Highland
Musculo·Skeletal
Associates, Inc.

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

February 18, 1997

John P. Calandra
Attorney at Law
Suite B1
10800 Pearl Road
Cleveland, OH 44136

RE: Donna L. Moore
Case No. 96CV1175 (Lake County)

Dear Mr. Calandra:

I evaluated the above plaintiff in my office on January 16, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on March 7, 1996. The plaintiff was evaluated without legal counsel present.

She presented with a history of being the driver of a Chevrolet Lumina vehicle heading north bound on Route 44 in Lake County. Her cousin was a front seat passenger in the vehicle. They were approaching Route 2 when a truck, coming off of the exit ramp, pulled out suddenly in front of them. She could not stop her car and a front end impact occurred. The momentum of the truck, and the way the car was hit, spun her car in a counterclockwise direction a number of times. She was not wearing a seat belt.

There were a number of bodily impacts that she could recall. She hit her head on the front window, as well as the driver's side window. She also may have struck her face or neck on the steering wheel. She also was thrown forward and backwards. Her knees struck the dashboard, the left worse than the right. There may have been a momentary loss of consciousness.

Immediately after the accident she remembers having severe head **pain.** She was evaluated by Lake County EMS squad who cut her out of the car and conveyed her with full spinal protection to the Lake East Hospital Emergency Room.

Complaints at the time of the emeryency room visit included neck **pain** and left Iower leg pain. There was also a claim that she hit her head. **A** tentative diagnosis was made of a neck sprain and knee pain secondary to a car accident. The urine testing was normal. The did not claim to have any loss of consciousness. Essentially she was treated and released for a soft tissue injury. **A** series of x-rays were performed including chest, cervical spine and left knee, and all of these were totally Within normal limits.

She then followed up under the care of Dr. Frank Sailors in Lake County. He was somewhat concerned about her left ann complaints. Her left arm appeared to be "bluer" than the right arm. Initially he felt she may have had a "crushed artery". This was probably a type of Raynaud's phenomenon. He started her on some heat treatments for her neck, shoulder and back. According to the medical records provided for review, the therapy sessions were very minimal in number.

She has seen a number of physicians including a Dr. Kamanar, a neurologist who did EMG and nerve conduction studies of her left upper extremities. These studies were performed on **April** 19, 1996. Review of these records were entirely within normal limits. She also saw a Dr. Wallace who was affiliated with Lake Hospitals. **A** nerve block was suggested but was declined.

According to the plaintiff, she has not had a great deal of care since that time. There has been multiple visits to the Lake East Emergency Room, the last visit was, in fact, the evening before this exam. She would have an evaluation, receive some medication, and this has essentially been her care to date. The left knee contusion was managed conservatively. She still has some ongoing soft tissue complaints.

EMPLOYMENT HISTORY: She was not working at the time of the accident. She had recently quit her job working third shift as a nurse's assistant. She currently works as a part-time cashier in a local convenient store.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries to her neck, back, or lower extremities. She is a smoker.

CURRENT SYMPTOMS: At the time of this evaluation she was not taking any prescription medications. She still had some ongoing complaints of her neck, left arm, mid scapular region, and low back, as well as in her knees, left greater than right, and left foot.

In reference to her cervical spinal region, she complained of pain and tenderness in the anterior aspect of her neck. This was around her "Adams apple". This was very sensitive to the touch and she felt like something was "stuck" in her throat. It seems to increase and decrease related to nervousness and to direct pressure. She feels this is a more constant type of symptoms.

In reference to the posterior aspect of her neck, this is mostly in the lower third of her cervical spinal region. She complains of an aching pain and stiffness, and a clicking sensation. When the neck muscles get stiff she gets a headache. Cold and damp weather seems to bother her and this seems to worsen with muscular tension. Tilting the head to the left and right seems to relieve this. This symptom is not consistent and seems to vary.

In reference to her left arm, she complains of a constant aching pain that goes anteriorly from the shoulder down to the ring and little finger of the left hand.' She describes this as a constant aching **pain.** Occasionally the left arm is "blue". This was noted when she first came in on a snowy day. In the warmth of the exam room, the color appeared to eventually become normal.

Her mid scapular area is characterized by an aching and "stabbing?' **pain.** It sometimes "catches my breath." This is primarily in the muscles on either side of the spine and does not radiate farther laterally than the medial border of the scapula.

There is a separate distinct area in the low back region, just below the waist level at midline. This is "not as bad". It is also on an intermittent basis and seems to be influenced by repetitively lifting her young three year old child.

In reference to her lower extremities, she complains of an intermittent popping sensation in both of her knees. There was a slight indentation where the left knee was "black and blue" after the accident. She complains of some aching **pain** radiating along the anterior aspect of the left leg down to the foot region. When she plantarflexes her foot she feels a catching sensation on occasion.

PHYSICAL EXAMINATION revealed a pleasant 21 year old female who appeared in no acute distress. Her gait pattern was noted to be normal walking in and out of the exam suite. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally.

Examination of her cervical spine revealed tenderness around the anterior laryngeal area. There was no spasm, dysmetria or muscular guarding only "tenderness". The posterior neck muscles appeared to be well developed. There was some soreness in her neck when she placed her chin on her chest. There was no objective restriction of motion in forward flexion, extension, side bending, and rotation. No spasm, dysmetria or muscular guarding were noted in any of the major neck, upper back or shoulder muscle groups.

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. A full range of motion of both elbows, wrists, and small joints of the hand were noted. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally,

As noted, there was some darker tone to her skin when she first came into the exam room. By the time the physical examination was performed the skin appeared to be of proportional color between her left and right upper extremities.

Examination of her lumbar spine revealed a complaint of "stiffness". She was able to bend forward to touch her mid tibial level with good reversal of her lumbar lordosis. Hyperextension, side bending, and rotation showed minimal limitations of motion. Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. Her leg lengths were equal. A full range of motion of both hips was noted. Neurologic examination of both lower extremities including sensory, motor and reflex testing were normal. Circumferential measurements of both lower extremities at the upper and Iower thigh, and upper and lower calf level, were **equal** and symmetrical bilaterally.

Examination of her knees were essentially normal. There was a small residual indentation that she claims was from the motor vehicular accident. No other objective abnormality was noted in her lower extremity.

IMPRESSION: Subjective residuals of a cervicothoracic and lumbosacral strain or sprain, resolved contusions of both knees, left worse than right. Resolved closed head injury.

DISCUSSION: **A** number of medical records were reviewed. These included the records from the Lake County Hospital Systems, including the emergency room, and nerve conduction studies, and records from Dr. Frank Sailors and Dr. David Wallace. A packet of x-rays were reviewed from the Lake Hospital Systems and Dr. Sailors.

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.

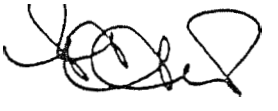
On the basis of this evaluation, she continues with subjective complaints with only very minor stiffness noted in some of her major skeletal muscle groups. She has never

been on a comprehensive physical therapy program or a home stretching maintenance program. This would be the only medical recommendation on the basis of a normal physical examination, but continuing subjective complaints. As noted above, she has not had a great deal of care and treatment for her soft tissue injuries.

Review of the medical records confirms the minimum medical care provided. There was a full evaluation done at the time of the emergency room visit, but no traumatic abnormalities were noted.

At the time of this evaluation she had objectively recovered from any soft tissue injuries sustained. Despite her somewhat lengthy complaints there was no abnormalities noted that would be considered permanent in nature. There was no evidence of any preexisting conditions that were permanently aggravated or accelerated. On the basis of this evaluation, no further care or treatment is necessary or appropriate from a medical standpoint. The only treatment that could be offered at this point would be for an appropriate flexibility and conditioning home exercise program. This would need, at the most, three to four physical therapy sessions. No additional diagnostic studies were indicated on the basis of this evaluation. The long term prognosis is favorable.

Sincerely,



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

RCC/bn

cc: File