Highland
Musculo-Skeletal
Associates, Inc.

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RE: Theresa R. Shank
Case #94 CV 113554 (Lorain County)
File #1700-12580

Dear Mr. Roman:

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 March 12, 1994. This accident occurred in the evening at approximately seven or eight o'clock, and she was the driver and solo occupant of a 1958 Cutlass Supreme vehicle. The accident occurred in the vicinity of Second Street and Middle Avenue in Elyria, Ohio. She was heading in a southbound direction. A vehicle was stopped in front of her, the light changed and both she and the vehicle in front of her started moving. At this point she was rear-ended and the force of the impact forced her car into the car in front of her. There was front and rear damage, but the rear impact was worse than the front impact.

At the moment of impact she felt she was thrown forward and backwards, striking her head on the headrest. She did not lose consciousness, although she was somewhat shaken. She had her hands on the steering wheel with her elbows flexed. Her vehicle was drivable. The cars were moved into the Court House parking lot, which was apparently across the street. She subsequently drove to her sister's home and her sister drove her to the hospital. Mer major complaint at that time was headache

She was evaluated at the Elyria Memorial Hospital Emergency Room with primarily neck and head pain. The injury was described as a "MVA approximately 1-2 miles per hour, head jerked into headrest - padded, onset of neck pain 2 minutes later." An examination was performed, as well as x-rays of the cervical spine which were normal. She was discharged with instructions of placing ice and then heat, with follow-up with her family physician. She was to return to the emergency room if she had any further problems.

Subsequently she came under the care of Dr. M. P. Patel, being referred by her attorney. Dr. Patel has been following her intermittently since that time. Initially there were weekly visits for examinations, and a number of medications were tried as well. She was sent for physical therapy for a "few sessions" at the Elyria Memorial Hospital which didn't help to any great extent. The therapy records indicate that she was seen in late March and early April. It appears by the records that she only had two or three physical therapy sessions.

She subsequently was sent to the Advanced Imaging Center at Richmond Heights General Hospital for a series of diagnostic scans. These included a scan of the head, an MRI of the neck and low back, which were interpreted as normal. She recently, less than a week ago, had a second MRI of her lumbar spine done at Regional Diagnostics in Parma. Again, the low back scan was normal.

The treatments continued on a regular basis through November of 1994 and then intermittently after that point in time. She ultimately was out of work approximately five months from this accident, from late March of 1994 through August of 1994. She tried to return to work in a dental office and found this too difficult to work. She has done office work since then. She has been working at her present job for approximately seven to eight months.

She consulted with a number of other individuals as part of the diagnostic workup. She saw Dr. Howard Tucker, a neurologist, on or about April 28, 1994. This was approximately six weeks postop. There was a Tinel's sign noted in the left forearm

and *carpal* tunnel-like complaints in the left arm. This is probably related to an old work incident or accident. It was not felt that these were related to this particular motor vehicular accident. Dr. Tucker recommended that she have some audiological testing which was performed at Comprehensive Assessment Services. Those records were available for review.

CURRENT SYMPTOMS: She still continues to follow with Dr. Patel on an intermittent basis. He has prescribed her Flexeril, a muscle relaxant and Toradol, a mild analgesic which she takes "occasionally". The bulk of her symptoms are in the neck region. Initially after the accident there were some intermittent episodes of dizziness which occurred a few times and precipitated the audiological testing. This completely cleared and she has not had this complaint for a while. She has frequent occipital-type headaches which is described as a "aching pain, not a pounding headache". She uses some stretching techniques, as well as adjusts her posture and this seems to be tolerable. She also complains of a midline lower cervical aching type of **pain,** primarily in the trapezius and upper shoulder blade area. Again this is related to posture, position, and work stress.

In reference to her left arm, she has complaints of intermittent numbness and tingling about both elbows, the right was worse than the left, but the left hand was involved with the mild neurological complaints. She claims to have had no direct trauma. There was no bruising of the hand or forearm noted. She gets a dull aching pain when she attempts to do her hair, reaching and working over her head.

In reference to her low back, she has intermittent aching pain. She also has a vague sensation of "pins and needles" on the sole of the left foot. This does not follow any particular dermatomal pattern. She claimed to have some weakness in her legs after the accident, but this has improved with time. There was apparently a flare-up a number of weeks ago of her back pain and this prompted the second MRI on **April** 6, 1996. This was normal.

PAST MEDICAL HISTORY revealed a previous minor fracture of the left wrist which occurred in 1992. There was no reinjury of the left wrist associated with this accident.

PHYSICAL EXAMINATION revealed a pleasant, cooperative, 22 year old female who appeared in no acute distress. Her gait pattern was normal. She was able to heel and toe walk without difficulty. She appeared to be sitting in a comfortable position during the history portion of the examination. Arising from a sitting position was performed normally, as was ascending and descending the examining table.

Examination of her cervical, thoracic and lumbar spines revealed no objective findings in the form of chronic or subacute muscular irritation. There was no spasm, dysmetria or muscular guarding. Specific examination of her cervical spine revealed the claim of tenderness in the right trapezius muscle. There was no anterior or lateral neck discomfort. There was a full, unrestricted range of 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 a full range of motion of both shoulders in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally, Circumferential measurements of both upper extremities at the axillary, midarm, forearm, or wrist level were equal and symmetrical bilaterally. She is right handed.

The only abnormality noted, which was still somewhat subjective in nature, was a positive Tinel along the distal median nerve in the left hand. There was a positive Phalen's sign at approximately 20 seconds with numbness and tingling in the thumb, index, and middle finger of the left hand. This would be compatible with carpal tunnel syndrome.

Examination of her lumbar spine revealed full flexibility being able to bend fonvard to touch just above her ankle level. Hyperextension, side bending, and rotation were performed normally. Her straight leg raising both in the sitting and supine positions was performed to 90° bilaterally. There was a full range of motion of both hips and

knees. Neurologic examination of both lower extremities was normal. Absolutely no abnormality was uncovered.

IMPRESSION: Subjective residuals of a neck and back strain or sprain. Na evidence of a neurological injury of dysfunction.

DISCUSSION: I have had the opportunity to review a significant amount of medical records associated with her care and treatment. These include records from the Elyria Memorial Hospital, Drs. Howard Tucker, M. P. Patel, and Antonchou. Records from Dr. Raheja (EMG showing carpal tunnel syndrome), the Ohio Bureau of Workers' Compensation records, as well as those from the Tri-City Family Practice (family doctors). Additionally records were reviewed from the Richmond Heights General Hospital, Comprehensive Assessments, Inc., as well as the actual x-rays from Elyria Memorial Hospital, Richmond Heights General Hospital, Grace Hospital, and Advanced Imaging Center.

After careful questioning of the patient's history and physical Imitations, as well as after a careful physical examination and review of extensive records and x-rays, I have come to some conclusions concerning her ongoing level of physical impairment.

In my opinion, at worst, she sustained a minor soft tissue strain or sprain of the neck and low back. Without neurological abnormality or complaint, it is not common to obtain the significant amount of neurodiagnostic testing as was performed. All of the tests performed, including the MRI scans of her neck and low back (x 2) and the neurological evaluation, were entirely within normal limits. The only abnormality detected was a left carpal tunnel syndrome which, in my opinion, is unrelated to this accident. She continued over the years to have a variety of subjective symptoms without any objective findings.

In my opinion, she has objectively recovered from any soft tissue injury sustained. She had virtually a normal physical examination with the exception of the left carpal tunnel findings. On the basis of this evaluation, no further orthopaedic care or treatment is

necessary or appropriate. If her *carpal* tunnel symptoms worsen then a minor surgical procedure can be performed. It is my opinion that this left wrist abnormality is unrelated to this motor vehicular accident in question.

The long-tern prognosis is favorable. She has completely objectively recovered. On review of the medical records I have no clear explanation for the extensive period of time out of work (five months). Soft tissue injuries of this nature typically resolve within six to eight weeks and most individuals return to light-type of work by eight to twelve weeks. I have no orthopaedic explanation for the additional two months out of work.

In summary, there are no objective findings to support her ongoing subjective complaints. The long term prognosis is favorable. No further care or treatment is necessary or appropriate.

Sincerely,

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

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