Highland
Musculo-Skeletal
Associaces Inc.

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

May 22, 1997

G. Michael Curtin
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RE: Rose Peters
Case No. 308268
File No. 1109/14084-SF

Dear Mr. Curtin:

I evaluated the above plaintiff, Rose Peters, in my office on March 13, 1997, in reference to alleged residuals of injury sustained in a second motor vehicular accident which occurred on May 17, 1994. Throughout the history and physical she was accompanied by Chris Wallace, an attorney from the plaintiff's law firm.

As you will recall, I evaluated Ms. Peters previously on October 21, 1996, in reference to a January 21, 1991 motor vehicle accident. She was questioned at that time involving ongoing symptoms of her neck and back. The first injury residuals were primarily in her neck and in 1994 from her low back.

This current injury was a work related injury while she was employed as a **truck** driver for the Nabisco Company. She was operating a 24 foot straight **truck** in the vicinity of the Lander Road Circle with Chagrin Boulevard in Orange Village, Ohio. She had approached the circle from the west, heading in an east bound direction. As she was in the circle, a vehicle came in front of her and the driver's front bumper of her **truck** hit

the passenger side of the car. She claimed she could not stop the truck in time and this injury occurred.

Initially she felt some stiffness in the neck and arm, but as the day continued she began having low back **pain.** She claimed the low back had stiffened up by the end of the day. She was able to continue on that evening and, in fact, went to work the following day. It was at that time that she started having leg pain.

She was subsequently referred to the company doctor, Dr. Michael Harris, who initially saw her on June 21, 1994. Although she could not recall any specific emergency room treatment at the time of my evaluation, she was seen at the Medina General Hospital with routine x-rays of her neck and low back. There was some degenerative changes, as previously noted, at the C6-7 level. Her low back was within normal limits. According to his history she did consult with her family physician, Dr. Neil Grabenstetter, who prescribed a physical therapy program.

She had three weeks of hot packs, ultrasound, electrical stimulation, and massage, as well as some simple stretching exercises by the time she saw Dr. Harris for the first time. A more strenuous physical therapy program was recommended at the *Crystal* Clinic which took place over a one to two month period of time. According to the records on a follow-up visit with Dr. Harris, a notation was made of her visit with Dr. Barry Greenberg, a orthopaedic surgeon associated with the Crystal Clinic. He ordered an MRI scan of her lumbar spine which she reported had no abnormalities. X-rays done in the past were "unremarkable". She considers her primary doctor to be Dr. Harris.

She was out of work for approximately seven months. She has since returned to work with restrictions. She has maintained this lighter duty status with no lifting greater than 600 units per shift. She is also limited to work eight hours per day. She has maintained these restrictions up to the time of this evaluation.

Physical therapy was recently re-requested. She was last seen approximately two to three weeks ago by Dr. Harris. He maintains her on certain medications, including

Flexeril a muscle relaxant, Lodine an anti-inflammatory, and Ultram an analgesic which she takes for "severe **pain".**

PAST MEDICAL HISTORY reveals the previous 1991 cervical spinal injury, as well as a left low back injury a number of years ago. She believes this may have been 1990. According to Dr. Harris' records there was no mention of any previous low back trauma.

CURRENT SYMPTOMS: At the time of this evaluation she still continued to complain of **pain** in the **midline** sacral region, approximately S2 to S3. She claimed to have this **pain** virtually on a daily basis. This was described as burning tightness "like my sacroiliac joints are messed **up".** Her level of **pain;** however, was not localized at all in the region of the sacroiliac joints. This pain seems to worsen by the end of the week. Occasionally the pain is severe enough and she has to take a few days off and rest. This seemed to happen every week with more **pain** toward the end of the work week. She has had no recent x-rays or scans.

In reference to her low back, she complains of a burning and pins and needle **pain** which does not follow any known dermatomal pattern. The leg **pain** seems to be worse when the back pain is bad. When she is sitting for prolonged periods of time or repetitively lifting, she gets this bilateral leg discomfort. As stated above, this did not follow any particular dermatomal pattern.

PHYSICAL EXAMINATION revealed a pleasant 43 year old female who appeared in no acute distress. Her gait pattern was normal. She was able to heel and toe stand with only difficulty in balance. Arising from a sitting position was performed normally, as was ascending and descending the examining table.

Examination of her lumbar spine failed to reveal any objective signs of spasm, dysmetria, muscular guarding, or increased muscular tone. The area of her mid sacral area was actually much lower than the lumbosacral junction. The bone in this area seemed to be tender. There was no objective limitation of motion of her lumbar spine.

She was easily able to bend forward to touch the mid tibia level with a good reversal of her lumbar lordosis. Hyperextension, side bending and rotation failed to show any objective abnormality although she did complain of pain in this exact, well localized region with all of these maneuvers. Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. Her leg lengths were equal. Patrick figure four sign was negative. The most painful part of the examination was the palpation and physically touching this midline sacral area. A detailed neurological examination, including sensory, motor and reflex testing of both lower extremities, failed to show any precise deficit. No muscular atrophy was noted on inspection and circumferential measurements of both lower extremities at the upper and lower thigh and upper and lower calf level, were equal and symmetrical bilaterally.

IMPRESSION: By history, a strain or sprain of the lumbar spine. Complaint of bilateral leg pain that does not follow any neurological pattern. No objective neurological abnormalities. Reported negative MRI.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from MetroHealth Medical Center, her family physician Dr. Neil Grabenstetter and Dr. Barry Greenberg The results of the MRI scan were also reviewed.

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 clear by the history, at worst, she sustained a soft tissue strain or sprain of the Iow back. Although there were complaints of intennittent numbness in both lower extremities, this was not confirmed on any objective neurological testing. The most definitive study to indicate a neurological pressure due to injury about the spine, the MRI scan, was entirely within normal limits. Review of Dr. Grabenstetter's records clearly indicate multiple soft tissue complaints without any significant objective

abnormalities. Review of the records from Dr. Harris indicate no neurological dysfunction from an objective standpoint as well.

When she was evaluated by Dr. Greenberg, it is clear that there was essentially no neurological deficit. Her symptoms; however, were suspicious to be discogenic in origin. Performance of the MRI scan and the lack of findings to correlate with these symptoms, indicates that there was no disc or neurological injury.

She still continues to complain of intermittent neurological type symptoms without any objective clinical or radiological abnormalities. Her low back x-rays at the Medina General Hospital were normal as well. At worst, in my opinion, she sustained a soft tissue strain or sprain of the lumbar spine and/or sacroiliac joint. There was clearly no objective abnormalities to correspond with her ongoing subjective complaints.

On the basis of this evaluation, in my opinion, she has objectively recovered from any soft tissue injuries sustained. There was no neurological injury or discogenic problem that arose specifically from this motor vehicular accident in question. On the basis of this evaluation she has objectively recovered from any soft tissue injuries sustained, The long term prognosis is favorable. She is currently employed. On the basis of this evaluation, there are no objective findings that would prevent her from returning to her previous level of occupation. On the basis of this examination, no physical restrictions are necessary. She has objectively recovered. The prognosis is favorable. No further care or treatment is necessary or appropriate for her ongoing symptomatology.

Sincerely,

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

RCC/bn

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