

[REDACTED]

[REDACTED]

FELLOW OF THE AMERICAN ACADEMY OF  
ORTHOPAEDIC SURGEONS  
ST. PAUL PLACE SPECIALISTS



A University  
Affiliated  
Center  
Conducted

November 28, 2006

[REDACTED]

RE: [REDACTED]

[REDACTED]

File # : [REDACTED]  
SS # : [REDACTED]  
D/A : [REDACTED]  
DOB : [REDACTED]

One West Pennsylvania Avenue  
Suite 500  
Towson, MD 21204

[REDACTED]

[REDACTED] was seen at the Mercy Medical Center office today for an independent orthopaedic evaluation. [REDACTED] is 57 years old. He is currently employed part time in construction. His job involves installing mobile floor to ceiling office partitions. He states that the job involves fairly heavy work. He has been doing similar type of work for 19 years. [REDACTED] is currently being treated by his primary care physician only.

This patient stated that he was injured in a motor vehicle accident which occurred on February 25, 2005. The accident occurred when he was stopped at a "merge" ramp and was struck from the rear. He was in a small pick up truck; his vehicle was hit by a mini van. He was wearing a seatbelt at the time. He states that there was not much damage to his vehicle. It is his recollection that the damage was approximately \$1500.00. No front end collision occurred.

After the accident, [REDACTED] was able to get out of his truck by himself. He had no immediate pain. He recalls that the accident occurred on a Friday. He became stiff over the weekend. He saw his primary care physician on Monday complaining of neck and back pain. He does not recall specifically what treatment was given. He states that no surgery has been done relative to this accident but he is not certain if any surgery has been planned. He was employed full time at the time of the accident. He does not recall specifically how much time he missed after the accident but states that he has basically worked part time since then.



301 ST. PAUL PLACE ☪ BALTIMORE, MD 21202-2165 ☪ DIRECT (410) 385-0080

<http://www.MDMERCY.com>

FROM: [REDACTED]

TO: [REDACTED]

RE: [REDACTED]

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[REDACTED] is still complaining of pain in his neck and lower back. He specifically states that he had no prior pain in his neck or back before this accident. Specifically, he gives no history of any prior injuries or surgery referable to his neck or lower back.

Regarding his neck, he states that his pain has reached a plateau. He has pain in both trapezius muscles as well as at the base of his neck. He does not have headaches. Turning his head is stated to hurt at times. Coughing and sneezing do not hurt. He has no arm pain. He has had intermittent tingling in his right arm involving the index, middle and ring fingers. He tries to observe a 25 pound lifting limit. Lifting heavy objects is stated to hurt. Heat applications have not produced much help. He does not wear any braces or supports.

[REDACTED] states that before this accident, he had minor aches and pains only of his lower back. He states that he has had persistent back pain since the accident. His back pain has also reached a plateau. He localizes the pain to both the left and right of center. There is no leg pain or numbness. Coughing and sneezing do not hurt. Bending hurts at times. Sitting and standing are equally comfortable. When he lies down, he does not improve. He has not identified any one position which is best. He does not wear any braces or supports. He does not describe any difficulty walking. He has no bowel or bladder complaints. He has found that a heating pad helps somewhat; he does not do any exercises.

[REDACTED] is taking Tramadol, a non-narcotic analgesic, approximately four times a day. He is not certain how much benefit he gets from this medication. He has been taking Zoloft for seven or eight years relative to an unrelated condition. He also takes a muscle relaxant which he states makes him tired. He does not take any other medications currently. Review of systems is otherwise unremarkable.

The patient gives no other pertinent past history. He smokes between one and a half and two packs of cigarettes a day and has been strongly urged to quit. He acknowledges having consumed alcohol heavily but quit about eight years ago. His education includes a high school diploma. He is right handed.



FROM: [REDACTED]

TO: [REDACTED]

RE: [REDACTED]

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On physical examination, the patient was a tall, well developed, middle aged man who appeared his stated age and was in no apparent distress. He was alert and fully oriented. His stated height was 6'0" and his stated weight was 185 pounds. He appeared completely at ease. Examination of the cervical spine revealed no deformities. However, he tended to hold his head to the right side. The paracervical and trapezius muscles are soft and supple. Cervical range of motion was voluntarily demonstrated at less than one half of normal in all spheres. On bending to the left, he could only bring his neck back to the neutral position. Flexion and extension were similarly restricted. Cervical compression was painless. Biceps, triceps and brachioradialis reflexes were all brisk and symmetrical. There were no areas of diminished sensation to light touch in either upper extremity. All motor strengths were excellent.

Examination of the lumbar spine revealed flattening of the lumbar lordotic posture. Active lumbar range of motion was demonstrated at 60 degrees of flexion, 10 degrees of extension and 20 degrees bending to each the right and left side. There were no spasms limiting motion. There were no areas of localized tenderness. He appeared to change positions with ease. In the sitting position, straight leg raising was negative bilaterally to 90 degrees even when both legs were lifting simultaneously. Hip motion was painless. The flexion abduction external rotation maneuver produced no pain in either leg. The Achilles and quadriceps reflexes were brisk and symmetrical. There were no areas of diminished sensation to light touch in either lower extremity. All motor strengths were excellent.

This gentleman brought with him a number of diagnostic imaging studies for review. The studies were all recent. X-rays of the lumbar spine taken on September 8, 2006 showed moderate loss of height of the L5 disc space. Flexion and extension views did not show any slippage. The degenerative changes were felt to be appropriate for his age.



[REDACTED]

FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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An MRI of the cervical spine was done on May 28, 2006. Degenerative changes were seen at C5-6 and to a lesser extent at C6-7. There appeared to be at least the possibility of a soft disc component to a disc bulge seen at C5-6. Fairly extensive modic changes were seen at C6-7. There were minimal modic changes at C5-6. There was also the possibility of an annular tear at C5-6.

An MRI of the lumbar spine was just done recently on November 21, 2006. Multilevel degenerative changes were appreciated. Disc desiccation was seen at basically all levels. Disc bulges were seen at L2 and L5. These bulges appeared due to disc osteophyte complexes. Fairly extensive collapse of the L5 disc space was noted. There also appeared to be significant foraminal narrowing at L2.

Also forwarded for review were x-rays taken on March 28, 2006 at the office of [REDACTED] who are chiropractors. The copies which are furnished are of quite poor quality. The cervical spine films, however, show loss of cervical lordosis. There were fairly extensive degenerative changes seen at both C5 and C6. There are no oblique views furnished to allow visualization of the foramina.

X-rays of the lumbar spine taken at the same office also on March 28, 2006 are of sufficiently poor quality that they are barely interpretable. Unfortunately, on the lateral view, there appears to be some sort of film defect which has obscured the view of the lumbosacral junction. The disc spaces as visualized appear satisfactory. However, the L5 disc is not adequately visualized.

Also forwarded is another MRI of the cervical spine. This study is dated June 6, 2005. On this study, there is extensive degenerative change seen at C6-7 and lesser change at C5-6. Bulges are seen at both levels which appear to be disc osteophyte complexes. On the more recent cervical spine MRI, I was concerned that there was an annular tear at C5-6. That finding is not present on this earlier study.



FROM: [REDACTED]

TO: [REDACTED]

RE: [REDACTED]

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November 28, 2006

These films are being returned to your office under separate cover.

An extensive package of documents has also been provided for review. I note in the answers to interrogatories number #16 that there is basically acknowledgement of a pre-existing condition which might have rendered [REDACTED] more subject to injury. In the answers to interrogatory #19, this patient's prior medical history is outlined including treatment for alcoholism. In the answers to interrogatory number #20, the likelihood of a pre-existing condition is also raised. There is also an issue regarding lost wages discussed in these documents.

I have also reviewed the deposition of this gentleman taken on September 25, 2006. In this deposition, he indicates that he was "jerked" by the impact. There was a bruise on his shoulder apparently from his seatbelt. The vehicle was drivable afterwards. There is no specific mention regarding the amount of damage sustained to his vehicle. There is no indication of any prior medical history of significance. This patient entered treatment at "Living Health Chiropractic" on March 28, 2006, more than one year after the date of the accident. He had complaints of neck and back pain at the time. At that point, he was working eight hours a day, three days a week. He had described his work as being moderately heavy. He described his job in the same manner to me today. A number of different diagnoses were made. I have some questions regarding the interpretation of some of the findings of [REDACTED] the chiropractor who was treating him. I note, for instance, that complaints of tenderness were associated with "malposition". Apparently, this patient was treated only through April 7, 2006. In a note prepared by [REDACTED] he indicated that "the patient did not comply with the recommended treatment plan". He appears to have received relatively few treatments.

There is an office visit note of February 28, 2005 indicating that the patient was complaining of a stiff neck. The pain was on the left side. There was no radicular pain. A mild cervical strain had been diagnosed. He had been seen by a nurse practitioner apparently at his primary care physician's office. Ibuprofen, over the counter form, was prescribed along with heat and rest.



FROM: [REDACTED]

TO: [REDACTED]

RE: [REDACTED]

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He was seen at the same office on March 2, 2005 complaining of left shoulder pain which began "yesterday while lifting heavy object at work". A left trapezius muscle strain was diagnosed and a similar prescription was given. A further record of June 15, 2005 also indicates that he had neck complaints only. The MRI was reported to have shown degenerative disease but no impingement. It was also noted that he had undergone chiropractic and physical therapy treatments which had not helped. Apparently, he was having difficulty working in construction. He was given a note at that time to limit his activity.

Once again, on September 2, 2005, complaints were limited to his neck. He was seen on that day to obtain a prescription to help him quit smoking.

X-rays of the cervical spine had been taken on April 1, 2005. Degenerative changes were seen at the C6-7 level as well as at C5-6. Bilateral foraminal osteophyte formation was also observed at those levels.

Please note that these films have not been provided for review. I would be most interested in reviewing them if they can be forwarded to my office and I will prepare an addendum to this report at that time. These x-rays clearly indicate that this patient had significant pre-existing degenerative cervical disc disease.

An intake form from the Fiore Chiropractic Clinic is dated April 18, 2005. At that time, he was complaining of a stiff neck as well as grinding pain in his lower back. He was also seen by [REDACTED], an orthopaedic surgeon, on April 26, 2005. A cervical strain superimposed on degenerative cervical disc disease was diagnosed. A lumbar strain was also diagnosed. X-rays of the lumbar spine taken on that date were stated to be "essentially unremarkable". X-rays of the cervical spine were confirmed to show degenerative disc disease. [REDACTED] had observed that the chiropractic treatments which he had received had irritated his discomfort and instead he was referred to Atlantic Rehabilitation. A structured physical therapy program was advised.



[REDACTED]

FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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On May 10, 2005, he saw [REDACTED] again and had indicated that he was feeling better as long as he was not physically active. He still had some aching in the left side of his neck. There was some restriction of cervical motion. Additional therapy was advised. On May 31, 2005, [REDACTED] had recommended an MRI of the neck.

The study was done on June 6, 2005. Multilevel degenerative disc disease was noted. There was no evidence of disc herniation. I agree with that assessment. [REDACTED] had indicated then that he did not think that further physical therapy would be helpful. He was advised to continue light duty. [REDACTED] also indicated that he explained to the patient "that his accident has aggravated a pre-existing condition and it may take up to six months before his condition stabilizes". A follow up visit was arranged on July 12, 2005 at which time [REDACTED] had indicated that he thought the patient had reached maximum medical improvement. The patient stated that he felt "about the same" at that time. The possibility of alternative employment was raised at that time.

This gentleman had been seen at Health South Physical Therapy beginning April 29, 2005. Cervical lumbar strains had been diagnosed at the time. A treatment plan had been recommended. I note that he was subsequently discharged on July 5, 2005 because of non-compliance regarding attendance.

The MRI of the cervical spine done on June 6, 2005 was interpreted by [REDACTED] the radiologist, as showing no cervical disc herniations. However, multilevel degenerative disc herniation was noted. Some neural foraminal narrowing had occurred as a result of the degenerative change. None of the changes described are posttraumatic in nature.



[REDACTED]

FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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On July 19, 2005, this gentleman began treatment with [REDACTED] a physiatrist, who specializes in pain management. Spasms were described in the upper trapezius muscles and a course of trigger point injections were given. The spasms were primarily on the left side. His range of motion was described as being limited. I note in the history given that he was described as having been "jolted very hard" by the accident but he did not experience pain until two days later. This type of pain origin is compatible with soft tissue injuries, not with a structural injury. I note also that this gentleman had been confined to light duty during this time of treatment. There are also records of some lost days from work. There is no indication of any lengthy time lost from work. He appears to have missed a few days directly after the accident only.

He was not able to work during periods of time when light duty was not available.

In a note of March 15, 2005 prepared by [REDACTED] a nurse practitioner associated with Maryland Primary Care Physicians, this gentleman had a 40 pound lifting limit specifically regarding pain in his neck. There is no mention of any back pain.

On June 8, 2006, this gentleman was seen by [REDACTED] a neurosurgeon, relative to neck pain with some right arm radicular complaints. The possibility of an anterior cervical fusion from C5 through C7 was raised if the patient's pain did not respond to pain management treatment. A subsequent MRI of the cervical spine was reported on May 23, 2006. There was the possibility of some progression of the neural foraminal narrowing at C5-6 and C6-7 levels. Disc osteophyte complex encroachment was noted. The radiologist mentioned the fairly extension degenerative change at the C6-7 level. X-rays taken of the lumbar spine on September 8, 2006 were interpreted by the radiologist as showing fairly severe degenerative changes at L5-S1 with no evidence of instability. I agree with this assessment. The radiologist also states that there was "mild diffuse disc bulging at L4-5". I am not certain how that diagnosis can be made on the basis of a plain x-ray.



FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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I note at one point that a discogram had been requested. I do not have any records which would indicate whether or not that study had ever been done.

This patient was seen again at Physical Medicine and Pain Management Associates where he had seen [REDACTED] originally; on July 14, 2006, he was seen by [REDACTED]. Once again, the possibility of non-surgical management was raised. I do not have a subsequent note indicating whether or not any further treatment was conducted by [REDACTED]. There are no other records provided regarding treatment relative to his current injury. I would have been interested in seeing damage reports or photographs of the vehicles involved. This information might give some clue regarding the magnitude of the impact involved.

There were also packages of medical documents pertaining to treatment for prior conditions. There were records pertaining to the arthroscopic surgery of his right knee done in 1997. There are records by [REDACTED] an emergency room physician, of September 16, 2002. At that time, he was experiencing some left arm tingling. This gentleman had indicated in his deposition that he could have been having a heart attack. The numbness was stated to be in the C8 distribution which would imply a cervical origin. A CT of the spine was ordered at that time and showed "multilevel degenerative changes with narrowed neural foramina at C4-5, C7-T1 and C3-4 bilaterally". It is apparent, therefore, that he had pre-existing degenerative cervical disc disease. It is also evident that he likely had prior cervical radiculopathy on the left side.

Despite the voluminous nature of the documents provided, additional information is not obtained.

Please note that review of the extensive documents provided including the imaging studies required approximately three (3) additional hours.



FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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It is my impression, first of all, that this gentleman had pre-existing degenerative cervical disc disease. There is no indication on any of the imaging studies that any type of structural injury was sustained. He has persistent symptomatology which is fairly typical for degenerative cervical disc disease. He may have had an exacerbation of his pre-existing condition.

The medical records do not provide convincing evidence that this patient sustained a lumbar injury as a result of this accident. There are no reports of lumbar discomfort until more than one month after the accident. He had seen several physicians during that time. It is my opinion that his low back pain is most likely not causally related to his motor vehicle accident.

[REDACTED] is correct when he states that extended periods of physical therapy are unlikely to be helpful. This patient has been the benefit of what was most likely well intended but unsuccessful treatment. It should be noted, however, that this patient was also relatively non-compliant regarding following up on treatment. Completion of a course of treatment may have resulted in reduction in his current level of discomfort.

It is my opinion that further treatment at this point is not likely to be helpful. It is also my opinion that further pain management services are highly unlikely to produce any improvement.

It is my impression that this patient has a twenty five percent (25%) permanent partial physical impairment of his cervical spine at this time. He has advanced degenerative cervical disc disease. There is no indication that a structural injury occurred as a result of this accident. Therefore, of this twenty five percent (25%) impairment, it is my opinion that twenty percent (20%) predated the accident and five percent (5%) relates to the accident in question. This rating has been given utilizing the American Medical Association Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> Edition, and additional factors have been considered, including pain, weakness, atrophy, loss of endurance, and loss of function. I have reached these conclusions with reasonable medical certainty. The opinions rendered in this report are based on clinical assessment, examination and documentation and rendered with a reasonable degree of medical certainty.



[REDACTED]

FROM: [REDACTED]  
TO: [REDACTED]  
RE: [REDACTED]  
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It is also my opinion that this patient has no impairment of his lumbar spine due to the accident in question. I have real questions regarding whether any of this patient's lumbar spine complaints should be attributed to the accident or rather due to other causes.

I note with interest a report by his primary care physician that this patient had injured his left shoulder lifting a heavy object a short time after the motor vehicle accident. This raises real questions regarding this gentleman's physical capacities.

Regarding the necessity for treatment which he received, it is my opinion that the treatments which he received through [REDACTED] office with Health South were reasonable. The consultation with [REDACTED] in June, 2005 was reasonable. It is my opinion that treatment after that date was unlikely to produce any benefit and as a result, in my opinion, were not necessary relative to this accident.

If there are any questions, please direct them to this office.

Very truly yours,

[REDACTED]  
Orthopaedic Surgeon

[REDACTED]  
Enclosure

