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February 18, 1985

Mr. Richard J. McGraw
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2150 Illuminating Building
Cleveland, Ohio 44113

Re: Cora L. White
Case No. 82950

Dear Mr. McGraw:

Cora White was examined on February 18, 1985 regarding an accident which occurred on March 23, 1984. This 60-year-old female informed me, in the presence of her counsel, that she had been injured in March of 1984 when she was driving an automobile which was at a "slow stop". Her vehicle was struck from behind by a second car. She was wearing seat belts at the time of the accident and "blacked out for a few minutes". She did not recall whether or not she had struck her head. She was taken to Huron Road Hospital where she was examined, treated and released. By that time, she was aware of pain in her neck and back "all the way down". She received an injection at the hospital and "was already doped".

Approximately six to seven days after the accident, she came under the care of Dr. Kaffen who examined her and prescribed medication. Initially, she was examined by him every two weeks and then once a month. She continued under Dr. Kaffen's care during 1985 and has been seen by him approximately once a month. She is scheduled to see him in several days.

She has not been examined by other physicians nor has she been hospitalized.

At the time of this examination, Mrs. White stated that she had pain in the posterior aspect of her cervical spine which was increased when she turned her head "a certain way". There was no associated arm radiation. In addition, she had pain in the lumbosacral area which radiated into the posterior aspect of her left thigh and into her calf. All of her toes felt "stingy". She recalled that her leg radiation began "right after the accident; about one week later". She indicated that the medication which she had received at the hospital was "so strong it took me a week to get my thinking thoughts on", There were no activities which increased her back symptoms and she indicated "my back just actually hurts". A Valsalva maneuver produced only back pain.

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Her past medical history indicated no symptoms referable to her cervical spine prior to the accident. In 1979, she had sustained an injury to her low back while lifting a patient. She came under Dr. Kaffen's care and was last examined by him in June of 1983 for the earlier injury. Following her accident of March of 1983, she developed left leg pain for the first time and had not returned to work "because I haven't been able. It's my back, my leg and the medication. I can't drive with the medication". She had been working as a home health aide and homemaker prior to the recent accident. She was taking Darvon when her pain was "real bad" and had taken none on the day of the examination. She also took "muscle relaxors every day" and had taken one on the morning of this examination. She had sustained no new injuries.

Physical examination revealed a female of approximately her stated age who was of short stature and moderately overweight. She indicated that she was 5 feet 3 inches tall and weighed 150 pounds. She arose from the sitting position without difficulty, ambulated without limp and was able to ascend and descend the examining table in a normal fashion.

Examination of her cervical spine revealed normal cervical lordosis without evidence of paracervical or trapezius spasm. There was tenderness to palpation in the right trapezius. There was approximately 50 percent of normal cervical flexion, complete cervical extension and approximately 25 percent of normal lateral rotation and lateral bending bilaterally. These maneuvers were performed in a cogwheel-like fashion.

Examination of her shoulders revealed no evidence of atrophy, deformity or localized tenderness. There was a full range of abduction, external rotation and internal rotation. There was approximately 140 degrees of forward flexion bilaterally which was accompanied by pain in the low back.

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There were no areas of localized tenderness to palpation in the lumbosacral area, sacroiliac joints or sciatic notches. Forward flexion was restricted such that the fingertips reached the mid tibias and she arose from the flexed position by placing her hands on her thighs. Lateral bending, heel and toe walking were performed normally. Burns' test was considerably positive as she complained of low back pain as she attempted to sit back on her heels.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal on the right. It was limited to 15 degrees from the horizontal on the left and was accompanied by pain in her entire left leg. Supine straight leg raising was restricted to 45 degrees on the right and to 15 degrees on the left, on the right, there was low back pain and on the left, there was leg pain. Lasegue's maneuver decreased this pain bilaterally. Further neurological

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examination of the lower extremities revealed symmetrical patellar tendon reflexes, a questionably diminished left Achilles tendon reflex with normal motor power and normal sensory perception.

Radiographs of the cervical spine revealed no evidence of fracture or dislocation. There was slight narrowing of the C3-4 interspace.

Radiographs of the lumbosacral spine and pelvis revealed no evidence of fracture, dislocation or disc space narrowing, There was minimal spurring in the lower lumbar spine.

I have reviewed the material forwarded to me and note that the emergency room records of Huron Road Hospital indicate that Mrs. White was treated in that facility on March 23, 1984 for her symptoms of "Pain in neck & lower back, Tingling felt in feet". The record is generally illegible although the diagnosis appears to be "Whiplash. Hyperventilation". Radiographs of the cervical and lumbosacral spine were obtained.

In his letter of September 10, 1984, Dr. Kaffen summarizes his treatment of Mrs. White between March 30, 1984 and August 22, 1984. At the time of the initial examination, a week after the accident, the patient had neck, low back and left leg symptoms. No abnormal neurological findings were noted. Dr. Kaffen describes the patient's past history and does not indicate whether or not she had prior left leg radiation. On subsequent examinations, "The physical examination remains essentially unchanged". His diagnosis was "Cervical and lumbosacral myofascitis, traumatic in nature".

Based on the information available to me, I believe that Mrs. White was involved in a vehicular accident on March 23, 1984 and that she sustained a cervical and lumbosacral strain. She continues to be symptomatic almost a year after her accident and although she may have the symptoms which she describes, there is nothing on physical examination to substantiate her complaints with respect to her cervical spine. There are findings which apparently substantiate her complaints of left leg radiation, although these were not previously noted by Dr. Kaffen. Conversely, there are several physical findings which indicate either a degree of emotional overlay or an attempt on her part to exaggerate. Thus, unless additional information becomes available which clearly indicates left lumbar nerve root compression, I believe that Mrs. White will have no permanent disability directly attributable to this accident.

"Great" Prognosis if you are on "examining" rather than "treating" physician.

Very truly yours,

DBBrooks M.D.

Dennis B. Brooks, M.D.

DBB/anm