Highland
Musculo-Skeletal
Associates, Inc.

Robert C. Corn, M.R., **F.A.C.S.**
Timothy L. Gordon, M.D.
Orthopaedic surgeons

March 23, 1997

D. John Travis
Attorney at Law
Seventh Floor, Bulkley Building
1501 Euclid Avenue
Playhouse Square
Cleveland, OH **441**15

RE: Holly A. Schechter
Case No. 310413
File No. 82976-69059

Dear Mr. Travis:

I evaluated the above plaintiff in my office on March 18, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on June 24, 1994. She was evaluated in my office without legal counsel, friend, or family present.

She was the driver and solo occupant of a Buick Skyhawk vehicle heading in an east bound direction on Shaker Boulevard at the Brainard Circle. This accident occurred approximately five o'clock in the evening. She had stopped waiting to make a right hand turn when a rear end collision occurred. Her vehicle was allegedly forced 45 feet into the intersection.

At the moment of impact she stated she was thrown forward and had her head turned to the right. She allegedly struck the left side of her face and cheek on the steering wheel. There was no 'loss of consciousness.

She was initially conveyed to the Meridia Hillcrest Hospital Emergency Room where the initial care and treatment was rendered. It was felt after diagnostic x-rays that she had "acute contusion in left temporomandibular joint secondary to MVA and a history of chronic TMJ symptoms". According to the plaintiff; however, these symptoms had totally resolved prior to this motor vehicular accident. No significant abnormalities were noted on the temporomandibular joint x-rays and no subluxation or dislocation was noted at the TMJ joint level.

She subsequently returned to Dr. Mark Kyle, her dentist who specializes in TMJ abnormalities. He had initially sent her to Mr. Michael Lepp, a physical therapist, for her prior condition. This time he sent her to the Block Physical Therapy, Inc., where she began having a series of treatments to her neck and upper left shoulder region. She stated that she went through therapy off and on for about a year. She was sent by Dr. Kyle, further recommended by Dr. Stein, her first treating orthopaedic surgeon Dr. Hissa, and lastly by Dr. Dennis Brooks. Her treatments did not change significantly and included a TENS unit and/or electrical stimulation, moist heat, ultrasound, massage, as well as a home exercise program. She was also prescribed a soft cervical collar which she claims to wear all the time that she is in the car and a round cervical pillow that she uses on a daily basis as well.

As noted above, she was also evaluated by Dr. Richard Stein, her internist, who saw her on or about June 25, 1994. He prescribed some medication for her but basically was not involved in her day to day care.

Approximately five months after the accident on November 30, 1994, she was evaluated by Dr. Edwin Hissa, an orthopaedic surgeon. He noted the history of initially neck **pain** and then left upper shoulder pain. Physical examination showed some coracoacromial ligament tenderness about the shoulder, but no significant signs of impingement. She was again referred back to physical therapy. He saw her on a number of occasions, November 30, 1994, December 16, 1994, and January 25, 1995.

Her last treating physician was Dr. Dennis Brooks, an orthopaedic surgeon, on February 7, 1995, approximately eight months after the motor .vehicular accident. The history was presented of two incidences, the motor vehicular collision of June 14,1994 and an elevator incident in which it stopped suddenly and she twisted her low back. It appears that the low back was the primary purpose of Dr. Brooks' evaluation and treatment. Some of the therapy at that point in time was also directed to her lumbar spine as well.

There has been no improvement in her symptoms. She still continues to have left-sided neck and left upper back and periscapular type of pain. There is also some increased jaw pain when she chews. She was also recently seen Dr. Scott Alperin, an oral surgeon, who had an MRI scan performed of her temporomandibular joints. Some surgery was recommended although the details were not discussed. From the time she left Dr. Brooks' care, she has not had any further orthopaedic care or treatment. She is "considering" surgical procedures on her temporomandibular joints.

Also, as stated above, she continues to use certain supports. She uses a neck pillow every night, a mouth plate which helps her bite, both day and night, and a cervical collar while she is in the car. She cannot take anti-inflammatory medications and is only taking Tylenol.

EMPLOYMENT HISTORY: She works three days a week in the office for her husband's general dentistry practice. She claims to have lost some time from work related to this accident.

PAST **MEDICAL** HISTORY revealed only temporomandibular joint problems related to a previous car accident. She claimed never to have specific orthopaedic complaints prior to this collision.

CURRENT SYMPTOMS: As noted above, when she travels in the car is when she has most of her symptoms. She has a numbness and aching in the left neck and paraspinal muscle region. She also has a general feeling that the neck is "stiff". Most

of her discomfort is in the left trapezius muscle. Muscular massage seems to help. The pillow also seems to help to some degree. All of her symptoms are solely on her left side. There are no complaints that could be even vaguely considered radicular in nature. No other significant areas of referred pain were noted.

PHYSICAL EXAMINATION revealed a pleasant 47 year old female who appeared in no acute distress. Her gait pattern was normal. She was noted to sit, stand, and move about the examining room in a normal fashion. She held her head in a normal upright position and demonstrated a normal posture and stance.

Examination of her cervical spine revealed no spasm, dysmetria, muscular guarding or increased muscle tone. She did claim to have some tenderness in the left cervical paraspinal area and the left upper trapezius area. She complained of muscular "knots" but none were detected. She also complains subjectively of stiffness, but absolutely none was detected. There was full, unrestricted, motion of her cervical spine in forward flexion, extension, side bending and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was no decreased muscle tone or muscle bulk in the neck, upper back, or penscapular region. Both shoulders and upper extremities examined normally.

IMPRESSION: Subjective residuals of a cervical strain and/or left temporomandibular joint problem. No objective evidence of ongoing musculoskeletal abnormality. Normal physical examination.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from the Meridia Hillcrest Hospital, Dr. Richard Stein, Dr. Edwin Hissa, and Dr. Dennis Brooks. Records were also reviewed from Block Physical Therapy for her various treatment sessions.

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, there is no orthopaedic abnormality detectable from an objective standpoint. She still complains of neck, upper back and periscapular type of shoulder pain without any objective abnormalities. As noted above, there is a full, unrestricted range of motion of her cervical spine in fonvard flexion, extension, side bending, and rotation. There was no abnormality in scapular movement. Despite her subjective symptoms of a stiff neck and "knots in my muscles," none was detected.

On the basis of this evaluation, in my medical opinion, she has objectively recovered from any soft tissue neck injury sustained. I will not comment on the relationship of her subjective symptoms to. temporomandibular joint dysfunction. She is claiming to have a level "8 or 9" type of pain which was difficult to explain on the basis of a normal physical examination. She continues to have a variety of subjective symptoms without objective abnormalities on orthopaedic examination.

On the basis of this evaluation, she has objectively recovered. No further care or treatment is necessary or appropriate from an orthopaedic standpoint. The long-term prognosis is favorable.

Sincerely,

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

RCC/bn

cc: File

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Timothy L. Gordon, M.D.
Orthopaedic Surgeons

March 23, 1997

William L. Hawley
Attorney at Law
108 Main Avenue, SW
Suite 500
PO Box 1510
Warren, OH 44482-1510

RE: Shirley Peace
File No. 3385-1392

Dear Mr. Hawley:

I evaluated the above plaintiff in my office on March 18, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on June 11. 1994. In addition to the history and physical performed, a complex set of medical records was reviewed. She was evaluated without the presence of friend, family or legal counsel present.

She presented with the history of being the dnver of a Chevy S10 pickup truck with an empty cargo bed, her 26 year old son as a front seat passenger. They were traveling on the Oak Street extension in Youngstown, Ohio. She was on her way home. The street was described as residential in nature. A motor vehicle backed out of the driveway, struck the passenger side of he truck, and forced it across traffic. Despite the fact that the vehicle was "totaled" she was able to drive it home.

She sought no medical care or attention initially. Her first medical contact was with the Youngstown Osteopathic Hospital Emergency Room, being evaluated on June

13,1994. At that time she complained of diffuse spinal discomfort. Multiple x-rays were taken of the cervical, thoracic and lumbosacral spines. As will be discussed below there was a rather extensive history of problems with her low back stemming from a work related injury. The cervical spinal films revealed mild spondylosis and osteoarthritis at the C5-6 level with disc space narrowing. There was also facet disease at the same level. This was ultimately the same level that was operated on in 1995. The lumbar spinal films revealed some spondylosis and arthritis, primarily at the L5-S1 level.

Her discharge diagnosis was multiple contusions and strains or sprains of the cervical, thoracic and lumbosacral area. There was no specific well localized pain in her neck area. She could not recall any particular care other than being referred back to her previous family physician, Dr. Adon Weinberg.

According to the records, Dr. Weinberg was the primary physician following her for her low back condition prior to this motor vehicular accident. He again saw her after the accident on June 14, 1994. He recalled the history presented of the car accident on June 11, 1994. *Primary* abnormality was the low back.

This physician followed her from mid-June through, according to the records, early December of 1994. This was approximately a five to almost six month period of time. Surprisingly, the medical records do not indicate any care or treatment for her cervical spine. The treatments were primarily to her lumbar spine. There was no suspicious symptoms that could be categorized as suspicious for cervical disc trauma nor were there any symptoms recorded that would be even vaguely reminiscent of a herniated cervical disc. Review of Dr. Weinberg's past records do indicate a previous mention of neck, mid back, and low back pain. There is no documentation throughout the balance of 1994 of any care or treatment rendered for her cervical spine.

According to the medical records she came under the care of Dr. James Paris who initially saw her on February 2, 1995. The chief complaint at that time was pain in

the neck, right shoulder, right arm and back. She also complained of headaches, She did tell this physician that she had been involved in a motor vehicular accident. She did not recall any care or treatment. Because of the suspicious nature of her symptoms, it was felt that additional x-rays were necessary. She had a cervical spinal series of x-rays which showed both the narrowing at the C5-6 level and the osteophyte formation. It was felt that she may have a herniated C5-6 disc. An MRI scan was ultimately performed of both her neck and her low back which confirmed the suspicion of a herniated cervical disc. She was seen in consultation by Dr. H. L. Khanna, a neurosurgeon. He reviewed the scan of March 27, 1995, and felt that surgery was necessary. She ultimately had her anterior C5-6 fusion with, according to the medical records, removal of bone spurs, on or about April 11,1995.

Postoperative she has done actually quite well. Her cervical spinal symptoms have totally resolved. She has no further radicular symptoms. She followed with Dr. Khanna for a period time and she believes all of her treatment was completed by 1995. There was no documentation of any treatment from the 1994 accident to February of 1995 and she claims no treatment after 1995.

She is currently on no medications.

EMPLOYMENT HISTORY: She is currently employed as a dishwasher. She was nat employed at the time of the motor vehicular accident.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries to her neck. There was; however, on review of Dr. Weinberg's records, some mention of neck pain in the past.

CURRENT SYMPTOMS: She has occasional pain and stiffness in the posterior aspect of her neck. There is absolutely no arm pain. There is no weakness, numbness or tingling. It was her right arm that was affected. She feels that she is "normal".

PHYSICAL EXAMINATION revealed a pleasant 47 year old female who appeared somewhat older than her stated age. Her gait pattern was normal. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed in a normal fashion.

Examination of her cervical spine revealed a well-healed scar along the anterior aspect compatible with her surgical history . There was full mobility of her cervical spine in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. No atrophy was noted in the neck, upper back, or penscapular musculature. A full range of motion was noted in both shoulders in forward flexion, extension, abduction, internal and external rotation.

Examination of both upper extremities showed the right arm to be slightly larger than the left on circumferential measurements. She is right side dominant. The extremities were measured at the axillary, midarm, forearm and wrist level, and no abnormality in the form of weakness or decreased muscle bulk was noted in her right upper extremities. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

IMPRESSION: By history, mild cervical strain or sprain, thoracolumbar strain or sprain. No objective cervical spinal injury. No neck complaints documented for eight months after the motor vehicular accident. Herniated disc unrelated to motor vehicular accident.

DISCUSSION: I have had the opportunity to review a significant amount of medical records associated with her care and treatment. These included comprehensive records from the Youngstown Osteopathic Hospital, Dr. A. Weinberg, Dr. J. Paris, Midlothin Medical Center, Youngstown Osteopathic x-ray reports, records from Dr. H. L. Khanna, the MRI Cooperative, as well as the extensive records from the Bureau of Workers' Compensation.

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 my opinion, within a reasonable degree of medical certainty, that no herniated disc was sustained in the motor vehicular accident of June of 1994. Typically with herniated discs, there is immediate pain in the neck compatible with a severe soft tissue strain or sprain. Within 72 hours to, at the most, a week's period of time, some radicular symptoms are appreciated by the patient. Had an acute herniated disc occurred directly related to this trauma, then these symptoms would have manifested. As stated above, there is no documented care or treatment for her neck until February of 1995, almost eight months after the motor vehicular accident in question. On a chronological basis, it is my opinion that the disc herniation, surgery, and follow-up care were unrelated to the motor vehicular accident in question.

Specific review of the records also showed that the same disc that was operated on showed long standing degenerative changes at the time of the motor vehicular accident emergency room evaluation. It is my opinion that the disc herniation was unrelated to trauma and probably related to the degenerative process which had been going on for many years. Without any documentation of any neck or radiating pain, one cannot tie the symptoms of her cervical spine and right upper extremity to the motor vehicular accident in question.

The injury sustained, at worst, was a minor cervical and lumbosacral strain or sprain. There is no objective evidence, either radiologically or clinically, of any significant aggravation of a pre-existing condition. There is no evidence that there is any permanent aggravation or acceleration of any pre-existing condition. The medical treatment necessary as a result of this motor vehicular accident, in my opinion, was solely the emergency room visit, and possibly the first three or four weeks of follow-up treatment with Dr. Weinberg. The entire care and treatment,

including the MRI scans, in my opinion, were unrelated to the motor vehicular accident in question.

On the basis of this evaluation, the long-term prognosis is good. There is complete resolution of her symptoms. There is a normal physical examination. She has objectively recovered. On the basis of this evaluation, no further care or treatment is necessary or appropriate.

Sincerely,

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

RCC/bn

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