Highland
Musculo·Skeletal
Associates, Inc.

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

April 20, 1996

Kevin P. Murphy
Attorney at Law
108 Main Avenue, SW
Suite 500, PO Box 1580
Warren, OH 44482-1510

RE: Valerie Stuhldreher
File #4403-113

Dear Mr. Murphy:

I evaluated the above claimant in my office on April 12, 1996, in reference to alleged residuals of injury sustained in a slip and fall which occurred on February 21, 1993. Throughout the history and physical she was accompanied by a friend, Laura Young.

This evaluation was specifically in reference to alleged residuals of injury sustained in a fall on the icy pavement at a Burger King Restaurant on Route #422 in Niles, Ohio. She describes this restaurant as close to the East Wood Mall. It was about lunch time and it was cold and rainy, but getting colder. She specifically said there was no ice and no snow when they entered the restaurant. She was there with her husband and two children, a girl, age four, and a boy, age two. As they were leaving the restaurant she noticed that it was "red icy". .While walking across the brick pavement, her feet went out from under her and she fell backwards, sitting hard on her buttock area and also striking the back of the head on the ground "very hard". She was shaken and "dazed" but there was no loss of consciousness. She seemed to be nauseated at that time.

Her husband assisted her to the car and reported the injury to the manager. She is not certain whether any one else witnessed the fall. Subsequently she was evaluated at the

Trumbull Memorial Hospital Emergency Room where she was evaluated and multiple x-rays were performed. Complaints were made of pain in the head, low back, and right clavicular area. Multiple x-rays were performed, including that of the neck, low back, and skull, all of which were normal. A chest x-ray was also normal. X-rays of the clavicle were normal. She was discharged with a diagnosis of acute cervical and lumbar strain, scalp contusion and contusion of the right clavicle.

Subsequently she came under the care of her family physician, Dr. Robert Eddy, who treated her conservatively for a period of time. He discontinued the cervical collar and sling, and provided her with a series of medications but Advil seemed to work the best. She had physical therapy only one time with him in his office. This consisted of a manipulation for severe headaches. She treated with Dr. Eddy through July and then sought another opinion.

She was then referred to Dr. James Krumpak, III, a chiropractor in Youngstown, Ohio. He saw her initially on November 6, 1993, approximately eight months after the accident. Apparently she had no documented medical care during the summer months of 1993. He tried her on a series of manipulations and repeated the x-rays. Ultrasound, electrical stimulation, and manipulations were performed initially three times a week, then twice a week, and then once a week. She still sees this physician on an as necessary basis. One of the symptoms that she was having was that of some numbness in the left upper extremity and right big toe. For that reason she was referred to Dr. Robert Gilliland, a neurologist, who saw her initially on January 24, 1994, approximately ten months after the accident. He had her go through a series of diagnostic studies including an EEG, evoked cortical response, EMG and nerve conduction studies of all four extremities. *All* of these tests were normal. An MRI scan was performed of her brain and her lumbar spine on February 5, 1994, both of these studies were normal. He followed her for a period of time for essentially a soft tissue injury to her neck and back, and what he also felt was a thoracic outlet syndrome and post traumatic loss of smell. The patient did not complain of any olfactory problems. Despite her long-term subjective complaints, there was absolutely no objective findings on any of these diagnostic tests.

PAST **MEDICAL HISTORY** failed to reveal previous or subsequent injuries to the above described area.

EMPLOYMENT HISTORY: She is currently employed in a secretarial capacity. She has not lost any time from work and no lost wages were reported to me.

CURRENT SYMPTOMS: At the time of this evaluation she still complains of intermittent episodes of pain in the neck and back. The base of the neck tends to "swell" which prompts her to go back to the chiropractor for manipulations. The left side is usually worse than the right side. She also has a diffuse aching **pain** in the trapezius muscles bilaterally. There is intermittent complaint of pain and soreness in the left ann, and difficulty moving the left arm. She uses a heating pad for these episodes. In addition, there is complaint of left ann burning and numbing type **pain** into the index and middle finger of her left hand. As noted below, there were some signs of left *carpal* tunnel syndrome.

Concerning her low back, most of the pain is in the midline paraspinal region below her waistline. She also has some pain radiating into the buttock and coccygeal region on occasion. The right lower extremity gets numb and aching with sitting in certain positions for too long a period of time. She claims that her right big toe is numb all the time.

PHYSICAL EXAMINATION revealed a somewhat heavyset 28 year old female who appeared in no acute distress. 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 heel and toe walk without difficulty. No gross atrophy was noted on evaluation of both lower extremities.

Examination of her cervical spine revealed no spasm, dysmetria, or muscular **guarding** She claimed to have some tenderness in the trapezius muscle, the left side worse than the right, but no objective findings were noted to correspond with these subjective complaints. 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.

Examination of the left hand and wrist revealed a mildly positive Tinel sign at the volar flexion crease. With a Phalen's maneuver, there was numbness felt within 15 seconds indicating mild left carpal tunnel syndrome.

Examination of her lumbar spine again revealed no spasm, dysmetria, or muscular guarding. She was fairly flexible being able to bend forward to touch just above her ankle level. There was good reversal of her lumbar lordosis with this maneuver. Hyperextension, side bending, and rotation were performed without limitation. Her straight leg raising both in the sitting and supine positions were performed to 90° bilaterally. There was a full range of motion of both hips and knees. Neurologic examination of both lower extremities was normal.

IMPRESSION: Subjective residuals of a soft tissue strain and sprain to the neck and low back. Negative extensive diagnostic work-up. No objective residuals of injury.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from St. Elizabeth's Hospital, Trumbull Memorial Hospital, Drs. Eddy, Gilliland, and Krumpak; office notes from Dr. Richard Gentile. Records were also reviewed from the multiple MRI scans and electrical provocative studies.

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 the injury was described, this was essentially a contusion and sprain of the Iow back and neck with a contusion of the head. There was minimal medical care in the form of therapeutic treatments. She did not start any modality treatments until she saw the chiropractor approximately eight months after the accident. The diagnostic workup done by Dr. Gilliland for her suspicious subjective symptoms was essentially normal.

No evidence of thoracic outlet syndrome or nerve root compression was identified. The MRIs were "clean" from any traumatic, developmental, or degenerative process. Essentially she continues to have a variety of subjective symptoms without any objective findings clinically, radiologically, or by electrodiagnostic testing.

At the time of this evaluation she has objectively recovered from any soft tissue injuries sustained. On the basis of this evaluation no further care or treatment is necessary or appropriate. At worst she sustained a minor soft tissue injury to her neck and back. She has never been enrolled in any comprehensive muscular rehabilitation or conditioning program. In my opinion, with appropriate home exercises, the bulk of her remaining subjective symptoms can be eliminated. The clinical carpal tunnel syndrome, in my opinion, is unrelated to the accident in question. She has objectively recovered and the prognosis is favorable.

Sincerely,

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

RCC/bn

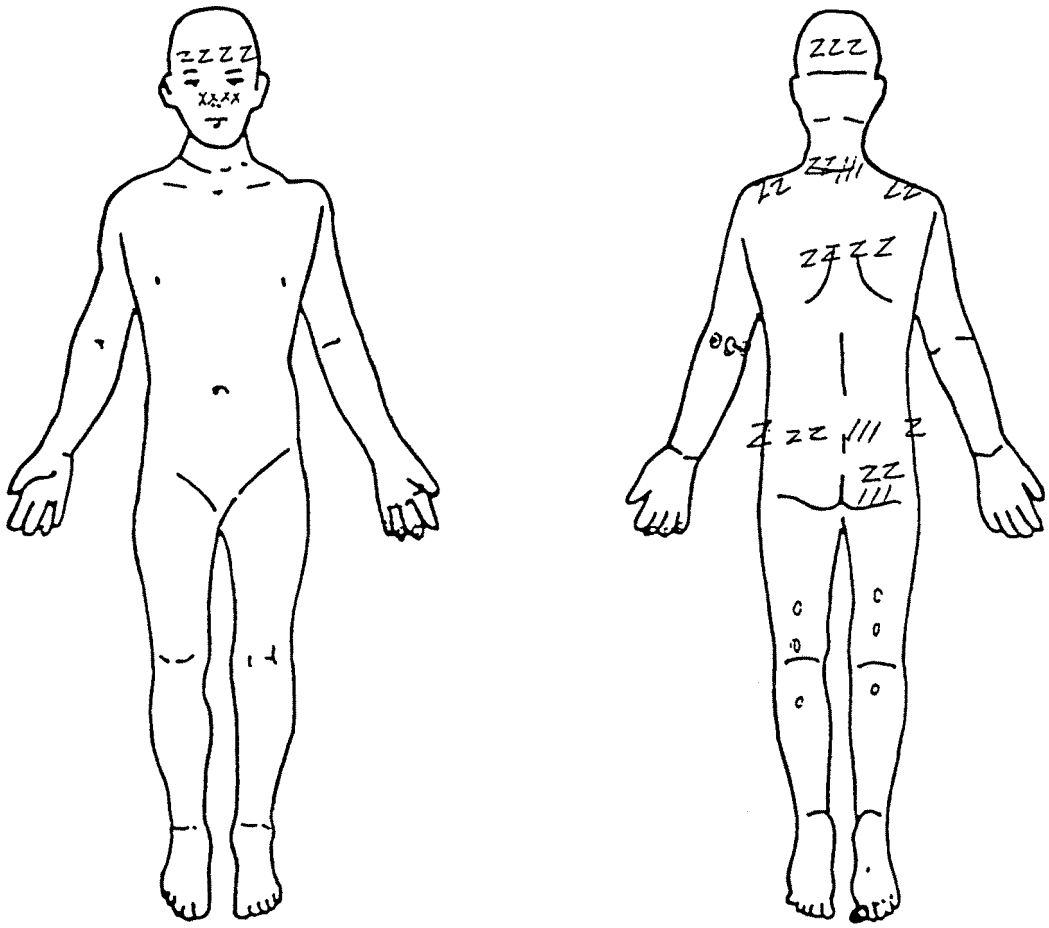
cc: File

HIGHLAND MUSCULO-SKELETAL ASSOC., INC.

PAIN PATTERN DRAWING

PLEASE INDICATE ON DRAWING N P E AND LOCATION OF PAIN USING CHOICES BELOW.

PINS AND NEEDLES = OOOO BURNING = XXXX STABBING = //// DEEP ACHE = ZZZZ



FRONT VIEW BACK VIEW

RATE YOUR **FAIN** 0 = No Pain ⟶ 10 = Extremely Intense

1. Right now	0	1	2	3	4	(5)	6	7	**8**	9	10
2. **At** its worst	0	1	2	3	4	5	6	7	8	9	(10)
3. At its best	0	1	2	(3)	4	**5**	6	7	8	9	**10**

PATIENTNAME: Val Stuhldreher