Highland
Musculo-Skeletal
Associates, Inc.

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RE: Carolyn Berk
DOI: 2/25/95

Dear Ms. Sukel:

I evaluated the above plaintiff in my office on March 12, 1997, in reference to injuries sustained to her left knee in a slip and fall which occurred on February 28, 1995. This incident occurred approximately 9 o'clock in evening at the Cooker's Restaurant in Beachwood at the LaPlace Mall. She and three other friends were sitting in a booth in the bar area of the restaurant. They had been in the restaurant for approximately one-half hour and had already placed their orders. The plaintiff does not drink alcohol and was drinking only coffee.

Prior to the arrival of their meal, she was walking towards the ladies room when she fell on the floor. This occurred approximately two booths away from where she and her party were sitting. She landed in the kneeling position, mostly on her left leg, in a twisting fashion, and could not get up on her own. She was helped up by her friends and some other clients of the restaurant. She then went by herself, walking to the ladies room to "clean myself up". She was able to go down some steps and came back to her table, and started eating her meal. Apparently half-way through the meal, she began having increasing left knee **pain.** She reported this to the manager and then the friend that she drove to the restaurant with, took her home. She was able to climb the

steps to her apartment and noted some swelling in the knee. She claimed not to have been able to walk in a normal fashion.

The knee somewhat swelled up overnight and she went on to work. She was employed at the Christian-St. John's Store at the Parmatown Mall in retail sales. She started working at approximately 10 o'clock that day and by 3 o'clock in the afternoon the left knee joint was very swollen. She drove herself horns.

It was the day after the accident that she first sought medical attention at the Southwest General Hospital Emergency Room. She did drive herself to the emergency room where she had x-rays and an examination. She believes she may have been seen by the orthopaedic consultation, Dr. Benjamin Richmond, at that time, but she could not recall. She was given a knee immobilizer and crutches.

The following day she was seen by Dr. Richmond at his Parma office. She was examined by staff. It was felt that she had a contusion of the left knee and to rule out a torn meniscus. She subsequently underwent an MRI scan of her left knee which was performed on March 28, 1995. This showed a tear of the posterior horn of the medial meniscus. There was a questionable tear of the anterior cruciate ligament, but none was noted by the radiologist. She then went through a course of physical therapy for electrical stimulation, massage, and she was given a smaller knee brace. She went through physical therapy for approximately two months and gradually was placed on a strengthening exercise program.

She has been followed for chronic headache problems at the Cleveland Clinic and did see one of their orthopaedic surgeon, Dr. Peter Brooks, on one occasion. He agreed with Dr. Richmond that the meniscus needed to be treated. Both of the orthopaedic surgeons who saw her felt surgery was necessary, but she declined.

CURRENT CONDITION: Essentially she has had no care or treatment for the past year and one-half. She is on a home exercise program in which she tries to do some leg lifts. At work, she has to bend, lift, and squat. She has difficulty at the end of the

day because of decreased strength. She also noted some swelling in the left knee at the end of the day. When she has discomfort it is either medial or lateral. She has difficulty climbing up to her second floor apartment without using the railings.

In addition, she complains of leg cramps in the left thigh at night. The knee seems to hurt her with repetitive type of movements and she feels that she is somewhat slowed up at work. There is a daily swelling with pain everyday in the left knee. She states she works approximately 54 hours per week in hourly and commissioned sales.

CURRENT MEDICATIONS include no medicines for her left knee. She is on a series of medications for her chronic headaches including one Aspirin per day, Donnatol for her stomach, Inderal and Valium 5 mg three times a day.

EMPLOYMENT HISTORY: She stated that she lost some time out of work from the beginning of March of 1995 through July 10, 1995.

PAST MEDICAL HISTORY failed to reveal any previous problems with her Ieft knee. She did have some pain in her right knee with medial and anterior joint line pain. She was seen by Dr. George Kellis for this. On February 12, 1992, she underwent an MRI scan of the right knee which showed some early degeneration of the medial meniscus of the right knee but no tear.

PHYSICAL EXAMINATION revealed a pleasant 62 year old female who appeared somewhat younger than her stated age. Her gait pattern was normal. She was able to arise from a sitting position without difficulty. She was able to heel and toe walk without difficulty.

Examination of the left knee revealed no effusion. There was no atrophy of her left thigh or left calf on circumferential measurements. There was no significant measurable effusion on circumferential measurements.

Examination of her left knee revealed some tenderness along the medial joint he. There was full extension to 140 degrees of flexion (full range of motion). Her medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no evidence of cruciate ligament tear. There was no rotatory instability noted. A negative Lachman and negative pivot shift test were noted. However,. the McMurray and Apley test were very positive dong the medial aspect, compatible with her MRI abnormality.

IMPRESSION: Probable tear of the left medial meniscus. By history, related to the February 28,1995 injury.

DISCUSSION: I have had the opportunity to review the results of the MRI scans of both of her knees, as well as the office notes from Dr. Richmond. Consultation letters were also obtained from Dr. Richmond as well. I have not yet seen the records from the Cleveland Clinic or Parma Community Hospital.

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.

The injury in question was competent to create the medial meniscal pathology. For some reason this was felt to be an anterior cruciate ligament tear as well. The *history* presented was not that of an anterior cruciate ligament injury. She was able to ambulate and do modified stair climbing within hours of the injury. No severe swelling was noted and, in fact, she did not seek medical attention until the following evening after work. This scenario is more likely *than* not solely related to a meniscal tear.

I do believe the care and treatment rendered by Dr. Richmond, the therapy, and the consultation with Dr. Peter Brooks was appropriate. I do believe that she does have a medial meniscal tear. This is a "curable" abnormality. This would necessitate only an arthroscopic procedure. No ligament reconstruction would be necessary. There would be a two to three week period of modified activity with progressive weight bearing

after the surgery. This apparently was not explained in great detail by her treating physicians and she never went along with their recommendations for surgical correction,

The long term prognosis is favorable with the knee surgery. There is usually a very benign postoperative course with a resolution of the mechanical symptoms in a very short period of time. If she does not undergo the surgery then her condition will not improve. This is clearly a surgically curable condition. Without the surgery; however, her symptoms will not change.

When the additional medical records arrive, I will review those and report any changes in the above opinions.

Sincerely,

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

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