Defense Medical

ORTHOPAEDIC SURGEONS, INC.
CRYSTALCLINIC
MUSCULOSKELETAL CENTER

February 28, 1994

Doc. 460

Mr. Edward H. Corbett
1800 One Cascade Plaza
Akron, Ohio 44308-1195

Re: [redacted]

Dear Mr. Corbett:

The above-captioned patient was seen by me on February 28, 1994.

HISTORY AS GIVEN BY THE PATIENT

The patient stated that on October 19, 1991 while driving her car and wearing her seatbelt and while the care was moving, she was hit on the driver's side. As a result of the impact, she was lurched forward and she almost went through the windshield. She twisted at the same time and she also hit her left knee on the dashboard. Two hours later she went to Akron City Hospital Emergency Room. X-rays were taken and she was referred to Dr. McCluskey. He told her that she had a neck and back strain. He sent her for physical therapy at Tallmadge Therapy Center for about three months. According to the patient there was no improvement. Three months later she went to see Dr. Brower, a spine surgeon. Meanwhile a CAT scan had been ordered. At the time she saw Dr. Brower her complaint was that of back and left leg pain. She was told that she had a nerve entrapment at the fifth lumbar vertebra. She stated that this was diagnosed by a CAT scan. Dr. Brower also ordered a MRI which was done at Akron City Hospital. He finally did surgery on her back on November 9, 1992 to free the nerve in her lower back. She stated that he removed a facet hinge joint at the L5-S1 level. She stated that surgery helped but she still had lots of discomfort in the back and left leg for which she is presently taking Motrin. The last visit with Dr. Brower was six months ago. The patient stated that following her back surgery Dr. Brower sent her for some more therapy in Tallmadge and this continued until the middle part of 1993. The patient stated that she was having trouble with her left knee all along but no attention was given to the left knee or any specific

treatment until after her back surgery. Because of persistent pain Dr. Brower sent her to Dr. Acus who told her that she damaged the covering of the bone in her knee due to the blow that she received in the car accident. He gave her three cortisone shots which according to her did not help. He finally took her to surgery on October 5, 1993 to remove some of the bad cartilage. She stated that she was told that in some areas there was bone on bone. She had no physical therapy subsequent to her knee surgery but she stated that she has been doing her home exercises for her back and one of them is riding the bike. Her last visit with Dr. Acus was in November 19, 1993.

PAST HISTORY felt the knee PT was OK

The patient denied any previous problem with her left knee. She did have some problem with the lower back for which she was treated by Dr. Gardner, D.C. in 1987 or 1988. At that time she had some back discomfort and received treatment in the form of "acupressure." He treated her for a couple of months. She denied any other injuries or illnesses. She did have a hysterectomy about 25 years ago.

WORK STATUS

Patient is an operation manager at Best Western Motel. The patient stated that she had worked all along since the accident, taking little time off following the two surgeries.

CHIEF COMPLAINT because she stayed at Hotel

Her chief complaint at time of examination was discomfort in her lower back and down the left lower extremity in the back of the thigh and the calf of the leg. She had some difficulty walking. She had some discomfort in the anterior part of her left knee. She had difficulty bending her knee. She stated that occasionally her left knee locks and snaps. She also had some slight numbness on the top of her right foot and up her right leg.

RECORD REVIEW

There is record of a visit to Akron City Hospital Emergency Room on October 19, 1991 with a chief complaint of low back pain due to motorvehicular accident. She was diagnosed as having an acute lumbar strain and a contusion of the right elbow and the Left knee. X-ray of the lumbosacral spine revealed some degenerative changes.

There is record of a CT of the lumbar spine taken on November 5, 1991 which revealed no evidence of spinal canal narrowing or compression of the neural tissue. There ws some calcification of the ligamentous flavum at the L1-L2 level.

There are records of treatments given at Tallmadge Physical Therapy starting on November 20, 1991.

There are records which I assume belong to Dr. McCluskey dating from November 21, 1991 and extending to March 31, 1993.

The patient was also seen by Dr. Ford at Summit Rehabilitation. He reported on March 19, 1993 that his impression was that the patient had chronic low back pain with recent exacerbation from a motorvehicular accident associated with spinal arthritis and irritation of facet joints. Apparently the patient gave Dr. Ford the history that she had problems with her low back for 30 years and for which she occasionally was treated successfully by a chiropractor. The patient told him that the motorvehicular accident of October 1991 severely exacerbated her low back pain. EMG of the left lower extremity was normal.

The patient was seen by Dr. Brower on July 22, 1992. His assessment revealed that the patient had a L5 nerve root entrapment. He decided to order a MRI of the lumbar spine. The records further indicate that the patient was followed by Dr. Brower up until July 21, 1993. On September 11, 1992 Dr. Brower reviewed the MRI and he felt that although the radiologist found no foraminal stenosis, the disagreed with the interpretation and he felt that an overgrown facet joint was impinging on the fifth root on the left side and he felt that this correlated with the clinical findings. He recommended a microdecompression of the L5 on the left.

The patient was taken to surgery at Akron City Hospital on November 9, 1992. The preoperative diagnosis was lateral recess stenosis of L5. The postoperative diagnosis was the same and the operation consisted of a microdecompression of L5 on the left. The patient was hospitalized from November 9 to November 12, 1992. Dr. Brower also felt that the facet joint was incompetent and there seemed to be a defect in the pars interarticularis although this was not apparent on x-ray. He felt here was significant scar formation around the nerve root and there was some blood vessels adherent to it. Postoperatively she still had some minor residual discomfort which was gradually improving. On February 5, 1993 the patient complained of recurrence of back pain and numbness in the dorsum of the foot. He stated that he felt that the patient was acting like she had a new disc herniation but he felt that he would like to treat her conservatively and ride the storm out for the time being. On April 14, 1993 Dr. Brower mentioned that the patient was doing well with the rehabilitation program but she still had some tingling in the dorsum of the right foot but she did not have pain. The patient complained to him of some left knee pain with crepitation with standing. She had full range of motion but did not have any joint line tenderness. The ligament appeared to be intact. X-rays of the left knee revealed a lateral subluxation of the patella on the sunrise view. Dr. Brower felt that if the knee continued to bother her he will refer her to another doctor.

On May 19, 1993 the patient was seen by Dr. Brower, stating that she was lifting a table at work when she started to have some lower leg pain. He felt that this was a low back injury but because of the suggestion of some neurogenic claudication he felt that another MRI with gadolinium was in order to rule out the possibility of scar tissue. Apparently the MRI was done and on June 1, 1993 he reported that the MRI showed the fifth root to be widely decompressed. There was no evidence of disc herniation. His final office note was on July 21, 1993. He

stated that [redacted] at this point was really not making much progress with physical therapy. He felt that the leg pain was on the basis of the chronic changes within the nerve which was badly compressed at the lateral recess for a long time. He felt that no additional surgical intervention was in order and recommended that he see her on an as needed basis.

Dr. McCluskey, in a report dated May 11, 1993, stated that he first saw the patient on October 21, 1991 with complaints of neck, shoulder and low back pain. He initially gave her medication and sent her physical therapy. He then ordered a CAT scan of the lumbosacral spine. He also sent her to see Dr.Ford at Edwin Shaw Hospital and finally he recommended that the patient see Dr. Brower who according to him found that she had a nerve entrapment in her back which needed to be freed.

Dr. Brower, in a report dated December 3, 1993, stated that the x-ray revealed a very large left sided facet joint at the L5-S1 and the CAT scan revealed some bone entrapment of the fifth nerve root on the left side. He mentioned that the patient underwent a microdecompression of the L5 nerve root on the November 9 ,1992 and that she was found to have a defect through the pars interarticularis which was not apparent on the initial x-rays. There was significant scar formation around the nerve root. Dr. Brower repeated the findings on his office visit on April 14, 1993 where the patient at that time was complaining of left knee pain with crepitation. He also reported that the patient reinjured herself at work on May 19, 1993, lifting a table. He ordered another MRI which revealed no evidence of disc herniation or spinal stenosis. He concluded that in view of the fact that the patient had no back or leg problem prior to her accident suffered on October 19,1991, he felt that it was within a reasonable degree of medical probability that her subsequent problems were caused by the accident. He also felt that the patient sustained a lumbar strain lifting a table at work. He felt that the patient had degenerative disc disease and foraminal stenosis and he felt that although this was preexisting to the accident she was asymptomatic until the car accident and therefore her problems were directly related to the motorvehicular accident. Apparently, Dr. Brower did not get from the patient the same information that Dr. Ford did of a 30 year old history of low back problem needing chiropractic treatment.

Dr. Acus, in a report dated December 21, 1993 stated that that patient described to him that her left knee hit the dashboard during the motorvehicular accident of October 19, 1991 in addition to injuring her back. She complained of locking and catching in the left knee but no buckling. She had pain climbing stairs but she did not have significant swelling. On examination he found some gross retropatellar crepitation and by sunrise views she had some narrowing between the patella and the lateral femoral condyle. Following no relief with Marcaine and Celestone injection into the knee joint, the patient underwent an arthroscopy of the left knee. A grade IV chondromalacia of the patella as well as medial femoral condyle was found and this required chondroplasty. He further stated that the condition he treated [redacted] for was directly related to the accident

and that she sustained a permanent injury and that the injury accelerated and aggravated an underlying condition in the form of chondromalacia of the patella. He felt that particularly the chondromalacia of the medial femoral condyle was not the result of the accident but probably due to underlying condition present prior to the car accident.

PHYSICAL EXAMINATION

The patient gave her height as 5 foot 7 inches and her weight as 135 pounds.

The examination of the left knee revealed no evidence of crepitus upon rubbing the patella against the femoral condyle and she has no pain in the process. She has crepitus in the opposite non injured right knee. She had equal range of motion in both knees. There was no effusion of the left knee. There was no atrophy of the left thigh compared to the right. There was no evidence of atrophy over the vastus medialis of the left knee indicating good rehabilitation of that quadriceps.

Examination of the lower back revealed some tenderness to pressure over the lumbosacral spine at the operative cite. She also had some tenderness over the left paravertebral muscle of the lumbosacral area. She has some tenderness over the left sciatic notch. The range of motion of the lumbosacral spine seemed to be restricted and painful in the extremes of flexion, extension, lateral rotation and lateral bending in the standing position. The sitting straight leg raising was negative. She had hypoactive ankle reflexes but she had symmetrical deep tendon reflexes of the knee. The sensation to pin prick revealed a slight decrease over the L5 and S1 dermatomes on the left. The muscle strengths in both lower extremities seemed to be good.

X-RAYS

The patient did not bring any x-rays with her. In the records available at hand there is no copy of any report of the MRI and CAT scans which were performed on this patient. X-rays taken in our office today revealed bilateral minimal lateral subluxation of the patella with narrowing of the lateral joint compartment. The medial and lateral joint spaces seemed to be well preserved bilaterally. X-ray of the lumbosacral spine revealed the presence of a decompression laminectomy at L5 with removal of the facet at that level.

CONCLUSION

In conclusion, it appeared that the patient has sustained, as a result of the motorvehicular accident of October 19, 1991, a muscular and ligamentous strain of the lumbosacral spine superimposed over a preexisting long history of chronic back problems with spinal stenosis. I believe the accident aggravated her preexisting condition causing her back to become more symptomatic. Dr. Brower was under the impression that the patient had no previous problem with the lower back and

therefore assumed that her preexisting lateral canal stenosis and spinal stenosis was asymptomatic and was made symptomatic by the car accident. He attributes the scarring found around the nerve root to the motorvehicular accident. Dr. Ford's letter indicated that she told him that she had a 30 year old history of chronic back problems for which she has had treatment.

As far as her left knee is concerned, my examination revealed the presence of chondromalacia in the opposite noninjured knee and the same x-rays findings as on the injured knee. Therefore, it is reasonable to assume that the chondromalacia of the left knee was preexisting to the accident and was made symptomatic by the accident as this patient never gave a history of a previous knee problem.

Very truly yours,

Zouhair K. Yassine, M.D.
Professor of Orthopaedic Surgery

ZCY/mt