Highland
Musculo-Skeletal
Associates, Inc.

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Orthopaedic Surgeons

April 19, 1997

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1520 Standard Building
1370 Ontario Street
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RE: Tamara Hausen
Case No. 302520 (Cuyahoga County)
File No. 3375

Dear Ms. Siskovic:

I evaluated the above plaintiff in my office on April 17, 1997 in reference to residuals of injury sustained in a motor vehicular accident which occurred on February 2, 1994. She was not accompanied by any individual at the time of this evaluation.

She presented with a history of being a front seat passenger in a motor vehicle that was operated by her boyfriend, and no fiance, Benjamin Stachowiak. The vehicle was described as a 1984 Chevrolet Cavalier in the vicinity of Euclid Avenue and Richmond Road, heading in a south bound direction. Her sister was a rear seat passenger side occupant of the vehicle as well.

As they were proceedmg through the intersection in a south bound direction, a car which north bound essentially turned into the front end of their car. There was, according to the Oho Traffic Crash Report, primarily front end damage. At the moment of impact she was thrown forward with seat belt injuring her left shoulder and sternal area. She apparently bit through her lower lip with her teeth and some bottom

front teeth were loose. She also struck her right knee on the dashboard along the medial aspect. This became bruised and swollen rather quickly.

She was conveyed by ambulance with full protection to the Meridia Euclid Hospital Emergency Room. At the emergency room she had the appropriate x-rays and evaluation. A superficial abrasion was noted along the medial aspect of her right knee. X-rays of the sternum failed to reveal fracture. Neck and chest x-rays were normal as well. The right knee films were normal with no effusion present and no signs of fractures or dislocations. She was essentially treated and released.

She was subsequently referred to Dr. Louis Maggiore by her attorney for conservative management of her soft tissue injuries. She was started on a "comprehensive conservative regimen"' including some heat and ice type treatments, as well as some analgesics. An MRI scan was performed of her right knee because of ongoing symptoms. She was subsequently referred to Dr. Robert Anschuetz, an orthopaedic surgeon. Again, the variety of treatments and therapeutic measures were attempted. The MRI scan failed to show any interarticular pathology. On the basis of her failure to improve ultimately she underwent a diagnostic arthroscopy performed at the Meridia Hillcrest Hospital on May 25, 1994. Preoperatively the physician felt there would be a meniscal tear by the interarticular anatomy was essentially normal with the exception of some "torn tissue" overlying the front of the meniscus. This was removed and essentially this was the only abnormality noted.

Postoperatively she seemed to have done fairly well. There was some relief of her pain which reoccurred to some degree when she resumed her preoperative routine. She had off and on symptoms with standing and walking for long periods of time. Her condition has stabilized and she has not had any medical care since early 1995. She has no residual chest complaints.

EMPLOYMENT HISTORY: At the time of the accident she was a student at Cleveland State University. She did not lose any substantial time from her part-time

job at a local McDonald's Restaurant. She does lose three days out cf **work** after her surgery. Her work was modified to some degree so she could sit for a longer period of time. She is currently employed as a teacher's aide at a Montessori pre-school in Willoughby, Ohio.

CURRENT CONDITION: She is presently on no medications. She is working on a full time basis. She does have some ongoing symptomatology.

With prolonged standing and walking she occasionally has a throbbing and aching **pain.** This is on a very intermittent basis with prolonged activity. Most of the discomfort is around the anterior medial patella portal. She has no residual chest complaints. Her lower loose teeth were booded by her family dentist and these healed without consequence. She is fully active and does not restrict her activity in anyway, shape or form.

PAST MEDICAL HISTORY failed to reveal previous knee or chest trauma. She did fall off of a piece of playground equipment and fractured her skull when she was five years old. She did recover from this quite well.

PHYSICAL EXAMINATION revealed a very pleasant 23 year old female who appeared in no acute distress. Her gait pattern was normal. She was able to arise from a sitting position without difficulty. Ascending arid descending the examining table was performed in a normal fashion.

Examination of her cervical spine revealed a full range of motion in forward flexion, extension, lateral bending and rotation. Protraction, retraction, and elevation of the scapulae was performed normally. There was a full range of motion of both shoulders, elbows, wrists and small joints of the hand. Neurological examination of both upper extremities was normal. There was no objective signs of injury. There was no residual chest complaints.

Examination of her left knee revealed three well-healed arthroscopic incisions. Other than the incisions, she had a completely normal examination. There was no effusion noted. A full range of motion from 0 to 140 degrees of flexion. Her medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no rotational instability noted. Patellofemoral examination was normal. No atrophy was detected in either lower extremities.

IMPRESSION: Resolved contusions to the chest and left knee. Resolved dental injury.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. The records included the Ohio Traffic Crash Report, records from Meridia Euclid Hospital and Meridia Hillcrest Hospital, records from the MRI Center in Willoughby Hills, as well as her two physicians, Dr. Maggiore and Dr. Anschuetz.

After careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning her ongoing level of physical impairment.

It is clear both subjectively and objectively the plaintiff has completely recovered from the injuries sustained. Other than the occasional nuisance type of aching discomfort around the inframedial patellar portal she is asymptomatic. She is fully active and has no restrictions. There was never any permanent injury suspected. She has no complaints of any permanent residual abnormality.

Review of the medical records indicate appropriate care provided by Meridia Hillcrest Hospital and Meridia Euclid Hospital, and Dr. Robert Anschuetz. She did have some conservative care and treatment rendered by Dr. Maggiore. It was probably appropriate to proceed with an MRI scan. Because of the failure to improve, the arthroscopic surgery, a minimally invasive surgical technique, is commonty used.

Although a significant abnormality was suspected, on some "torn tissue" was noted. She had good relief with the surgery. In my opinion, the bulk of the care and treatment provided was necessary and appropriate.

In conclusion, this is a **23** year old female who, for the most part, is subjectively recovered and has objectively recovered from any soft tissue injuries sustained. The care and treatment was appropriate. She has not had any care or treatment for over two years. She has objectively recovered. No further care or treatment is necessary or appropriate. No permanent injuries were sustained. No pre-existing conditions were permanently aggravated or accelerated. The long term prognosis is quite good.

Sincerely,

Robert C. Corn, M.D., F.A.C.S.

RCC/bn

cc: File