Highland
Musculo-Skeletal
Associates, Inc.

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RE: Michelina Cantalamessa
DOI: 11/9/93
File No. 1974-SF

Dear Mr. Williams:

I evaluated the above plaintiff in my office on October 30, 1995, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 9, 1993. This was a work-related incident involving a motor vehicular accident in which she was the driver and solo occupant. While approaching the intersection of Atlantic and Bonnie Bray in Warren, Ohio. A vehicle apparently came from her left, through a stop sip, and she was unable to stop her vehicle. She was wearing a seat belt. She was wearing a late 'model Cadillac which was her husband's car.

At the moment of impact she was thrown forward and struck her head on part of the interior of the car. She did claim to definitely be unconscious. The first thing she actually remembered was being inside the ambulance. She cannot specifically recall striking any portion of the car.

Initially she was conveyed to the Trumbull Memorial Hospital Emergency Room where she had a series of x-rays and examinations performed. X-rays were taken of her spine and head, as well as including a CT scan. Although she complained of some

pain in her knee, there were no x-rays performed. She was ultimately discharged with a diagnosis of multiple contusions and abrasions with blunt trauma to the head.

Subsequently she came under the care of Dr. James Brodell, an orthopaedic surgeon, who evaluated her initially on November 24, 1993, approximately two weeks after the accident. Most of the pain at that time was on the right side of her head and neck. She was also complaining about pain in the anterior aspect of her right knee. She tended to avoid patellofemoral stressing type of activities such as going up arid down stairs, stooping, squatting or kneeling. Physical examination at that time showed some tenderness throughout the right trapezius and paravertebral area, but there was no spasm or any objective signs of Injury. Concerning her right knee, however, there was a superficial bruise and abrasion over the supralateral aspect with no effusion, and essentially a normal examination. His initial diagnostic impressions were cervical sprain or strain, and osteochondral contusion of the right knee.

He recommended some nonsteroidal anti-inflammatory medications, as well as physical therapy.

Follow-up examination was not performed until May 1, 1995, approximately 18 months after the accident in question. She was still having some difficulty with her right knee with persistent aching pain. X-rays in 1993 were noted to be normal and an MRI scan in January of 1995 showed evidence consistent with a possible tear of the medial meniscus. Physical examination revealed only tenderness dong the medial joint line with no other objective abnormalities. It was felt that she had a torn meniscus and arthroscopic surgery was allegedly discussed.

She was also followed during this time period by Dr. Hyo Kim, a physical medicine and rehabilitation physician, in Warren, Ohio. He treated her with a series of modality treatments including neuroprobe, interferential, stimulation, ultrasound, heat, and therapeutic stretching and strengthening exercises. She seemed to respond well to this with initial subjective and objective improvement.

A second orthopaedic consultation by a Dr. Rah was performed. He reviewed the films, examined her and also recommended surgery on the basis of this slightly abnormal MRI scan and her persistent symptoms.

At the time of this evaluation in October of 1995, she had seen Dr. Brodell in May of that year and had had no other care or treatment performed. Subsequent review of the medical records indicates a visit on January 26, 1996, with increased mechanical symptomatology. Further surgery and rehabilitation was discussed. It was unknown whether she ever went through any surgical procedures.

EMPLOYMENT HISTORY: She is the manager and owner of Enzo's Restaurant in Warren, Ohio. This is a family owned business. She claims to have continuing difficulty standing, walking, and lifting. These do not interfere significantly with her ability to work, but do make the time at work more uncomfortable.

PAST **MEDICAL** HISTORY failed to reveal any previous or subsequent injuries with her knee.

CURRENT SYMPTOMS: At the time of this evaluation she continued to have ongoing pain in her neck and right knee. In reference to her cervical spine she complained of pain primarily at the base of her skull and the muscles intermittently "get real tense." She sometimes has a sensation of "'knots" which she claimed to feel at the time of this evaluation but, as will be discussed below, there was no objective correlation. Most of her discomfort is in the cervicothoracic region and the right trapezius with intermittent headaches. With stress, lifting or carrying, this area usually bothers her. She is right handed and claims to be weaker in her right arm.'

In reference to her right knee, it "'swells every night". She has difficulty fully extending her knee. Prolonged standing and walking seems to bother her. She claims to have some popping around the kneecap area with stair climbing. "It sounds like a cracked knuckle" was her description. When the knee is tired she claims that it gives out or it gives way. The bulk of her discomfort is anteriorly in the region of the patella and **below** the medial joint line. These were not in the specific locations that are routinely compatible with meniscal abnormalities.

PHYSICAL EXAMINATION revealed a pleasant 46 year old female who appeared in minimal distress. She was observed walking in and out of the examining room, and

she walked with a normal gait pattern. There was no **limping** detected. She was able to walk on her heels and toes without difficulty. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally. These simple composite type of movements need multiple muscular elements in the spine, upper and Iower extremities. She performed these objectively in a normal fashion.

Specific examination of her cervical spine revealed a claim of tenderness in the right paraspinal cervical area and right trapezius. There was no objective evidence of spasm, dysmetria, muscular guarding or increased muscle tone. There was noted a full range of motion in forward flexion, extension, side bending and rotation of her cervical spine. Protraction, retraction, and elevation of the scapulae were performed normally. There was a full range of motion of both shoulders in forward flexion, extension, abduction, internal and external rotation. The neck, upper back, and periscapular area appeared to be normal and proportionally developed with no visible atrophy.

Specific examination of her right, compared to her left, upper extremity, showed, as noted, a full range of motion of her shoulders, elbows, wrists, and small joints of the hand. **A** detailed neurological examination including sensory, motor, and reflex testing of both upper extremities was entirely normal objectively. Despite her claim of weakness, circumferential measurements at the axillary, midarm, forearm and wrist level showed approximately 1 cm enlargement of the right arm, clearly indicating normal usage and a right hand dominance.

Examination of her right knee revealed no effusion. She claimed to have tenderness around the patellar area, along the medial aspect, as well as along the proximal medial tibia. The bulk of her pain was below the patellar tendon region although there was some vague complaints of discomfort in the anterior joint line region. Specifically, on objective testing, there was a full range of motion in forward flexion and extension. Her medial and lateral, as well as anterior and posterior ligamental complexes were intact, There was a negative Lachman sign. There was no evidence of rotational instability. Patellofemoral examination was essentially normal. Circumferential measurements of both lower extremities at precise levels, approximately 5 inches

above and 6 inches below the patella, were equal and symmetrical bilaterally. Neurovascular examination of both lower extremities was normal.

IMPRESSION: Subjective residuals of a cervical strain or sprain. Status post contusion of the knee. Abnormal menisci on MRI scan.

DISCUSSION: I have had the opportunity to review a number of records concerning her care and treatment. These included records from the Trumbull Memorial Hospital, Dr. James David Brodell, Dr. Hyo Kim, St. Joseph's Riverside Hospital (physical therapy in December of 1993), Western Reserve Imaging Center which included the results of the MRI scan and the actual x-rays done associated with her emergency room visit. Medical records from her family physician, Dr. Rocco Basciano, were also reviewed.

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.

These opinions are based primarily on the examination which was carried out in late October of 1995. There have been some medical records reviewed that were generated after the time of that evaluation. My opinions on her objective findings were based solely on my examination.

It is fairly well indicated in the medical records that the primary injury was a contusion of the right knee and a probable soft tissue strain or sprain of the cervical spine. There was a head contusion which failed to show any intracranial bleed. Her neck, upper back and shoulder symptoms improved to a great extent with the physical therapy provided. This would be the typical expected result.

I have not had the opportunity to review the actual MRI scan. The findings as noted by both Dr. Rah and Dr. Brodell would be compatible with a probable degenerative meniscal tear. There was some degeneration of both medial and lateral menisci. Her ongoing symptoms; however, seem to be more related to the patellofemoral joint and not to the meniscal area. I do believe, within a reasonable degree of medical certainty,

if these mechanical symptoms persist then an arthroscopic surgery would be appropriate. It is my opinion, based on a reasonable degree of medical certainty, that if this procedure was performed it would be approximately 20 to 25 percent related to the motor vehicular accident in question and 75 to 80 percent related to her ongoing mild degenerative joint disease.

On the basis of my evaluation, the long-term prognosis is favorable. Despite her ongoing subjective complaints of upper extremity weakness there is no evidence, on neurological or orthopaedic examination, of any significant abnormalities. In fact, the dominant right upper extremity appeared to be larger whch would indicate normal usage in a right hand dominant individual. *Also,* despite her long term complaints in her right knee, objectively, the knee examined normally.

It is therefore my opinion that the long-term prognosis is favorable. On the basis of this evaluation, the arthroscopic surgery is not mandatory. If it is performed in the future, it is only to a small extent, related to the alleged soft tissue injury sustained in the form of a contusion. The injury as described would not typically cause meniscal degenerative disease but, more likely than not, damage or injure the femoral condyle. If no condylar damage was noted and only minor degenerative meniscal tears, in my opinion, those findings would not be compatible with the injury as described.

On the basis of this evaluation, no further orthopaedic care or treatment is necessary or appropriate. She has objectively recovered from any soft tissue injuries sustained. The long term prognosis is favorable. If the actual MRI scans become available, or if further information on her present condition is forwarded to me, I will be glad to review these.

Sincerely,

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

RCC/bn

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