Highland
Musculo-Skelet
Associates, Inc.

April 3, 1997

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

Judson J. Hawkins
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1660 West 2nd Street
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RE: Donna Filson
Case No. 310276

Dear Mr. Hawkins:

I have had the opportunity of reviewing two large packets of additional medical records in reference to the above plaintiff, Donna Filson. These included extensive records from MetroHealth Medical Center (421 pages) and records from Southwest General Hospital (361 pages).

The only records pertaining to musculoskeletal complaints are those related to the two emergency room visits. The bulk of the records include OB-GYN history, as well as her extensive medical problems including cardiac disease.

The initial impressions expressed are unchanged.

Sincerely,

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

RCC/bn
cc: File

Highland
Musculo-Skeletal
Associates, Inc.

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

February 24, 1997

Judson J. Hawkins
Attorney at Law
Suite 480
Skylight Office Tower
1660 West Second Street
Cleveland, OH 44113-1454

RE: Donna Filson
Case No. 310276
Date of Evaluation: 2/21/97

Dear Mr. Hawkins:

I evaluated the above plaintiff in my office on February 21, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on August 23, 1994. She was the driver with a friend as a front seat passenger. She described her vehicle as a 1981 small Ford car. The accident occurred approximately 4:30 to 5:00 in the afternoon, in the vicinity of Dennison and Fulton Roads on the west side of Cleveland. She stated she was stopped in the line of traffic when a rear end collision occurred. She saw the accident coming and "braced myself'. She was on Dennison at the Fulton intersection. She distinctly remembers three separate impacts on the rear aspect of her car. She claimed to have hit the truck that was in front of her as well. She described the damage as "the back end was folded in half'.

At the moment of impact she stated she was thrown forward and backwards injuring primarily her left shoulder and arm. After the accident she was evaluated initially at the MetroHealth Medical Center Emergency Room complaining primarily of chest pain . She was unable, at the time of this evaluation, to remember any of the details of

2/25/97

her care and treatment. The primary chief complaint, according to the records, was chest pain for 20 minutes after a car accident. She apparently denied hitting the steering wheel. She was recently discharged, approximately two weeks prior to this accident, with a heart attack, according to her story. There was also complaints of dizziness, but review of the records did not reveal any specific musculoskeletal pain. She was evaluated by a cardiologist and, according to the subsequent medical records, signed herself out against medical advice. She, of course, cannot remember any of these incidences.

Her family then conveyed her to the Southwest General Hospital Emergency Room where she complained of a decreased sensation below her neck and an inability to move. A series of x-rays were performed including cervical and lumbar spines. The cervical spine revealed rather diffuse spondylosis (degenerative arthritis and degenerative disc disease) and the lumbar spine also revealed degenerative changes. Because of the neurological complaints, she was admitted to the hospital for 23-hour observation and evaluated by the trauma team. No traumatic abnormalities were noted. She was discharged the following day with a diagnosis of probable neck sprain. It was also brought out in her history about her chronic lumbar spinal condition. The only thing she distinctly remembers is being told that she still had her IV in place when she went to the Southwest General Hospital Emergency Room. There was no indication of that in the Southwest records.

She then claimed to see a number of physicians in the interim before she went to Parma Therapy. She could not recall what happened during this period of time, which was approximately two months. She was initially evaluated at the Parma Therapy Clinic on October 31, 1994, with neck, back, left shoulder and left hip pain. She had a variety of physical therapy sessions through late January of 1995. Medications'were primarily that of muscle relaxants and pain pills.

Because of a failure to improve a MRI scan was performed of her cervical spine at the Regional MRI of Parma on February 2, 1 995. This basically showed only multiple level degenerative disc disease from C4 through C7. There were no traumatic lesions noted.

She apparently had one orthopaedic consultation with Dr. Gerald Yosowitz. This was on March 2, 1995. She has had no significant care or treatment, other than being seen by her family physician, since early 1995.

She is currently on a variety of medications including Ibuprofen, Darvocet and Tylenol with Codeine. She is also on a variety of heart medications. She also, from a medical standpoint, suffers from emphysema and occasionally takes "breathing medicine".

EMPLOYMENT HISTORY: The claimant was not employed at the time of the accident and is currently unemployed.

PAST MEDICAL HISTORY did reveal "a bad back" which she attributes to arthritis for the past 10 years. She also has some "bad discs" in her low back. She has had intermittent treatment for this. She claims to have never had any previous problem with her cervical spine.

Review of the medical records that were provided included records from the Lutheran Hospital. She was seen on November 4, 1995 with a problem of low back pain and leg pain. There was no mention of any neck problems, nor was there any mention of any motor vehicular accidents in the past. Extensive records were also reviewed from the Marymount Hospital. These were somewhat of poor quality. No cervical spinal treatment was sought or given from this institution.

CURRENT SYMPTOMS: In reference to her lumbar spine this, she believed, was transiently aggravated by the car accident. The back condition has reverted to the previous type of low back pain which she has primarily on the left side at the iliac crest level. This is a deep aching pain which she had prior to the motor vehicular accident in question. There was a period of time when it was worse. She had great limitations in reference to her low back prior to the accident in question and mopping, lifting and doing her household chores had been a problem for quite some time.

The bulk of the ongoing symptoms are that of soft tissue, aching pain localized rather specifically in the left trapezius muscle, There is some head movements which seems

to bother this **pain** which is described as a deep aching pain. Occasionally there is a "shooting pain" in the neck, Ieft upper back and shoulder region. There are no true radicular complaints. At sometime in the past she was given a cervical pillow, but because of her breathing condition, she is unable to lay flat and use this device. She does claim that the bulk of her symptoms related specifically to the car accident are in her cervical spinal region.

PHYSICAL EXAMINATION revealed a pleasant 47 year old female who appeared much 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 normally. She was able to **walk** on her heels and toes without difficulty.

Examination of her cervical spine revealed a claim of tenderness, primarily in the left trapezius muscle. This was approximately the level of C7 and below, down to the posterior aspect of the posterior clavicular area, precisely following the trapezius muscle. There was some occasional discomfort in the upper portion of the interscapular area, but this was not noted at the time of this evaluation.

On inspection, specifically there was no spasm, dysmetria or muscular guarding noted. A full range of motion of her cervical spine was noted in forward flexion, extension, side bending, and rotation. There was a claim of tenderness to deep palpation in the left trapezius muscle group only. 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.

A detailed neurologic examination including sensory, motor and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally.

Examination of her lumbar spine revealed no objective signs of injury or chronic muscular irritation. No spasm, dysmetria or muscular guarding, or increased muscle

tone was noted. There was about a 20% limitation of motion of her lumbar spine in forward flexion, extension, side bending, and rotation. This limitation was due solely to "pain". Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. A detailed neurologic examination of both lower extremities was completely within normal limits.

IMPRESSION: Cervical strain or sprain related to the motor vehicular accident in question. Chronic lumbar pain. X-ray and MRI evidence of multiple level degenerative disc disease and arthritis in the cervical spine and similar findings in the lumbar spine.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included the records from the MetroHealth Medical Center, the Southwest Genera1 Hospital, Lutheran Medical Center and the Marymount Hospital. Records were reviewed from Parma Therapy and Beachwood Orthopaedics, as well as the results from the Parma MRI of her cervical spine.

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.

.Review of the medical records clearly did not note any acute musculoskeletal injury at the time of the first emergency room visit. The patient had absolutely no recollection of these events. According to the medical records there was primarily chest pain, dizziness and some central nervous system reaction. There was; however, no sign of trauma. The appropriate testing, x-rays, etc., were performed, and she was also seen by a cardiologist.

According to the Southwest General Hospital records she left Metro against medical advice, and was admitted overnight for observation. At this time, a soft tissue injury was suspected. There was no explanation for the neurological complaints, that is the

left side facial numbness. Retrospectively, this may have been due to a neurological irritation although none was ever documented objectively.

The only care and treatment she has had to date has been conservative. She responded fairly well to a series of medications, as well as physical therapy modality type treatments. There was only one specialty evaluation and it was felt by the orthopaedic surgeons that she had, at worst, a soft tissue strain or sprain related to the accident by her history.

At the time of this evaluation, as noted, she had not had any medical care for almost two years. She does, however, continue to receive medications from her family physician. There are no plans to resume any physical therapy care or treatment.

At the time of this evaluation, it was this examiner's opinion, that, at worst, she sustained a minor soft tissue strain or sprain of the neck and back. This condition recovered objectively in a short period of time. No other substantial injury was noted. There was a significant degree of degenerative disc disease and arthritis noted in the neck, but no objective evidence of any permanent aggravation or acceleration of this condition. She has, in my opinion, objectively recovered from any soft tissue injury sustained. On the basis of this evaluation, no further care or treatment is necessary or appropriate. She has objectively recovered.

Sincerely,

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

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