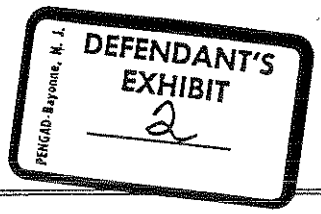
#523



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

ORTHOPAEDIC SURGERY

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

September 1, 1994

Mr. John B. Linamood
Attorney at Law
400 Tuscarawas Street, West
Suite 200 - P.O. Box 20870
Canton, Ohio 44701-0870

Re: Karen Lane
Case No. CV 94 03 0769
File No. 94-3-21

Dear Mr. Linamood:

Karen Lane was examined on September 1, 1994 regarding an accident which occurred on October 6, 1992.

When I initially walked into the examining room Mr. DeChant and Mrs. Laube were present, in addition to Mrs. Lane. Mr. DeChant agreed that he would be present during the history and that Mrs. Laube would be present during the physical examination.

Mrs. Lane, a 43-year-old housewife, informed me that she had been injured on approximately October 7, 1992 when she was driving an automobile which was stopped when it was struck from behind by a "full sized van." She was wearing a lap belt and shoulder harness and went "backward and forward and backward." She demonstrated that she had been "stretched to the max changing the radio station." Following the accident, she was "shook up altogether."

She did not receive any medical treatment for approximately three to four weeks, for she was "waiting to get better." She then came under the care of Dr. Shin, at the recommendation of a friend. At that time, she had pain in her neck and "whole back." She recalled that these symptoms began the morning after the accident. Dr. Shin referred her to Southwest General Hospital for "massage and therapy." She received treatment two to three times a week for approximately four weeks. She was re-examined by Dr. Shin on one or two occasions after the cessation of her therapy. Mrs. Lane indicated that she "quit therapy. It lasted about three hours." She also indicated that Dr. Shin instructed her in exercises. She did not "like exercises. I couldn't understand him."

In approximately June of 1993 she came under the care of Dr. Corn, at the recommendation of a "friend." Dr. Corn referred her to physical therapy. She received heat and massage and was instructed in exercises. The exercises "hurt." She attended therapy two times a week for approximately three weeks. After she completed her therapy, she did not return to Dr. Corn until May of 1994. He referred her for additional therapy. She was last examined by Dr. Corn in August of 1994.

September 1, 1994

Mr. John B. Linamood
Re: Karen Lane
Case No. CV 94 03 0769
File No. 94-3-21

She has not been treated by other physicians, nor has she undergone any specialized diagnostic tests. She indicated that both Dr. Shin and Dr. Corn suggested an MRI. She indicated that "I have claustrophobia" and felt she could not tolerate being in the MRI scanner.

At the time of this examination, Mrs. Lane complained that she experienced a sensation "like a little knife pain every day" in her low back. She would awaken at 6:00 a.m. Her symptoms were increased by "being on my feet and doing normal things; by doing too much housework - bending over the dishwasher or clothes dryer." Her symptoms were decreased by taking a hot shower. She took two tablets of Tylenol Extra Strength two to four times a day. She had taken two on the day of this examination.

She complained that she had pain in her right buttock which radiated down the posterior aspect of her right thigh to her knee. This had been present "since the accident - right after the accident." She would experience this symptom three times a week. Coughing, sneezing, and bowel movements did not produce leg radiation. She had not had any change in her bowel or bladder habits.

She indicated that when she slept for longer than an hour, her back "bothers me." If she "sits too long, my hands fall asleep." When the therapist pressed on her buttocks, it would "hurt too much." Approximately three times a week, her neck would "get stiff."

Her past medical history indicated no symptoms referable to her neck or low back prior to the accident. She had not sustained any new injuries. She had not been involved in any prior or subsequent injuries.

She was presently taking "an anti-inflammatory" once a day as well as Synthroid for a goiter. She had had two caesarean sections.

At the completion of the history, Mr. DeChant explained that Mrs. Lane's father had died after a diagnostic procedure. That explained his client's nervousness.

In general, Mrs. Lane was a poor historian. She was verbose and often answered questions that had not been asked.

Physical examination revealed a female of approximately her stated age who was somewhat overweight. 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.

September 1, 1994

Mr. John B. Linamood
Re: Karen Lane
Case No. CV 94 03 0769
File No. 94-3-21

Examination of her cervical spine revealed normal cervical lordosis without evidence of paracervical or trapezius spasm. There was normal cervical flexion and extension, approximately 50 percent of lateral rotation bilaterally, and approximately 75 percent of lateral bending bilaterally. All six maneuvers were performed in a ratchet like fashion. She complained of pain with extension and complained of stiffness with lateral bending. There was no tenderness with palpation of the spinous processes, paraspinal muscles, or trapezii. Mrs. Lane indicated that my palpation was too light. On very deep palpation, she complained of pain in the right trapezius and cervical spine.

Examination of the shoulders revealed no evidence of deformity, localized swelling, or tenderness. The active range of motion, in degrees, was: abduction - 180, forward flexion - 160, external rotation - 45, internal rotation - to T12, horizontal flexion - complete. At the extremes of forward flexion she complained of low back pain, and at the extremes of external rotation she complained of mid back and low back pain. The peripheral pulses were palpable in three positions.

Examination of the thoracic spine revealed no evidence of deformity or localized tenderness. Neurological examination of the upper extremities revealed symmetrical deep tendon reflexes, normal motor power, and normal sensory perception.

Examination of the lumbosacral spine revealed increase in the lumbar lordosis without evidence of paraspinous spasm. There was tenderness with the lightest of palpation of the midline and both buttocks. Forward flexion was restricted such that the fingertips reached the proximal tibias. Extension and lateral bending were performed completely. She complained of pain on all three maneuvers. Heel walking and toe walking were performed without evidence of weakness. She complained of low back pain with heel walking. She complained of pain with cervical compression and torso rotation bilaterally. In fact, she resisted any attempts at torso rotation. Burns' test was considerably positive as she complained of low back pain while sitting back onto her heels.

Further examination revealed that sitting straight leg raising could be accomplished to 80 degrees on the right and to 90 degrees on the left. The tripod sign was negative. She complained of low back and right buttock pain on the right. While performing plantar flexion of her right ankle, she also complained of low back pain. Supine straight leg raising was restricted to 5 degrees bilaterally and accompanied by low back pain. Lasegue's sign was negative. She allowed approximately 30 degrees of simultaneous hip and knee flexion and indicated this also caused low back pain. Further neurological examination of the lower extremities revealed symmetrical deep tendon reflexes, normal motor power, and normal sensory perception.

September 1, 1994

Mr. John B. Linamood
Re: Karen Lane
Case No. CV 94 03 0769
File No. 94-3-21

Page four.

No radiographs were obtained. I discussed the importance of obtaining radiographs and initially Mrs. Lane indicated that "I don't want all that radiation. A friend of mine died of cancer." I explained that an incomplete series would not allow appropriate evaluation of either her cervical spine or her lumbosacral spine. After a period of time, during which Mrs. Lane questioned the radiology personnel, I informed her that she was being very disruptive and that she could leave without having the radiographs performed. Mrs. Laube indicated that Mrs. Lane had reached this decision.

Dr. Shin's office records cover the period between November 10, 1992 and April 5, 1993. At the time of the initial examination, approximately a month after the accident, Mrs. Lane had symptoms referable to her neck, low back, head, and both hands. There is nothing to indicate that she had any leg radiation. Following a physical examination, Dr. Shin's diagnosis was "Cervical & lumbar strain c̄ myofascitis - MVA." Dr. Shin re-examined Mrs. Lane on three subsequent occasions between December 1, 1992 and February 4, 1993. The patient cancelled her appointment of April 5, 1993.

I have reviewed the very limited views of the cervical spine obtained on November 11, 1992. These demonstrate no evidence of fracture or dislocation. They do demonstrate considerable narrowing of the C5-6 interspace with associated anterior and posterior spurring.

I have also reviewed the very limited views of the lumbar spine obtained on November 11, 1992. These are very poor copies and do not allow adequate assessment of the L5-S1 interspace which the radiologist considered to be slightly narrowed.

The radiologist noted "The conventional views of the cervical and lumbar spine that are ordinarily taken at this institution were not allowed, the patient refused those views, and allowed only these limited views."

In his letter of February 1, 1993, Dr. Shin refers to "the medical report form." I would be willing to review that.

In his letter of December 8, 1993, Dr. Corn describes his examination of June 7, 1993. At that time, eight months after the accident, the patient had symptoms referable to her neck, low back, and "intermittent right leg pain." Physical examination revealed, among other things, "very minimal restriction of motion" of the cervical spine, "approximately 20% restriction of motion" of the lumbar spine, and normal sitting and supine straight leg raising. Dr. Corn's impression was "Chronic residuals of a neck and low back strain or sprain."

September 1, 1994

Mr. John B. Linamood
Re: Karen Lane
Case No. CV 94 03 0769
File No. 94-3-21

Page five.

Based on this information, I believe that Mrs. Lane was involved in a vehicular accident on October 6, 1992. I do not believe that she sustained any significant injuries.

At the time of this examination, Mrs. Lane has complaints referable to her low back, right leg, and neck. There is nothing on physical examination to substantiate these complaints. In fact, the manner in which she gives her history and her performance during the physical examination indicates that there is considerable emotional overlay present.

I believe that Mrs. Lane's present symptoms are unrelated to the accident of October 6, 1992. I further believe that she has no permanent disability directly attributable to that accident.

My opinions are stated with a reasonable degree of medical certainty.

Very truly yours,

DBBrooks

Dennis B. Brooks, M.D.

DBB/anm