DENNIS B. BROOKS, M.D.
INC.

ORTHOPAEDIC SURGERY

Mt. Sinai Integrated Medical Campus
26900 Cedar Road, Suite 325
Beachwood, Ohio 44122
Phone: (216) 514-4142
Fax: (216) 514-4139

September 5, 1997

Mr. Patrick F. Roche
Davis and Young Co., L.P.A.
1700 Midland Building
101 Prospect Avenue, West
Cleveland, Ohio 44115-1027

Re: [redacted]

Dear Mr. Roche:

[redacted] was examined on September 4, 1997 regarding an accident that occurred on November 6, 1995. The history was obtained and the physical examination was performed in the presence of Ms. Weizel.

This 34 year old female informed me that she was injured on November 7, 1995 when she was the driver of an automobile that was stopped when it was stuck by a second car "head on". She was restrained at the time of the accident, and was not rendered unconscious. She was "not sure if I hit the steering wheel or if the seat belt locked". Following the accident, she experienced pain in her chest. She was taken by ambulance to Allen Memorial Hospital where she was examined, treated and released to her home.

The following day, she was examined by a physician, at the recommendation of her employer. At that time, she was symptomatic with "mainly my chest", The doctor prescribed medication.

Within a week of the accident, she came under the care of Dr. Tan, who had treated other members of her family. Dr. Tan prescribed medication and physical therapy that included "ultrasound and a thing with electrodes". [redacted] received treatment to her chest and left shoulder blade. Initially, she received treatment every other day and, later, treatment one to two times a week.

During 1996, she continued under Dr. Tan's care and was re-examined by her once a week. [redacted] recalled that approximately a week after the accident, she developed "problems with the lower part of my neck". She continued to have neck, chest and "shoulder" symptoms. A chest x-ray was obtained that revealed no abnormalities.

At some point in 1996, [redacted] underwent an MRI of her chest and her neck. The chest MRI "didn't show anything", and the cervical spine MRI revealed that she "had a herniated disc". She recalled that at the time the MRI was obtained, she was experiencing "a bad headache, pressure on my neck, [and] tingling in the fingertips" of her left hand. The left hand symptoms began approximately six months after the accident and involved all of the fingers.

At some point, [redacted] was referred to a neurologist by Dr. Tan. The neurologist prescribed physical therapy, but [redacted] did not receive this treatment, for she "had to get pre-approved". She then returned to Dr. Tan and continued under her treatment during the remainder of 1996.

During 1997, she was examined by Dr. Tan "when I felt I needed to". She was last examined approximately four months prior to this examination.

During 1996, she was also evaluated by Dr. Shine, an orthopaedic surgeon, on one occasion. Dr. Shine "agreed with her diagnosis. There was a damaged ligament in my chest." She was examined by Dr. Shine before the chest MRI was performed.

At the time of this examination, [redacted] complained of symptoms in "the lower part of my neck" on the left side. She indicated that it felt "like a lot of pressure" in that area. She experienced these symptoms "everyday". Her symptoms were increased by working at her computer, by looking down, and by performing "everyday house work". When she looked down, she would become light headed. Her symptoms were decreased by lying flat, and using a heating pad which "helps a little bit".

Her neck symptoms radiated into the left scapular area where she experienced a "throbbing pain, an ache everyday". The same activities increased these symptoms, and the same modalities decreased these symptoms.

[redacted] indicated that she felt a "knot" in the left proximal portion of her chest. There was an associated "aching, burning feeling". She would experience these symptoms at the same time she experienced neck and left scapular symptoms. Thus, they occurred "quite often". They were decreased with the use of a heating pad.

Initially, she indicated that she had no other symptoms referable to the accident of November 6, 1995. She then indicated that her entire left arm felt "heavy" whenever she had neck symptoms. She continued to have a "tingling feeling" in all the fingers of her left hand.

Her past history indicated no neck, left scapula, left upper extremity or chest symptoms prior to the accident of November 6, 1995. She had not been involved in any prior vehicular accidents.

In the past, she had fallen and "hurt my hip". She had not been involved in any subsequent accidents, nor had she sustained any additional injuries.

At the time of the accident of November 6, 1995, she was working as a laboratory technician. She missed approximately one week from work. She was presently working full time.

Her past medical history indicated no long term medical problems. She was not taking any medication. She had not undergone any surgery.

Physical examination revealed a slender female of approximately her stated age who indicated that her height was ***5*** feet, **3** inches and her weight, 115 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 were no areas of localized tenderness with palpation of the spinous processes, paracervical muscles or trapezii. There was normal cervical flexion and extension, normal left lateral rotation, and normal lateral bending bilaterally. There was 50 percent of right lateral rotation. During this maneuver, she experienced pain on the left side of her neck.

Prior to palpating each radial pulse, I asked [redacted] if she was experiencing any hand symptoms. She indicated that her left hand was "tingling" at that time. The radial pulses were palpable with Adson's maneuver and the Military maneuver. The left radial pulse was not palpable during combined shoulder abduction and elbow flexion. She had no increase in her symptoms.

Examination of the shoulders revealed no evidence of atrophy, deformity or localized tenderness. There was a full range of shoulder abduction, forward flexion, external rotation, internal rotation and horizontal flexion. Impingement signs were negative. Shoulder girdle muscle strength was normal.

Examination of the thoracic spine revealed no evidence of deformity, spasm or localized tenderness. There was no scapular winging.

Neurological examination of the upper extremities revealed symmetrically active deep tendon reflexes. Muscle strength and sensory perception was normal. Phalen's sign was negative bilaterally. Hoffman's sign was negative bilaterally. Tinel's sign over each cubital tunnel, and over the right carpal tunnel was negative. Percussion of the left carpal tunnel was accompanied by dysesthesias in the left long and ring fingers. The lower extremity deep tendon reflexes were

2+. Babinski signs were flexor. Grip strength, as measured in this right hand dominant female with the Jamar Dynamometer, at position II was, R/L: 18/14; 18/10; 18/12.

Examination of the chest revealed slight prominence of the anterior aspect of the left chest compared to the right. [redacted] complained that she was "real sore" with palpation of the anterior aspect of the left 4th rib. There was no intercostal tenderness. There was no sternal tenderness, and there was costochondral tenderness.

Radiographs of the cervical spine revealed no evidence of fracture or dislocation. There was narrowing of the C5-6 interspace with bilateral neural foraminal narrowing at that level.

Radiographs of the chest and left ribs revealed no evidence of fracture or other deformity.

I have not received the Emergency Room records from Allen Memorial Hospital, or the actual radiographs that were obtained on November 6, 1995. Radiographs of the cervical spine obtained on November 6, 1995 were interpreted by the radiologist as demonstrating "Loss of cervical lordosis. Mild disc degeneration at C5-6. No fracture or dislocation." Radiographs of the chest were "[n]ormal".

Dr. Tan's records cover the period between November 10, 1995 and May 19, 1997. At the time of the initial examination, four days after the accident of November 6, 1995, [redacted] had thigh, upper back, neck and anterior chest symptoms. After performing a physical examination, Dr. Tan made the diagnoses, "S/S thoracic . S/S lumbar. S/S cervical. Costochondritis." She treated her with osteopathic manipulation and medication. Thereafter, she treated [redacted] on a frequent basis. By November 20, 1995, [redacted] had normal motion of her cervical and lumbosacral spine, and continued left chest symptoms. She continued to receive frequent treatment. On January 8, 1996, her chest burning was "gone". On January 22, 1996, "Pt acknowledge that she will only need OMT in thoracic probably on a monthly basis now." On February 5, 1996, she reported chest symptoms. Dr. Tan indicated that she prepared a "medical report" on that date (I would be willing to review that report). Thereafter, the patient received treatment at varying intervals. On September 16, 1995, ten months after the accident of November 6, 1995, for the first time, the patient reported left shoulder numbness. Dr. Tan noted "slight weakness in grasp left ann". She ordered an MRI of the cervical and thoracic spine.

After reviewing the results of the MRI that was obtained on September 19, 1996, Dr. Tan treated [redacted] with "ultrasound, EMS". This treatment was provided at varying intervals for the next eight months. On May 19, 1997, the patient complained of "pain in upper shoulder". Although Dr. Tan's records describe the extensive treatment that she provided for 18 months, her records rarely contain the results of any physical examination that she may have performed.

I have reviewed the MRI of the cervical spine obtained on September 19, 1996. At the C5-6 interspace, there is disc space narrowing and a posterior disc osteophyte complex. This is not causing nerve root compression.

I have reviewed the MRI of the thoracic spine obtained on September 19, 1996 and note that it is normal.

Dr. Shine's records indicate that he examined [redacted] on May 15, 1996, six months after the accident. He noted that the patient "had no radiation into the arms and no neck pain", and that she had "pain in the sternum...". After performing a physical examination, his impression was "persistent costochondritis".

Dr. Timperman's records indicate that he examined [redacted] on March 27, 1997, 16 months after the accident of November 6, 1995. At that time, [redacted] had head, neck, left upper extremity and left chest symptoms. Dr. Timperman reviewed the results of her various diagnostic studies and performed a physical examination. He noted, among other things, "There was indeed no pathology in the cervical spine...a prominence over the upper anterior left chest, which I believe is reflective of the patient's normal anatomy". His impression was "Neck pain, headaches, and left upper extremity discomfort of uncertain etiology."

Dr. Coates' records describe the treatment that he provided to [redacted] during 1991. The patient had fallen and injured her low back and right hip.

On October 14, 1991, Dr. Palekar evaluated [redacted] for her right hip complaints.

Based on this information, I believe that [redacted] was involved in a vehicular accident on November 6, 1995 and that she sustained a cervical strain and a chest contusion. These injuries required treatment in the immediate post-accident period. I do not believe that they necessitated the extensive osteopathic treatment that she received for approximately one and one-half years.

I do not believe that [redacted] sustained an injury to the *C5-6* intervertebral disc as a result of the accident of November 6, 1995. Had she done so, her symptoms and physical findings in the immediate post-accident period would have been different than those reflected in the records that I have reviewed. The findings noted on the September 19, 1996 MRI are a further manifestation of the intervertebral disc degeneration that was demonstrated on the plain radiographs obtained on the day of the accident. There is nothing in the material that I have reviewed that indicates that the pre-existing cervical spondylosis was affected by the accident of November 6, 1995.

At the time of this examination, almost two years after the accident, [redacted] has neck, left arm and chest complaints. Her physical examination demonstrates that she has completely recovered from the injuries that she sustained on November 6, 1995.

I believe that [redacted] has no permanent disability directly attributable to the accident of November 6, 1995.

My opinions are based on a reasonable degree of medical certainty.

Very Truly Yours,

DBBrooks

Dennis B. Brooks, M.D.

DBB/blf