Highland
Musculo-Skeletal
Associates, Inc.

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

April 9, 1996

Joseph G. Ritzler
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Dixie Singer
DOI: 9/23/93
File #1144/13541-CNI

Dear Mr. Ritzler:

I evaluated the above plaintiff in my office on April 9, 1996, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on September 23, 1993. The patient, at the time of the evaluation, recalled a rather significant history of being the driver and solo occupant of a 1956 Buick Somerset vehicle, heading in a northbound direction past the Wallings Road exit. She was in the right hand lane and a truck, alleging passing her, came in contact and impacted with the driver's rear portion of her vehicle. She was wearing a seat belt. The car went into a spin. She struck the left side of her head, probably against the window. The car apparently went across the freeway into the median and after spinning, landed on top of a V-shaped guardrail.

There was a loss of consciousness and she could not recall any of the details. The first thing that she remembers is "people screaming at me". Police and paramedics were on the scene, and a passerby had pried the door open and pulled her out of the car. Mer making the reports, an ambulance took her to the Parma Hospital Emergency Room where she was initially evaluated.

At the Parma Community Hospital she was evaluated. There was a contusion noted in the left parietal area of her scalp. It was felt after appropriate x-rays that she had an acute paralumbar strain and contusion, acute paracervical strain, right groin strain, secondary to this motor vehicular accident. A series of diagnostic studies, including blood, urine and x-ray studies, were normal. Multiple x-rays done of her chest, skull, cervical and lumbar spine, and pelvis, were negative for acute changes. She was ultimately released, with some medications in the form of pain medicine and muscle relaxants, to the care of her private family doctor, Dr. Larry Hoffman. A comprehensive review of the records show there was initially a complaint of numbness in the right big toe. There was no further description of a neurological complaint.

She followed-up with Dr. Larry Hoffman, approximately two days after the accident, complaining of diffuse neck and back pain. He did review the x-rays that were done. He started her on some physical therapy treatments at his office. This therapy included heat, ultrasound, electrical stimulation, and application of cold packs. Some osteopathic manipulation was performed. The physical therapy seemed to help her symptoms on a temporary basis but the "pain kept coming back". She was also started on a home stretching exercise program.

The next physician who took care of her was Dr. Gerald Seltzer. She had about "14 to 15 visits". This included electrical stimulation, heat, cold and massage therapy. Some medications were prescribed which "made me feel out of it". A low back brace was also prescribed which she used for about six to seven weeks. No medical records were available from Dr. Seltzer.

The next physician to take care of her was a chiropractor, Dr. Michael Masterson. He initially evaluated her after the injury, but did not treat her due to her many areas of soft tissue complaints. She ultimately came back under his care, according to the records, approximately November of 1993. She has been treating with this chiropractor since that time. She was seeing Dr. Masterson periodically over the years for chiropractic manipulation. It seemed to help relieve her neck and upper back "stress" related to her work. She still receives treatments, including manipulations which relieves her neck and upper back pain. At times she has an intennittent

"sensation" in the right arm and right leg which the adjustments completely resolve. He also convinced her place of employment, a Bank One Branch office, to obtain a chair with a lumbar support. She continues to see the chiropractor on an as necessary basis, the last visit was approximately one week prior to this evaluation. She also continues using a home stretching routine, as well as her stationary bicycle.

EMPLOYMENT HISTORY: She, at the time of the accident, was an assistant manager for a Bank One Branch office. She was totally out of work for about three and one-half weeks, and went part time four to five hours a day for about a week and one-half. After that she has been working full-time. She is currently a manager at the Middleburg Heights Branch office.

PAST **MEDICAL** HISTORY failed to reveal any previous spinal injuries of problems. She did not discuss any prior trauma. The medical records indicate that she was seeing Dr. Masterson in April of 1985 for a motor vehicular accident which occurred on March 31, 1985. She was complaining of neck, upper back, arm, and low back pain at that time. There was, according to Dr. Masterson's records, complete resolution of her symptoms by May 13, 1985, about a month and one-half after he initially started seeing her.

CURRENT STATUS: She is currently on no medications. She is employed on a full-time basis. She still has some soft tissue complaints, primarily low back, mid back, and upper back. There is also associated headaches which can be at the base of her skull posteriorly, as well as frontal headaches which are probably related to an ongoing intennittent sinus condition.

In reference to her cervical spine, she complains of an aching pain and throbbing pain which seem to increase with certain movements. The neck sometimes feels "stiff and sore like there are knots in it". The trapezius muscle region, as well as her upper back and the base of her neck, seem to be the most involved. Stress at work, as well as working over a desk or at her computer for long periods of time, seem to aggravate this symptom. There are no complaints radiating into her shoulder or upper extremities.

Her thoracolumbar area has the same type of discomfort, an aching pulling-type of pain, as does her low back at about the iliac crest level. The pain is described as a stiff aching and/or a throbbing pain. She has difficulty with sleeping. Sitting for long periods of time bother this. Housework, especially vacuuming can increase this discomfort. She limits her repetitive bending and lifting and "won't push myself' to avoid having painful episodes. There are no complaints of radicular lower extremity discomfort.

PHYSICAL EXAMINATION revealed a pleasant 51 year old female who appeared somewhat older than her stated age. Her gait pattern was normal. She was able to heel and toe stand without difficulty. Arising from a sitting position was performed normally, as was ascending and descending the examining table.

Examination of her cervical spine revealed no signs of subacute or chronic muscular inflammation in the form of spasm, dysmetria or muscular guarding. There was minimal restriction of motion in forward flexion, extension, side bending, and rotation. Some tenderness was noted in the trapezius and upper back muscles, but no objective findings were noted to correspond with these complaints. Protraction, retraction, and elevation of the scapulae were performed normally. There was no sign of periscapular or upper back muscular atrophy. A full range of motion of both shoulders was noted in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. A detailed neurological examination including sensory, motor, and refles testing of both upper extremities was normal. No atrophy was noted on circumferential measurements at the axillary, midarm, forearm, or wrist level.

Examination of her lumbar spine failed to show any objective signs of chronic inflammation in the form of spasm, dysmetria or muscular guarding. She was able to bend forward with good reversal of her lumbar lordosis, bending to the mid tibia level. Hyperextension, side bending, and rotation was performed with less than 10% restriction of motion, although pain was claimed at the extreme of motion. Her straight leg raising in both the sitting and supine positions were performed to 90° bilaterally. Neurologic examination including sensory, motor and reflex testing of both lower

extremities was normal. No atrophy was noted on circumferential measurements at the mid and upper thigh, or mid calf region. There was no sign of neurological dysfunction.

IMPRESSION: Subjective residuals of a soft tissue strain or sprain of the neck and low back. No evidence of ongoing neurological or musculoskeletal objective findings.

DISCUSSION: I have had the opportunity of reviewing a number of medical records associated with her care and treatment. These include the records from the Parma Community General Hospital, Dr. Larry Hoffman, Dr. Michael Masterson, North Shore Diagnostics and Rehabilitation Center, and the Ohio Traffic Crash report.

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 stated above, this was a fairly significant accident involving property damage. It appears that she had a soft tissue concussion, as well as soft tissue skeletal injuries of her neck, upper 'back, and lower back region. The only care she had was quite conservative. She had simple modality therapy, as well as some stretching exercises, which seemed to gradually resolve the bulk of her symptoms. She was out of work for only three and one-half weeks, and then part-time for two weeks. She has been working full-time since that time. The ongoing chiropractic manipulation was similar to the same treatments she had prior to the motor vehicular accident in question. They seemed to be restricted to simple modalities and chiropractic manipulative therapy.

On the basis of this evaluation she has objectively recovered from any soft tissue injury sustained. As noted, there was a normal physical examination with the exception of her subjective symptoms at the extremes of range of motion. There was no objective evidence of any significant treatable orthopaedic or neuromuscular abnormality. She has, in my opinion, objectively recovered from any soft tissue injury sustained. On the basis of this evaluation the long-term prognosis is favorable. No further orthopaedic

care or treatment is necessary or appropriate for her continuing complaints. The prognosis is favorable.

Sincerely,

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

RCC/bn

cc: File