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ORTHOPAEDIC SURGERY

#514

December 14, 1987

Mr. John S. Rea
Attorney at Law
815 Superior Avenue, N.E.
Cleveland, Ohio 44114

Re: Marianne James
File No. 1700-6272

Dear Mr. Rea:

Marianne James was examined on December 14, 1987 regarding an accident which occurred on September 13, 1985. This 33-year-old female informed me, in the presence of Ms. Lenahan, that she had been injured on September 13, 1985 when she was sleeping on a couch in her living room. At that point, a car "drove through the house. I was thrown from the couch to the dining room." Mrs. James indicated that the car exited from the side of the house, and "everything came down in front of the house." She was aware of pain in her left anklet left hipt left shoulder, and neck. She was taken to Lakewood Hospital where she was examined, treated, and released with "a cervical collar and medication."

Three days after the accident, she came under the care of Dr. Kay, at the suggestion of a relatives. He treated her with "ultrasoundt hot packs, and a TENS" approximately three times a week until January of 1986. She was re-examined by Dr. Kay approximately once a week.

In January of 1986, Mrs. James came under the care of Dr. Corn. He referred her to Mr. McCoy who treated Mrs. James with "cervical traction and hot packs and ultrasound." She received this treatment approximately two times a week until approximately June of 1986. She was re-examined by Dr. Corn "periodically."

Thereafter, she continued to use her TENS and to apply "hot packs" and perform exercises.

In January 1987, she resumed her physical therapy and received treatment two times a week for approximately two months. She was re-examined by Dr. Corn in June of 1987 and August of 1987.

Mrs. James has not been examined or treated by other physicians nor has she been hospitalized.

At the time of this examination, Mrs. James indicated that she had a "headache." She pointed to the posterior aspect of her cervical spine in the area of the occiput. Her headaches were "sporadic," although she could experience "two to three a day." There were no particular activities which caused the headaches. There was no arm radiation.

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Mrs. James was also symptomatic with respect to her low back. She indicated that after "sitting for a couple of hours" as well as bending over and scrubbing floors, she would experience a "bad toothache" in her low back. By moving around or having her back massaged, her symptoms would decrease. Her back pain was present "almost every day." There was no associated leg radiation.

Mrs. James had no other symptoms referable to the accident under discussion. She was presently taking Extra Strength Tylenol twice a day. She had taken none on the day of this examination.

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

Prior to the accident, she had worked as a secretary. Following the accident, she was away from work for nine or ten months. She then returned to work on a part-time basis, for approximately 12 weeks. She began full-time work in the mid part of 1986.

Physical examination, performed in Ms. Lenahan's presence, revealed a female of approximately her stated age who was of average proportions. She indicated that her height was 5 feet 5 inches and her weight, approximately 135 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 no tenderness with palpation of the occiput, paracervical muscles, cervical spine, or either trapezius. There was a full range of cervical flexion, extension, and lateral bending. There was approximately 25 percent limitation of lateral rotation bilaterally. Lateral rotation and lateral bending were performed in a ratchet like fashion. Neurologic examination of the upper extremities revealed normal deep tendon reflexes) motor power, and sensory perception.

Examination of the lumbosacral spine revealed normal lumbar lordosis without evidence of paraspinous spasm. There were no areas of tenderness with palpation of the lumbosacral spine, paraspinal muscles, sacroiliac joints, or sciatic notches. Forward flexion was accomplished such that the fingertips reached the toes.' Extension and lateral bending were performed completely. Heel walking and toe walking were performed without evidence of weakness or of pain.

Further examination revealed that sitting straight leg raising could be accomplished to the horizontal bilaterally. The bowstring test was egative. Supine straight leg raising could be accomplished to 90 rees bilaterally. Lasegue's test was negative. Further neurologic ination of the lower extremities revealed symmetrically hyperactive tendon reflexes, normal motor power, and normal sensory perception- i signs were negative.

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Radiographs of the cervical spine revealed no evidence of fracture, dislocation, or degenerative change.

Radiographs of the lumbosacral spine and pelvis revealed no evidence of fracture, dislocation, or degenerative change.

I have reviewed the material which you forwarded and note that Mrs. James was treated in the Emergency Room of Lakewood Hospital on September 13, 1985. At that time, she gave a history that she was "thrown to the floor - No LOC." The impression of the examining physician was "Acute Cervical Strain & Multiple Contusions." Radiographs of the cervical spine, pelvis and sacrum, and left ankle were "normal."

In his letter of January 23, 1986, Dr. Kay summarizes his treatment of Mrs. James which began on September 17, 1985. At that time, four days after the accident, she had complaints of headaches and complaints and physical findings referable to her cervical spine, left shoulder, thoracolumbar spine, and left ankle. Dr. Kay's "diagnosis of contusion and sprain to the cervical and dorsolumbar spine, contusion and sprain to the left shoulder and left ankle" are consistent with these symptoms and physical findings. 'His diagnosis of "a mild concussion" is not. Although Dr. Kay's fee bill indicates that he re-examined Mrs. James on five occasions before his final examination of January 17, 1986, he does not describe the physical findings which may have been present on those occasions and which may have necessitated the extensive physical therapy between September 17, 1985 and January 17, 1986, At the time of the examination of January 17, 1986, Mrs. James had symptoms and physical findings with respect: to her spine and left shoulder.

In his letter of October 7t 1986, Dr. Corn describes his examinations of January 2, 1986 and September 29, 1986. At the time of the initial examination, approximately four months after the accident, Mrs. James was symptomatic with respect to her cervical and lumbosacral spine. Dr. Corn's diagnosis of "sprain of the cervical and lumbosacral spines with diffuse cervicothoracic and lumbosacral myofascitis" is consistent with his patient's symptoms and physical findings. On the second examination, nine months after the accident, the patient was "doing quite well. There was a very minimal restriction of motion of her cervical spine, less than 10% of predicted normal. There was no pain. Her low back pain was totally eliminated and she examined perfectly normally."

In his letter of June 24, 1987, Dr. Corn describes his examination of June 18, 1987. He learned that Mrs. James had been "doing fairly well until approximately January of 1987." The physical examination of June 18, 1987 "[a]s compared to the last examination, on September 29t 1986, there was approximately the same degree of restriction only there was no pain."

Based on this information, I believe that Mrs. James was involved in an accident on September 13, 1985 and that she sustained a cervical

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dorsolumbar strain and contusions to her left shoulder and left ankle.. These injuries may have necessitated some treatment in the immediate post-accident period.

At the time of this examination, more than two years after the accident, Mrs. James has symptoms referable to her cervical and lumbosacral spine. Although she may have the symptoms which she describes, there is nothing on physical or radiographic examination to substantiate her complaints or to indicate that she has any permanent disability directly attributable to the accident of September 13, 1985.

Very truly yours,

DBBrooks

Dennis B. Brooks, M.D.

DBB/anm