Highland
Musculo-Skeletal
Associates, Inc.

Robert C. Corn, M.D., F.A.C.S.
Timothy L. Gordon, M.D.
Orthopaedic Surgeons

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Lynn A. Lazzaro
Attorney at Law
The Superior Building, 21st Floor
815 Superior Avenue, NE
Cleveland, OH 44114-2701

RE: Carol Willen
Case #288355
File #1700-12892

Dear Mr. Lazzaro:

I evaluated Carol Willen in my office on February 6, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on June 29, 1993.

Ms. Willen was a well-documented historian. She presented to me, not only a copy of her written daily log of her pain and symptoms, but also a log of all of her medical appointments. As you are aware, there were long gaps in her medical care and treatment for which she was able to give me a detailed explanation.

She was the driver of a large 1990 Buick station wagon caring two adult colleagues with her on the date of injury. She was in Shaker Heights in the vicinity of Norwood arid Chagrin Boulevard. There was a great deal of construction in the area. She was assisted in directions by a colleague, and proceeded through that intersection with a green light. The driver's side of her vehicle was hit and damaged by an oncoming Chevette which essentially broadside her vehicle.

The impact was in the driver's front and rear door, and the frame was significantly bent; the vehicle was totaled. At the moment of impact she was thrown forward and backwards in a somewhat twisting fashion. There was a contusion to her left hip from the door being forced inward. She had her right arm and body in a somewhat fixed position by the arm rest on the bench-type of front seat. She was moved in a side-to-side direction.

One of her coworker's was able to walk back to her home, pick up the other car, and slie was taken to the University MedNet facility on Lakeshore Boulevard. At that time she underwent an examination and x-rays. No fractures were seen. Diagnostic x-rays were completed both that day and the following day. There was one orthopaedic evaluation by Dr. Matthew Kay, but the remainder of the treatments were by Dr. Norton Winer, a neurologist. Tllis physician first evaluated her on July 9, 1993, arid has been her treating physician since that time.

She saw Dr. Winer on an intermittent basis through the summer and early fall of 1993. An MRI scan was performed, which was normal, of tier cervical spine at MagnaTech. Somatosensory testing was also normal, as was the neurological examination. She did not see Dr. Winer from October of 1993 until September of 1995, a period of approximately 16 months. During this time period she went through a series of physical therapies, August, September and October. of 1993, arid then one visit in April, three in May, and one in June of 1994. This initial physical therapy was conducted at Meridia Hillcrest Hospital. This was for neck traction, MEMS, arid muscle stimulation. She describes the initial type of pain she had in her neck as mostly at the C7 area and below, described as severe neck pains with spasm and "fireworks" in these muscles. This ranged from the base of the neck to the mid-scapular region. There was some low back tenderness, but the low back was not tlie prominent area of problems. She also had intermittent symptoms of a "'cold numbness" in the left upper extremity, but the true paresthesias tliat she complains of at this point in time did not start until January of 1995.

She went through a second series of physical therapy at the Mt. Sinai Integrated Campus, from February of 1995 through July of 1995, for a total of 13 treatments. This included more exercises, neck traction, use of a theraband, as well as home stretching exercises. There was one consultation with Dr. Spano, a thoracic and general surgeon. The idea of a thoracic outlet syndrome was entertained but no further diagnostic studies were done. There was no change in the type of physical therapy performed after that visit in June arid July of 1995. She has had no therapy since that time.

She was followed intermittently by Dr. Winer with, again, some rather large spans of time periods during which she continued on her home treatment without any physician or physical therapy supervision. She also claims that some of the large gaps in time when she received no documented treatment, there were a number of deaths in both hers and her husband's family.

A second motor vehicular accident occurred which she tendered to trivialize. This occurred on May 3, 1995. Slie was stationary at a red light and a "minor" rear-end collision occitrred. This did iiot affect the left side neck paresthesia in any way, shape or form. She had basically anterior and lateral neck pain which seemed to be very short lived.

CURRENT SYMPTOMS: **Ai** tlie time of this evaluation she complains mostly of a poorly defined area of aching pins and needley sensation which she describes as a "dysesthesia". It follows somewhat of a sleeve-type of distribution which can include the upper back, shoulder, scapular region, but radiates down to above the level of the wrist. She was carefidly questioned as to the parts of the arm that bothered her more. She claimed at the time to be more sensitivity about the left ulnar nerve, but again this did not follow any particular dermatomal yatteni. She has a cold sensation in this area as well. This used to be a hot, burning sensation, but has been modified with the medications as will be noted below. She claimed to have a level "5" discomfort at the time of this evaluation. No other diagnostic or therapeutic modalities have been

recommended. She was referred to University's Pain Management Clinic. She has riot been evaluated.

CURRENT MEDICATIONS include Neurotin, a anti-seizure medication. This seems to suppress some of her pain. She has only been on this for a little over a week at a very low dosage. Dr. Winer and she plan to increase this medication. She was on a great deal of inflammatory medications which did not help her subjective neurological discomfort. The Neurotin makes the numbing feel more "cold". It's uncomfortable, but it seems to be greatly preferable to the "hot sensation'' she had prior to the anti-seizure medicine.

PHYSICAL EXAMINATION revealed a pleasant 47 year old female who appeared in no acute distress. Her gait pattern was normal. She was observed to walk in arid out of the examining room normally.

Examination of her cervical spine failed to show any objective abnormalities in the form of spasm, dysmetria or muscular guarding. She claimed to have some tenderness in the upper trapezius muscle due to the fact that she was doing excessive computer work on the day of this evaluation. Range of motion of the cervical spine was performed in an unrestricted fashion. This was noted to be normal in forward flexion, extension, side bending and rotation. What was somewhat surprising is that rotation to the left tended tu subjectively mildly increase her neurological symptoms, as did tilting to the left, not to the right. An Adson type of maneuver did not significantly increase her pain when related to rotation to the left and rotation to the right. It was somewhat similar indicating no acute inflammation in the upper cervical nerve roots or brachial plexus due to "stretching".

The muscular development in the neck, periscapular, and upper back muscles was normal and proportional on her injured left side, as opposed to her dominant right side. Protraction, retraction, and elevation of the scapulae were performed normally. There was a full range of motion of both shoulders, elbows, wrists, and small joints of the hand. Circumferential measurements of both upper extremities at the axillary, midarm,

forearm, or wrist level showed no significant atrophy. The right arm was slightly larger (less than *li2* cm) in the forearm and biceps region, compatible with right side dominance. The ulnar nerve aloiig the medical aspect of the left elbow was somewhat tender to percussion. (There was no bruising noted in this area after the injury.) The balance of the neurologic examination including sensory, motor, and reflex testing was normal. No atrophy was noted in the thenar muscles of the hand.

In summary, despite the long-standing neurological complaints, no objective neurological findings were noted. This would certainly be compatible with the fact that no abnormalities were noted in the neurosensory, as well as EMG and Nerve Conduction Study. The MRI was also reported as normal.

IMPRESSION: Subjective dysesthesia of the left shoulder girdle and left arm following a non-physiological distribution. Tllis was the equivalent of a "stocking glove" distribution, mild sensitivity of left ulnar nerve.

DISCUSSION: I have had the opportunity to review a series of medical records from the University MedNet which included the records from her neurological consultations and the results of the scan **aid** electrodiagnostic studies. There was also a significant amount of records including the patient's own diary and log, as well as repetitive drawings. There were also records from Meridia Hillcrest Hospital that were reviewed. **A** packet of x-rays was also reviewed from University MedNet.

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.

As noted above, her personal documentation, both verbal and written, is in exquisite detail. When one carefidly looks at the pattern, this appears to be <u>at worst</u> residuals of a chronic soft tissue strain or sprain. The complex neurological evaluation and follow-up care, including the multiple x-rays and scans performed, failed to show <u>objective</u> documentation of an ongoing neurological or neurocircular symptomatology.

She was essentially treated over tlie years for essentially a soft tissue injury. Although a neurological lesion was suspected and a subjective loss of strength on evaluation, no specific objective abnormalities were ever noted. It was suspected that she suffered a stretch injury to the left brachial plexus which her neurologist felt was the source of the recurrent pain, numbness, and tingling. There were, however, never any specific objective findings to support her subjective complaints. Carefully reviewing the MedNet records, the only abnormalities were subjective in nature, that is on muscle testing the diminished sensation to pinprick.

The second motor vehicular accident which occurred on May 3, 1995, was somewhat trivialized by tlie patient at the time of tlis evaluation. It was felt by her treating physician that there was probably an acute exacerbation of her neck, upper back, and shoulder discomfort as a result of this 1995 incident. It was also felt by lier physicians that this only subjectively exacerbated her pre-existing symptomatology. Although Dr. Winer describes the "probability" of "permanent nerve damage" these are only subjective in nature in the form of numbness and tingling. There was no objective residual to correspond with tliese complaints.

At the time of my evaluation, as noted above, there was a paucity of objective findings to support her long-term subjective complaints. There was no objective evidence of any muscle weakness. The only abnormality was some irritation of the left ulnar nerve. There was no history of direct trauma or black and blue mark in this area. In summary, the physical examination was essentially normal.

On the basis of this evaluation, the long-term prognosis is favorable. There has been a good response to the medications to date. With a normal diagnostic workup, it is doubtful that any significant further orthopaedic or neurosurgical care would be necessary or appropriate. There has never been a true documentation of a traumatic neurological lesion. On the basis of this evaluation she has objectively recovered. Subjectively, she still continues to have well-documented complaints without any

objective findings. She has objectively recovered from die soft tissue injury sustained. In my opinion, her present level of complaints are due to both the 1993 and 1995 motor vehicular collisions. She has objectively recovered.

Sincerely,

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

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