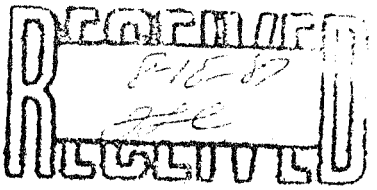

ROBERT D. ZAAS, M.D.
DENNIS B. BROOKS, M.D.
INC.

ORTHOPAEDIC SURGERY

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

#524

August 10, 1987

Mr. Harry Sigmier
Attorney at Law
25th Floor - Terminal Tower
Cleveland, Ohio 44113-2241

Re: Terry M. Johnson
File No. 1039-5574

Dear Mr. Sigmier:

Terry Johnson was examined on August 10, 1987 regarding an accident which occurred on June 7, 1986. This 29-year-old female informed me that she was injured on approximately June 6, 1986 when she was driving a car which was moving when it was involved in a collision with a second car. She indicated that the front end of her car was damaged. She had been wearing seat belts at the time of the accident. She recalled that she struck the windshield, did not not become unconcious, but was "in shock." She went: to Lakewood Hospital where she was examined, treated, and released.

The following day, she "hurt all over." She indicated "I'm sure I had a concussion. I was real drowsy."

Approximately two days after the accident, she came under the care of Dr. Brian Miller who treated her with ultrasound to her "low back and the cervical area." She received "daily" treatments. On July 5, 1985, she noted that she "couldn't stand." She went to St. John Hospital where she was examined, treated, and released. She was told that she had a "lumbar strain." She recalled that she was unable to walk because of back pain.

She returned to Dr. Miller for further treatment and was referred to Dr. Eltomey, "the neurosurgeon." He referred her to Fairview General Hospital for a CT-scan which demonstrated a "herniated disc." Ms. Johnson indicated that at that time she had pain which radiated from her right buttock into her right foot, "with severity." She had had some prior leg pain, but it was not as severe. Dr. Eltomey suggested that she continue with her ultrasound and exercises.

She returned to Dr. Miller and received additional ultrasound approximately every other day until October or November. She then received treatment approximately once a week.

August 10, 1987

Mr. Harry Sigmier
Re: Terry M. Johnson
File No. 1039-5574

During 1987, she was examined by Dr. Miller approximately once a month. She received treatment at intervals varying from two times a week to every two weeks. Her treatment depended on her symptoms. She was last examined by Dr. Miller approximately a week before this examination.

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

At the time of this examination, Ms. Johnson indicated "I'm O.K." She was specifically asked if she had any pain in her low back or legs, and she indicated that she did not. She volunteered that her symptoms "gradually started to get better. By September 1986, it really subsided." She then indicated that she would experience low back pain when she sat for longer than three hours or when she walked for more than ten to fifteen blocks. Coughing, sneezing, and bowel movements produced no leg radiation.

Her past medical history indicated no symptoms referable to her back prior to the accident. She had sustained no new injuries.

Physical examination revealed a female of approximately her stated age who was of short stature and considerably overweight. She indicated that her height was 5 feet 3 inches and her weight, 180 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 lumbosacral spine revealed increase in her lumbar lordosis without evidence of paraspinous spasm. There were no areas of localized tenderness with palpation in the lumbosacral area, sacroiliac joints, or sciatic notches. Forward flexion was accomplished such that the fingertips reached the mid tibias. When asked to bend forward and touch her toes, she indicated "I know I can't." Extension and lateral bending were performed normally. Heel walking and toe walking were performed without evidence of weakness or of pain, Burns' test was moderately positive.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally. Supine straight leg raising was restricted to 60 degrees on the right and accompanied by complaints of "the whole thing" (leg) hurts. Supine straight leg raising could be accomplished to 90 degrees on the left. Lasegue's maneuver was negative. Further neurological examination of the lower extremities revealed symmetrically active deep tendon reflexes, normal motor power, and normal sensory perception.

Radiographs of the lumbosacral spine and pelvis revealed no evidence of fracture or dislocation. There was narrowing of the lumbosacral interspace.

August 10, 1987

Mr. Harry Sigmier
Re: Terry M. Johnson
File No. 1039-5574

Page three.

I have reviewed the material which you forwarded and note that Ms. Johnson was treated in the Emergency Room of Lakewood Hospital on June 7, 1986. The record is somewhat difficult to decipher. The diagnosis of the examining physician was "Contusion L. upper arm. Pinpoint puncture R. heel." I am unable to identify any symptoms or physical findings referable to the low back.

Records from St. John Hospital indicate that Ms. Johnson was treated in the Emergency Room on July 8, 1986. At that time, a month after the accident, the patient was "[i]n NAD." The examining physician noted "Tenderness - LS junction. No NV ." His impression was "Low back muscle spasms." Radiographs of the lumbosacral spine were obtained and interpreted by the radiologist as demonstrating "the intervertebral disc spaces are well maintained." (I would be willing to review those radiographs and compare them with the ones at the time of this examination.)

Dr. Miller's office records describe his treatment of Ms. Johnson between June 9, 1986 and February 28, 1987. At the time of the initial examination, two days after the accident! the patient had a multitude of symptoms. Although she had findings referable to her head, neck, low back, abdomen, left arm, and left knee, there are no abnormal neurological findings. The basis for Dr. Miller's diagnosis of "Concussion" is unclear. Although the patient returned to Dr. Miller's office on numerous occasions, there is no record of these symptoms or physical findings which the patient may have had.

In his letter of July 14, 1986, Dr. Miller describes the initial examination and indicates that the patient "returned to the office nine more times for evaluation and therapy to her cervical and lumbosacral spine." He does not indicate the results of those evaluations. He does describe the evaluation of July 12, 1986 and describes no abnormal neurologic findings. His discussion is noted.

I have reviewed the CT-scan of the lumbar spine obtained on July 29t 1986. At that time, approximately seven weeks after the accident, the scout film of the lumbar spine demonstrates narrowing of the lumbosacral interspace. I would agree with the radiologist that there is a density consistent with a "central bulging of the L5 disc," at the lumbosacral interspace. There is no indentation on the dura nor is there any impingement on either the right or left nerve roots.

In his letter of July 31, 1986, Dr. Eltomey describes his examination of "7/22/86." At that time, approximately six weeks after the accident, he noted that "[t]he neurological examination is essentially normal except for mild sensory changes. Most of the patient's symptoms seem to be well localized to the lower lumbar region and is most likely related to acute lumbar myofascitis."

August 10, 1987

Mr. Harry Sigmier
Re: Terry M. Johnson
File No. 1039-5574

Page four.

In his letter of August 30, 1986, Dr. Miller indicated that his patient "was being treated in this office from severe lumbosacral strain." This letter was written approximately a month after the CT-scan was performed.

In his letter of October 14, 1986, Dr. Miller discusses the CT-scan and his patient's prognosis. He concludes that she "has sustained a herniated intervertebral disc as a result of the accident on June 7, 1986."

Based on this information, I believe that Ms. Johnson was involved in an accident on July 7, 1986 and that she may have sustained a cervical and lumbosacral strain. I do not believe that she sustained a herniated disc. The CAT-scan which was performed within two months of the accident did not demonstrate a herniated disc. Moreover, at the time of this examination, approximately a year after the accident, Ms. Johnson has no symptoms or physical findings suggestive of a herniated disc. She is minimally symptomatic and what symptoms she may have are probably on the basis of her pre-existent degenerative disc disease and her obesity. I am unaware of any material which would indicate that her pre-existent degenerative disc disease was affected by the accident. I believe that she has no permanent disability with respect to the accident of June 7, 1986.

Very truly yours,

DBBrooksMD

Dennis B. Brooks, M.D.

DBB/anm