Bulkley Building
1501 Euclid Avenue
Cleveland, Ohio 44115

Doc. 397

Re: Terrance Smith

Dear Ms. McKeon,

I saw this very nice gentleman in my office on 4-10-91. In addition to seeing the patient, I reviewed records from a hospital in Roanoke, Virginia, records from a hospital in Greenville, Pennsylvania, and records from the Cleveland Clinic. I should point out that the x-rays from his hospitalization in Virginia were not available. I did review the four M.R.I. scans which were done at the Cleveland Clinic following his surgery of 1-11-90, but I never saw the M.R.I. scan which was performed at the Greenville Regional Hospital in Pennsylvania. I also took a history and performed an examination on the patient. Before beginning with the history as detailed by the patient, I would like to point out to you the nature of the problem and the nature of the surgery that he had in Virginia. At that time, he was hospitalized for what seemed to be typical left cervical radiculopathy. A myelogram and enhanced CT scan of the cervical spine were performed at this time, and these studies showed two things. First *of* all, there was pressure on the thecal or dural sac ventrally, and there was also a filling defect involving the left C6 nerve root. At the time he had his surgery, a laminectomy, the free disc fragments which were compressing a nerve root were removed. The disc space itself was not entered, and one certainly would expect that the deformity produced by herniated disc would persist. I would also point to you that this is a perfectly acceptable standard approach to the treatment of this problem, and his benign post-operative course is evidence of this. He apparently did well until he had his fall in November, 1989. According to the emergency room records, the patient fell on his right shoulder. He complained of arm pain and shoulder pain, and he also had pain in and about the right elbow. X-rays were taken when he was seen, and there were no striking changes except for some very mild degenerative changes at C5-6 which obviously one cannot specifically relate to the accident in question. He was subsequently hospitalized at the Greenville Regional Hospital, and the records state very clearly that all of his complaints were limited to the right upper extremity. He described cottony feeling in the right upper extremity, his pain was limited to the right upper extremity, and the examining physician described a decreased right biceps reflex. Nerve studies were performed, and they were unremarkable.

He was then seen at the Cleveland Clinic, and it is a bit unclear to me specifically what his complaints were, but I certainly do get the feeling that when he was first seen and when he was first operated upon, all of his complaints were limited to the right upper extremity. There may have been

some sensory changes in the left upper extremity, but as far as I could tell from reviewing the records, there was no arm pain on the left side at all. To the best of my knowledge, diagnostic studies were not repeated, and apparently the decision to operate was based on the patient's complaints since one could not reasonably say that his right arm pain was due to the lesion described on the left side as described on the M.R.I. scan of December, 1989. It is apparent from reviewing the records, that the patient's complaints persisted, and several M.R.I. scans were done post-operatively. The left sided filling defect was still present, and the initial post-operative M.R.I. scan done in January, 1990 showed some mild bulging ventrally of the disc at C4-5 as well as the changes on the left side at C5-6. Again, none of this really explains the patient's right arm pain, and the sensory changes which were described by one examiner of the left arm are not really explained by this as well. Indeed, these sensory changes may have been functional since they were described by one examiner as extending from C5 to C8, This would basically encompass the entire left arm, and it is obvious that a single nerve root lesion or even two nerve root lesions could not cause this type of sensory loss. A repeat M.R.I. scan done in March, 1990, did not show any striking changes at C4-5, and one again saw the defect on the left side at C5-6 where he had his previous surgery. A subsequent M.R.I. scan done in April , 1990 revealed changes on the right side at C4-5 which I fully agree with, and the treating surgeon felt that perhaps this patient's complaints could now be explained by the appearance, for the first time, of a lesion on the right at C4-5. Surgery was performed. I don't know the date of this operation, and the records with respect to this surgery were not included.

At the time I saw the patient, he complained of headaches as well as pain in both upper extremities worse on the right side than the left. The headaches are like a stocking around his head. They are present constantly. When worse, the headaches may be present in the suboccipital area and in both temples. When he has them, they may occur several times a day and last for just a few minutes at a time. In addition to the bilateral arm pain, the patient complains of shooting pains in his neck which are present at all times. The arm pain is on the left side located over the left shoulder area and on the extensor surface of both upper extremities. It is not constant. He also has some pain in between his shoulders. Following his surgery, he has been on a work hardening program which includes three months of physical therapy. The right arm pain is present from the right side of his neck down to the arm to the fingers. He has numbness of the thumb andmiddle finger of the right hand which also hurt him. He also has a cold feeling on the index finger. As noted, and as I mentioned before, all of these complaints began after a fall when he landed on the right side of his body in November, 1989. As the patient told me, and as was recorded in his records, the patient had neck pain, headache, and right arm pain. According to the patient, following his first operative procedure, he really had no significant pain relief. Not only did his right arm pain persist or recur, he also complained of left sided pain. The second operative procedure was done, I believe in June, 1990. (6/7 : /9 0)

Re: **Terrance Smith**

At the time I examined this patient, there was no evidence of weakness. There was mild decreased appreciation to pin on the lateral aspect of the right upper extremity and forearm. There was tenderness over the extensor surface of the left forearm. The deep tendon reflexes in the upper extremities seemed to be a bit decreased when compared to the reflexes in his lower extremities. There were no pathological reflexes. There was a full range of motion of all extremities. I did not test his neck movement.

Obviously, there are a number of unanswered questions about this patient. It is very difficult to explain right upper extremity pain when the only abnormality one sees on diagnostic studies are to the left side, and seemingly, the changes were quite clear cut on his diagnostic studies. There is very little else that I can ssay about this patient, and it is very difficult, on the basis of all the diagnostic studies done, and I specifically refer to the last M.R.I. scan which was done in August, 1990, one cannot explain any of his persisting complaints on the basis of any of the diagnostic studies, and as I noted, specifically the last M.R.I. scan which showed no striking abnormalities. There is very little one can say about this gentleman whose pain, to me, is stil a bit mysterious with respect to its origin.

Obviously, I "didn't live" with this patient as a treating physician, and there may be aspects of his complaints which are not available in the medical records, and I specifically refer to complaints involving the left upper extremity prior to his initial operation.

Please call me if you have any questions after reviewing my report. This is a little complex medically, and many of the things are not absolutely clear cut.

Very sincerely,

Melvin Shafron, M.D.

MS:jr
enc.