Highland
Musculo-Skeleta
Associates, Inc.

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RE: Diane G. Harmon
Case No. 280178
File No. 3391
DOI: 11/30/94

Dear Ms. Siskovic:

I evaluated the above plaintiff in my office on January 20, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on November 30, 1994. Throughout the history and physical she was accompanied by her daughter, Audra.

As you know, the medical history is extremely complex. She has a long-standing history of chronic problems with her low back and neck region. These all started as far back as February 18, 1986. This was a work related injury in which she injured her neck, low back, and shoulder region. This same area was injured on two additional work-related incidences, January 27, 1988 and January 24, 1989.

There were three motor vehicle accidents which essentially, according to the plaintiff, involved the "exact same areas" of her body. These accidents were on November 13, 1992, June 8, 1994, this accident in question, November 30, 1994. She also did recall

a recent motor vehicular accident which was described as a "low velocity **parking** lot accident" in October of 1996.

The history that was presented was that she was still under the care of Dr. John Nickles for her previous neck and back symptoms. She had been treated for many years, as you are aware, for a chronic pain syndrome with repetitive epidural blocks, some of which were inpatient blocks. She was seen as recently as two weeks prior to the November 30, 1994 car accident, still complaining of an "8 to an 8-1/2" level pain, which is moderately severe pain, in both the neck and low back region.

She described the November 30, 1994 accident as a rear end collision. She and her daughter, **Audra,** were in a 1988 Mustang. She was wearing a seat restraint. The accident occurred in the vicinity of Route 306 and Mentor Avenue in Mentor, Ohio. She was heading in a west bound direction when she was rear ended by a Ford Econoline type of van. She stated that her seat belt "locked up" and she was thrown forward and backwards. She again injured her neck and left shoulder region, as well as her low back region.

She stated that she called "911" from her car phone, and police and EMS ultimately came on the scene. She was transported to the Lake West Hospital Emergency Room where she was x-rayed and evaluated. She may have had a pain shot and ultimately she was treated and released. X-rays at that time revealed some mild degenerative spurring in the upper lumbar and lower thoracic area. She was essentially treated and released for "acute exacerbation of cervical/lumbar disc disease secondary to MVA".

Subsequently she returned to the care of Dr. John Nickles, being seen on or about December 2, 1994. Her **pain** level was worse, raising from an "8 to an 8-1/2 to a 9". She also had pain radiating into her upper extremities. Dr. NicMes followed her on a routine basis through the winter and early spring of 1995. There was one emergency room visit at Meridia Hillcrest Hospital on April 12, 1995, with severe back pain. She was also admitted the following month for ENT surgery.

In addition to Dr. NicMes, throughout this time period she was also evaluated by Dr. M. P. Patel. Both of these physicians had seen her both prior and subsequent to the

November 30, 1994 accident. She also resumed physical therapy two to three times a week and had intennittent injections given by Dr. NicMes. Essentially this was the exact same care and treatment that she had prior to the November 30,1994 accident.

EMPLOYMENT HISTORY: She is a high school teacher in family and consumer sciences (Home Economics). She has been employed as a teacher for the past 21 years. There may have been some loss of time related to the November of 1994 accident, but she could not recall.

Throughout the bulk of 1995 she continued with the same type of treatments and the same type of discomfort. The pain eventually was recorded from "8-1/2 to a 10" certainly close to the same range she was prior to the November 30, 1994 accident. Additional blocks were performed in the Spring of 1996 by Dr. Ross and the Pain Management Program at Meridia Suburban Hospital. She has also been followed by the Cleveland Clinic Outpatient Department Pain Management Program. The initial consultation was in February of 1996.

She considers her current physician to be Dr. T. Dews, a physician at the Cleveland Clinic. The most recent injections were trigger point injections in the left side of her neck done around Christmas of 1996. She had previous blocks to her low back in the summer of 1996. These were carried out on a one a week basis for three weeks. There was a repeat MRI scan of her lumbar spine done at the Cleveland Clinic and she believes there was no change. There was certainly no alteration in the care and treatment provided. She has only been seen by the Pain Management people at the Cleveland Clinic and never by any of the spinal specialists.

She did recall this most recent accident in October of 1996. She was evaluated at Meridia Hillcrest Hospital for this and I did review the films taken in the emergency room. These were x-rays of the neck and low back, which essentially showed very mild degenerative changes. There were no traumatic changes whatsoever.

CURRENT MEDICATIONS include Librax for her stomach, Daypro which she takes once a day from The Cleveland Clinic, and a diuretic for "water retention".

As was briefly discussed, past medical history was significant. There were three work related injuries in the 1980's that specifically injured her neck and back. She has had a diagnosis of chronic pain syndrome and her Workers' Comp claim was reactivated in 1992. This included pain in the low back and left leg, left arm, left upper back and neck, as well as numbness in the fingers. This same area was injured in the three motor vehicular accidents of November 13, 1992, June 8, 1994, and November 30, 1994. She freely states that no new areas were injured and only her symptoms were worsened by the November 1994 accident. No additional pathology was ever recorded specifically related to the November 1994 injury.

CURRENT SYMPTOMS: The plaintiff, as you are aware, has ongoing symptoms in the left side neck and occasionally in the left arm, as well as low back and both lower extremities.

Concerning her cervical spine, she complains of pain primarily in the left trapezius area. The pain is always worse on the left side, but occasionally the right side trapezius area. This is the area that was most recently injected in December of 1995. She states that prior to the injections she was at a "7-1/2 to an 8" on a pain scale, and now is at a "4-1/2". There seems to be "radiation" not radicular type of pain that travels from the left trapezius area up to the left side of her neck paraspinal muscles and down into the left deltoid region. She also complains to have an intermittent tightness in this musculature.

Her left arm radiating pain is described as aching, not a numbness, tingling or burning. It seems to be only present when the left upper back and shoulder is at its worst. She also complains of headaches related to radiating discomfort. She has had a number of scans which have been essentially normal in reference to neurocompression abnormality. The plaintiff is right handed.

In reference to her lumbar spine, the bulk of her pain is diffuse aching pain, primarily in the lumbar paraspinal midline region. It is approximately the L3-4 level or at her beltline. She has the aching pain in her low back much more often than the severe pain

in her neck. The last blocks she had received was in September of 1996 prior to her return back to school. The back **pain** seems to be intermittent in nature as well. It is influenced by "quick moves," as well as cold, damp and rainy weather. This is essentially the same area that has bothered her off and on for about 10 years.

Concerning her lower extremities, she complains of a numbness and tingling on an intermittent basis in the **right leg.** This occurs primarily with prolonged standing, prolonged sitting, bending, lifting, carrying or even pushing the grocery cart. Concerning her **left leg,** there is no numbness, just an intermittent "stabbing pain". This again is aggravated with sitting and standing for long periods of time. Occasionally there is stabbing **pain** in her left buttock which seems to be related to activity and weather changes. She does not complain of any weakness in her upper or lower extremities.

PHYSICAL EXAMINATION revealed a somewhat subdued **42** year old female who appeared in no acute distress. She was noted to sit comfortably in a somewhat slouched position on the exam table throughout the history portion of the examination. She did not have any abnormal postural body movements and she looked very comfortable, and in no acute distress. Her gait pattern was normal. She was able to descend the examining table and ambulate normally. She was able to heel and toe walk without difficulty.

Specific examination of her cervical spinal region revealed no true neck pain. There was some tenderness in the left trapezius muscle but no objective signs of abnormality. There was no spasm, dysmetria or muscular guarding, or increased muscle tone in the anterior lateral posterior cervical musculature or in the upper back or periscapular musculature. There was full mobility of the scapulae in protraction, retraction; and elevation. There did not appear to be any atrophy and normal proportional muscle development in the neck and upper back, and shoulder area.

Range of motion of the cervical spine was minimally limited in forward flexion, extension, side bending, and rotation. There was over 90% of her preserved range of motion noted.

Examination of both shoulders revealed no atrophy. There was unrestricted forward flexion, extension, abduction, internal and external rotation noted on active and passive mobility. She did claim to have some discomfort at the extremes of forward flexion and internal rotation of the left shoulder. The elbows, wrists, and small joints of the hand examined normally. A detailed neurological evaluation including sensory, motor, and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities revealed a very slight enlargement of the right forearm as compared to the left. The upper extremities at the axillary, midarm and wrist Ievel were equal and symmetrical bilaterally.

Examination of her lumbar spine revealed no spasm, dysmetria, or muscular guarding. She claimed to have tenderness to deep palpation in the midline paraspinal muscles. There was unrestricted forward flexion being able to bend forward to touch just above her ankle level. There was good reversal of her lumbar lordosis with this maneuver. No spasm, dysmetria or muscular guarding or increased muscle tone was noted. Hyperextension, side bending and rotation were performed normally. Her straight leg raising in the sitting position was performed to 90 degrees bilaterally with a negative Lesague's sign . The supine straight leg raising; however, was limited at about 45 degrees with "back pain". Her leg lengths were equal. There was a full range of motion of both hips and knees. A detailed neurologic evaluation including sensory, motor and reflex testing of both lower extremities was normal. Circumferential measurements of both lower extremities at the upper and lower thigh, and upper and lower calf level, were equal and symmetrical bilaterally.

IMPRESSION: Subjective residuals of a recurrent cervical and lumbosacral strain or sprain. Chronic pain syndrome predating the motor vehicular accident in question. No newly identified anatomical areas or pathology noted specifically related to the November 30, 1994 accident.

DISCUSSION: As you are aware, there were voluminous medical records that were reviewed. These came from a variety of hospital sources including Meridia Hillcrest Hospital, Meridia Suburban, Brentwood Hospital, Cleveland Clinic, Marymount Hospital and Lake Hospital Systems. Extensive records were reviewed from the

Bureau of Workers' Compensation, as well as from a number of her treating physicians. These include Dr. M. P. Patel, Dr. NicMes, University Hospitals OB-GYN, the ENT physicians, as well as records from Drs. Nickles, Tim Gordon, and Dr. Mahejda. She had a number of EMG and nerve conduction studies that were performed by two neurologists, none of which showed any pathology from her neck region. She did have surgery for unrelated carpal tunnel syndrome.

Additional medical records were reviewed including the plaintiff's deposition, complex medical bills, as well as the results from her numerous MRI scans done in response to her subjective complaints.

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.

All of the above medical records were reviewed. The findings over the years have been very well documented and are primarily subjective in nature. There has been very little in the way of objective findings noted by any of her treating physicians. Even the most sensitive testing failed to show any precise traumatic abnormalities. She clearly had a diagnosis of chronic **pain** syndrome and had received multiple injections and blocks, both inpatient and outpatient, **prior** to the November 30, 1994 accident. The same type of treatment, based on her subjective symptoms, was continued after the November 30,1994 accident.

Instead of reviewing each and every group of medical records, this summary has been presented. It is my opinion, based on review of these records, that no new area was injured in the November 30, 1994 accident and no documented worsening of her condition other than some subjective increase in her pain was noted in the medical records. No anatomical abnormalities were noted on her scans. She had received essentially the same treatment she had prior to her November 30, 1994 accident as she did subsequent to the accident.

As stated above in the physical examination, despite her long-term symptoms and multiple injuries, the physical examination was fairly normal. There was no distinct

objective orthopaedic, neurological or neuromuscular abnormalities detected. There were only complaints of discomfort and stiffness, as well as some tenderness, It is my medical opinion, within a reasonable degree of medical certainty, that her current condition is a result of the sum total of all of her injury "experience". On the basis of this evaluation, she has objectively recovered from all of these injuries.

The long-term prognosis for objective abnormalities is good. There was some minor degenerative changes noted in her neck and low back years prior to the November 30, 1994 motor vehicular accident. There was never any worsening of these conditions noted after the November 30, 1994 accident. My review of the medical records did not reveal any permanent aggravation or acceleration of any of her pre-existing conditions. At worst, there was a transient subjective aggravation related to the November 30, 1994 accident.

The care and treatment that she has been receiving over the years has been solely based on her subjective symptoms. She has had a tremendous number of intermuscular and epidural injections. These have had some good results. The need for this treatment and the result of those treatments are solely subjective in nature.

On the basis of this evaluation, she has objectively recovered from any soft tissue injury sustained. There was no permanent injury sustained as a result of the November 30, 1994 accident. Her physical examination is within normal limits for her height, weight, and age. She has objectively recovered from any injuries sustained, As noted above, there was no objective evidence of any permanent aggravation or acceleration of any noted pre-existing condition.

Sincerely,

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

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