



May 6, 1997

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

Steven J. Protasiewicz  
Attorney at Law  
7029 Pearl Road  
Suite 310  
Middleburg Hts., OH 44130

RE: Anna Madercic  
CaseNo. 316910  
File No. 384-B-101

Dear **Mr.** Protasiewicz:

I evaluated the above plaintiff in my office on May 2, 1997, in the presence of her grandchildren, in reference to alleged residuals of injury sustained to her right upper extremity. She is a somewhat frail appearing woman. Some of the history was obtained from the plaintiff and some from her family.

The incident occurred at approximately 9:00 in the morning at the Ohio Savings Bank on Snow Road. She was by the outside doors in a line of clients waiting to get into the bank. Apparently some construction work was being done and allegedly there was a five inch difference in the grades going through the threshold of the bank. The plaintiff tripped, fell forward, and landed on either her outstretched arm or right shoulder. Her husband was parking the car and was unavailable to help her. Apparently she received little help from some of the other clients and it was not until some of the bank employees came that she received any assistance. The rescue squad was summoned and ultimately she was conveyed to the Southwest General Hospital Emergency Room. The date of the injury was September 3, 1996.

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The emergency room evaluation included a history and physical. There was a positive history for cardiac arrhythmia and there was no history presented of a loss of consciousness or a syncopal attack. The bulk of the discomfort was in the region of the right shoulder. The only discrepancy is that the history revealed the patient was at home, tripped and fell, but in fact this was incorrect.

X-rays revealed a fracture of the proximal right humerus in a very osteoporotic bone. She was treated in a sling and swath, and referred to Dr. Peter Bruno, an orthopaedic surgeon in Medina, Ohio.

Dr. Bruno followed her on an intermittent basis and the fracture healed without consequence. The last recorded visit in the records reviewed was on November 8, 1996. I am unclear whether she had any further visits with Dr. Bruno. The fracture subsequently healed. There has been no attempt at formal or informal rehabilitation. Some simple exercises were instructed. I am not clear as to the last time she had a physician look at her arm.

I do not believe she has had any medical care throughout 1997. The last recorded visit was in November of 1996. It does not appear in the letter dated March 7, 1997 that Dr. Bruno was aware of her current condition.

**PAST MEDICAL HISTORY** failed to reveal previous or subsequent problems with her right shoulder.

**CURRENT SYMPTOMS:** At the time of this evaluation she continued to have a diffuse aching pain from the lateral and anterior shoulder region, radiating down to just above the elbow. The **pain** is described as a deep burning and aching pain. The bulk of the **pain** seems to be in the lateral deltoid region with any attempt at usage. She has difficulty doing her activities of daily living due to stiffness and **pain**. There is no neurological complaints. She has some difficulty with dressing herself as well, primarily due to post injury stiffness. As stated above, she has never gone through any formal therapy.

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**PHYSICAL EXAMINATION** revealed a 87 year old female who appeared in minimal distress. Examination of her right shoulder revealed a very slight amount of atrophy of approximately 1 cm at the axillary level, as compared to the left. The circumferential measurements of the biceps, forearm, and wrist level; however, were approximately equal. There was decreased range of motion in forward flexion, abduction, internal and external rotation. Approximately 30% decreased range of motion was noted in all directions. There was pain at the extremes of motion. She had the same amount of active and passive range of motion of her shoulder.

The opposite shoulder did show some restrictions from normal. There was approximately 10% restriction of motion in all directions. There was no **pain** with motion.

A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

**IMPRESSION:** Healed fracture, right proximal humerus. Un-rehabilitated condition.

**DISCUSSION:** I have had the opportunity to review some medical records associated with her care and treatment. These include the medical records from the Southwest General Hospital and Dr. Peter Bruno. The records included x-ray results. I did not see any x-rays of her fractured arm.

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 obvious that the fall in question did cause an acute fracture of the right proximal humerus. This occurred in a pathological state known as osteoporosis, which is quite common in Caucasian females of her age group. This type of fracture very typically stiffens the shoulder to some degree. There is usually no difficulty with complete

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healing although complete recovery is highly dependent on active and continuing rehabilitation.

The current residuals of injury, in my opinion, are substantial but are not permanent. I do believe that she would greatly benefit from occupational therapy, approximately two times a week for a three to six week period of time. This would significantly enhance her range of motion and strength, as well as her agility and coordination. This would definitely improve her overall condition and allow her to be a great deal more functional than she has been over the past seven months.

The long term prognosis is usually fair to good with this type of injury. In my opinion, she has not reached her point of maximum improvement. This condition should not be considered permanent at this point in time. Undoubtedly, she will have some degree of stiffness in the shoulder which is not uncommon with this injury. I do believe that her post-accident residuals can be minimized with the above recommended therapy. She should have approximately 10% to 15% restriction of motion which may be on a permanent basis. I do believe she will substantially improve in the future with the appropriate therapy. I do believe the therapy is necessary and appropriate to complete her recovery and to reach her maximum post-injury potential. With the appropriate therapy this can be realized approximately eight to 12 weeks after the therapy is initiated.

Sincerely,

A handwritten signature in black ink, appearing to read 'Robert C. Corn', written in a cursive style.

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

RCC/bn

cc: File



# HIGHLAND MUSCULO-SKELETAL ASSOC., INC.

## PAIN PATTERN DRAWING

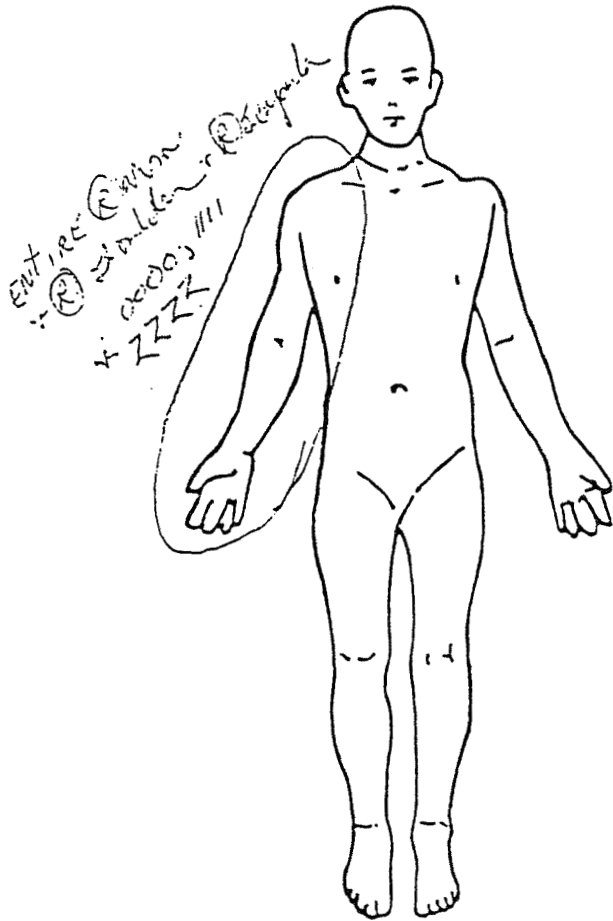
PLEASE INDICATE ON DRAWING TYPE AND LOCATION OF PAIN USING CHOICES BELOW:

PINS AND NEEDLES = OOOO

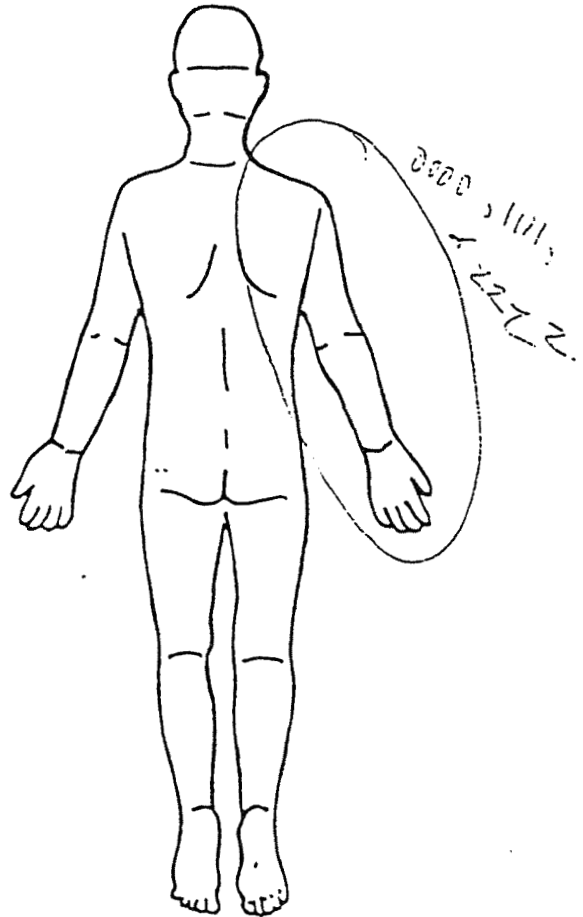
BURNING = XXXX

STABBING = ///

DEEP ACHE = ZZZZ



FRONT VIEW



BACK VIEW

### RATE YOUR PAIN

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

PATIENT NAME: Anna MIERCIC



OCCUPATIONAL THERAPY AND MUSCULO-SKELETAL ASSOC., INC.

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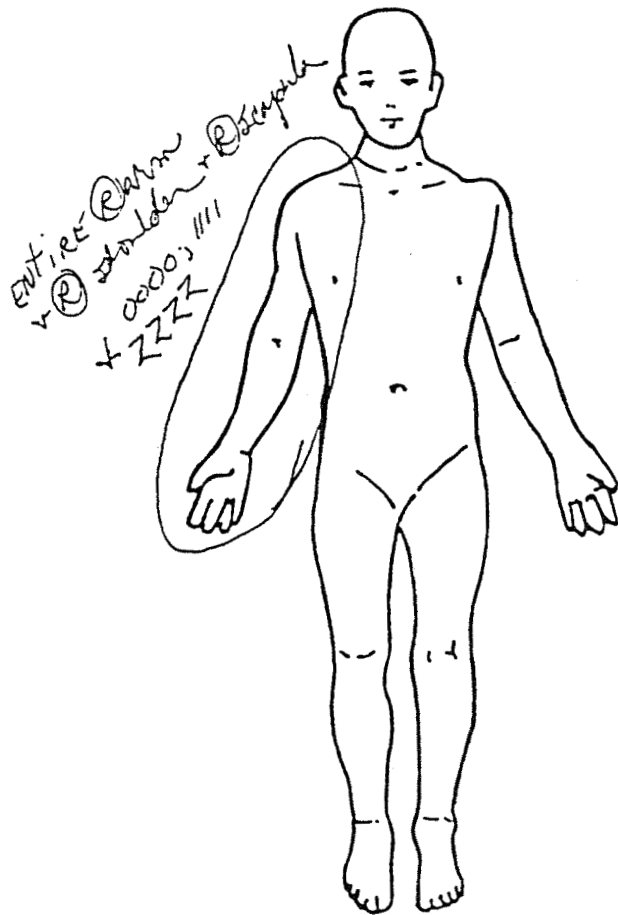
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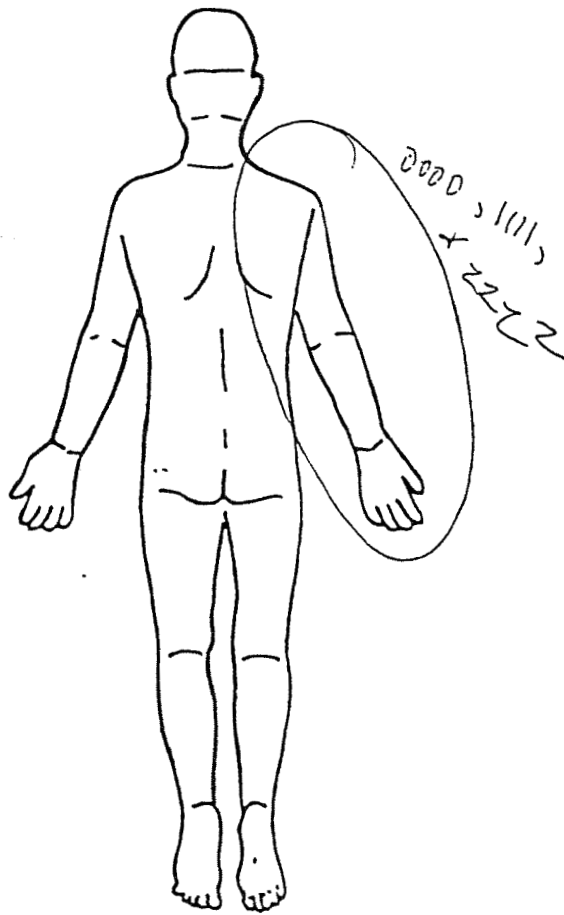
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PATIENT NAME: ANNA / DERIC