ROBERT D. ZAAS, M.D.
DENNIS B. BROOKS, M.D.
INC.
ROBERT C. CORN, M.D.

ORTHOPAEDIC SURGERY

26900 CEDAR ROAD
BEACHWOOD, OHIO 44122
TELEPHONE 216/464-4414

#541

July 16, 1981

RE: Melinda Weinberger

TO WHOM IT MAY CONCERN:

The above named claimant was examined by me on July 13, 1981, regarding alleged disability as a result of an accident which occurred on October 12, 1980. This 27 year old female informed me, in the presence of her counsel, that she was injured on October 12, 1980, when she was driving an automobile which was moving when it was struck on the left front end by a second car. The claimant was not wearing seatbelts at the time of the accident and was "thrown around" inside the car striking the driver's side door with her left elbow. She noted that she was "dazed" and the left side of her body was "tingling". She was taken to Lake County West Hospital where she was examined, treated and released.

The day after the accident, she called her physician, Dr. Bauer, and medication was prescribed. She was examined by him within a week of her accident and further medication and bed rest were prescribed. She then contacted Dr. Bauer by telephone because of continuing symptoms, and on approximately November 3, 1980, she was admitted to Euclid General Hospital for approximately three weeks. She was treated with pelvic traction, ice packs and physical therapy with ice. While in the hospital, she was also treated by Dr. Decello, "a back specialist". By the time of her discharge, she was "no better", for she continued to have pain in her low back and numbness in her right hand which had begun several days following the accident.

She continued her treatment with Dr. Bauer, and electrodiagnostic studies were performed. Further bed rest and restriction of activity was recommended. She has been examined by Dr. Bauer approximately every six to twelve weeks. She has not again been hospitalized.

At the time of this examination, the claimant stated that she was still having "a great deal of pain". She described pain in the mid portion of the thoracic area which radiated into the lumbosacral area where it was mostly tense. The pain also radiated down the outer aspect of the left thigh, into the posterior calf and bottom of the foot. With walking, she had pain in both legs. Activities such as standing for more than 15 minutes and walking for more than 30 minuter; increased her symptoms. A Valsalva maneuver produced mid thoracic pain. General housework also increased her symptoms, and when she attempted to cut meat, she would develop "shocks" throughout her right hand.

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The past medical history indicated that in approximately March of 1978, the claimant developed low back and left leg pain following a D&C. She was treated by a therapist and in June of 1978 was admitted to Lake County West for traction and physical therapy by Dr. Cop. She was then examined by Dr. Bauer in July of 1978 at which time electrodiagnostic studies were performed and medication was prescribed. She was admitted to Richmond General Hospital in September of 1978 for physical therapy and traction. She continued under Dr. Bauer's care. In June of 1979, she was involved in a vehicular accident when she *was* struck from behind. She sustained injuries to her neck and low back. At that time, she was eight months pregnant and was admitted to Lake County West Hospital. The claimant stated that prior to her accident of October 12, 1980, she was "getting considerably better". She had "less bad days and more good days", although she still had low back and left leg pain. She had had no prior right hand symptoms and had sustained no new injuries. Prior to her accident, she was working as a driving instructor and now was working for "short periods at a license bureau".

Physical examination revealed a female of approximately her stated who was of short stature and considerably over-nourished. She stated that she was five feet, three inches tall and weighed 160 pounds. She arose from the sitting position with the *aid* of her hands but 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 were no areas of localized tenderness to palpation. There was a full range of cervical flexion, extension, lateral bending and lateral rotation. Examination of the thoracic spine revealed increase in the thoracic kyphosis. There was no evidence of spasm or localized tenderness. There was a full range of shoulder motion bilaterally, and tests for thoracic outlet syndrome were negative. The neurologic examination of the upper extremities revealed normal deep tendon reflexes, motor power and sensory perception. Tinel's test over the carpal tunnel was negative bilateraily.

Examination of the lumbar spine revealed increase in the lumbar lordosis without evidence of paraspinous spasm. There was tenderness to the slightest of palpation extending from the thoracolumbar area to the sacrum. There was no sciatic notch or sacroiliac tenderness. Forward flexion was restricted such that the fingertips reached the knees, and there was mild restriction of extension and lateral bending. Burns' test was markedly positive. Heel walking and toe walking were performed without evidence of weakness but were accompanied by complaints of low back pain.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally. Paradoxically, supine straight leg raising was restricted to 10 degrees bilaterally and accompanied by low back pain. Lasegue's maneuver decreased this symptom. Further neurologic examination of the lower extremities revealed no measureable cslf atrophy, normal deep tendon reflexes and sensory perception. There was 2 giving way type of weakness of the extensor hallucis longus bilarerally.

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The claimant requested that no *x-rays* be obtained.

The paucity of information Forwarded *to* me includes a discharge summary from Euclid General Hospital which indicates that the claimant was treated at that *facility* between November 2, 1980 and November 21, 1980. The discharge summary includes a history of "prior back injury" but does not specify it's nature. The physical examination is summarized and does not describe specific neurological findings. There is nothing to indicate that the claimant had symptoms or physical findings referable to her right hand.

Based on the information presently available to me, I believe that the claimant was involved in a vehicular accident on October 12, 1980. According to her history, she sustained some injury to her lumbar spine which intensified pre-existing symptoms in this area and her left leg. Accordingly, it would appear that the hospitalization *at* Euclid General Hospital was necessitated by the accident.

At the time of this examination, the claimant continues to be symptomatic with her right hand, low Lack and left leg. There is nothing on physical examination to substantiate her complaints in her upper extremity. The complaints which she has in her back and left leg apparently are similar to those which she had prior to her accident, and although these symptoms are suggestive of nerve root compression, there is nothing on physical examination to substantiate these complaints. In fact, the many paradoxical physical findings noted on examination indicates that the claimant is exaggerating. Therefore, I do not believe that "future disc surgery" *is* indicated. I am unable to "determine the major extent of her pre-existing back problems as it relates to her accident of October 12, 1980."

Very truly yours,

DBBrooks M.D.

Dennis B. Brooks, M.D.

DBB/gr