Highland
Musculo-Skeletal
Associates, Inc.

Robert C. Corn, M.D., F.A.C.S.
Timothy L. Cordon, M.D.
Orthopaedic Surgeons

June 4, 1997

Gregory A. Huber
Attorney at Law
600 E. Smith Road
Medina, OH 44256

RE: Heather L. Johns
DOI: 1/7/94

Dear Mr. Huber:

I evaluated the above plaintiff in my office on May 23, 1997, in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on January 7, 1994. The medical history is somewhat complex in that her present condition is a reflection of the sum total of all of her musculoskeletal traumas. She had a number of work related incidences prior to this accident and two motor vehicular accidents after the motor vehicular accident in question. She was evaluated without friend, family, or legal counsel present.

MEDICAL HISTORY: She was the driver and solo occupant of a 1979 Olds full-size vehicle heading in a south bound direction on Route 42, toward Medina, Ohio. The driving conditions were noted to include snow covered roads. A vehicle coming in the opposite direction spun out. She tried to brake slowly to avoid the collision, but a driver and front side impact occurred. She was thrown forward and backwards. She did not impact any area of the car with her head or chest. Her right knee did strike the dashboard. She was able to brace herself with her arms extended out in front of her. There was no discomfort immediately and initially she was taken home by the tow truck driver.

That night she began having some right knee pain, including some bruising and swelling, as well as some aching discomfort in her neck and low back region.

The following day she was seen at the Southwest General Hospital Emergency Room describing the "head-on collision". Thorough examinations and x-rays were performed, all of which failed to show any traumatic abnormality. It was felt that she had a contusion of the anterior chest wall, acute neck sprain, acute abrasion and contusion of the right knee. No more significant injury was sustained. She was essentially treated and released.

She then returned back to her family physician, Dr. Neil Grabenstetter who saw her on or about January 10, 1994. He tried her on a variety of medications which seemed to help, but made her somewhat lightheaded. She subsequently returned to her previously treating chiropractor at Brunswick Chiropractor, primarily Dr. Michael Mulcahy. He started her on a routine of hot packs to her shoulders, neck and arms. This gave her some short time help, only a day or two. She continued; however, with 30 visits, through 1994.

She was employed at that time having two jobs. She lost the second job but continued to work at a nursing home doing nurse's aide type of duties.

A second motor vehicular accident occurred on December 12, 1994. Apparently she was following a junk truck. An engine black apparently fell off of the truck and she ran over the engine. She was seen later that day at the Medina General Hospital Emergency Room. X-rays were essentially normal. She could not recall any particular care or treatment. This essentially aggravated her neck. It bother her for "three or four weeks" and then back to her "baseline level" as a residual of the January 1994 Incident. She consulted with a Dr. Tulusiak on a one-time basis. His records were not available for review.

A third motor vehicular accident occurred on April 20, 1995. She was stationary at a red light when her vehicle was rear ended. She was thrown forward and backwards, and did not lose consciousness. This was a chair reaction type of collision. She was

evaluated later that day being brought with full spinal protection to the Parma Community Hospital. It was felt that she probably reinjured her neck and back. She was given a cervical collar, treated and released. She then saw Dr. James Lundeen for an unspecified period of time. His records were unavailable for review.

Ultimately she underwent an EMG and nerve conduction study that was ordered at the Southwest General Hospital by Dr. Lundeen. This was performed by Dr. A. N. Shah on July 11, 1995. A complete neurological evaluation of both upper extremities was normal. There was no neurodiagnostic positive findings. She believes she may have seen Dr. Lundeen in late 1993, probably November. She had no care and treatment through all of 1996, Until she saw Dr. Robert Zaas for a one-time evaluation on April 1, 1997. At no time did the medical record discuss any winging of the scapula. The plaintiff said that Dr. Zaas noted' this at the time of his evaluation. His letter did not; however, note any scapular winging.

Throughout the total medical care she has never been on any formal physical therapy. She has never worked with a licensed physical therapist for flexibility, conditioning, or strengthening exercises. Dr. Zaas mentioned this type of treatment, but this was never pursued. She does exercises at home.

EMPLOYMENT HISTORY: She is currently employed as a licensed practical nurse, having recently received her LPN license. She works in the TLC, a group home for the mentally retarded.

CURRENT SYMPTOMS: She still continues to complain of pain in the neck, upper back and shoulder region.. This is on an intermittent basis but more consistently in the upper back and trapezius muscles. Occasionally she has a complaint of numbness and tingling in her right ann. There was no history of a chest wall injury that would account for the scapular winging. She does claim to have weakness and difficulty elevating her right arm over her shoulder. When the neck is at its worst she develops diffuse aching, burning and tingling in both upper extremities. These did not follow any neurological patterns. (The electrodiagnostic studies were done because of these symptoms and were normal, as noted above.) When the pain is increased she

occasionally takes extra-strength Tylenol. She also tries to do some stretching exercises for her neck and shoulder.

She currently has no complaints in her lumbar spinal region. Any soft tissue injury that she sustained as a part of any of these accidents seems to have resolved.

In reference to her right knee, she complains of a dull aching pain in the anterior patellofemoral joint region. This occurs when she stands, sits, squats, kneels or climbs steps. She has never received any care or treatment for her knee complaints.

PHYSICAL EXAMINATION revealed a pleasant 24 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. She was able to walk without a limp. Heel and toe walking was noted to be normal. Ascending and descending the exam table was performed without difficulty and in a normal fashion. She appeared to be in no acute distress. She was having a "good day".

Examination of her cervical spine revealed a claim of tenderness in the trapezius muscle group bilaterally. There was some winging of the right scapula noted. There was difficulty elevating her right arm above her head. This was due to the mechanical disadvantage of this muscular weakness. Examination of her cervical spine; however, revealed no spasm, dysmetria, muscular guarding or increased muscle tone. There was a full range of motion in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was the mild winging noted. Examination of her shoulders, elbows, wrists and small joints of the hand failed to show any abnormality. There was no atrophy noted on circumferential measurements of her neck, upper back or periscapular musculature. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally. .

A brief examination of her lumbar spine failed to reveal any objective signs of my chronic muscular irritation or inflammation. There was a well preserved range of motion. Her hips and knees examined normally. No effusion was noted in her right knee. Her medial and lateral, as well as anterior and posterior ligament complexes were intact. There was a negative Lachman, McMurray and Apley test. Negative Fairbanks test was noted and no retropatellar crepitance was noted.

IMPRESSION: Subjective residuals of a cervical strain or sprain. Winging of the right scapular (etiology unknown). Resolved lumbar strain or sprain. Resolved right knee contusion.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include the records from the Southwest General Hospital, the Parma Community Hospital, Dr. Grabenstetter, Brunswick Chiropractic, Medina Community Hospital and Dr. Robert Zaas. Records were also reviewed of the EMG and nerve conduction study.
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 noted above there was a long standing history, as far back as 1991, in reference to her lumbar spine. This was injured in a lifting incident while employed at a local nursing home. She had continuing low back pain and treated with a chiropractor through 1993. The motor vehicular accident in question (January 1994) may have transiently aggravated her low back pain. She never had any specific care or treatment for her low back related to the motor vehicular accident.

In my opinion, at worst, she sustained a cervical strain or sprain. She elected; however, to go through chiropractic treatments. She admits that this did not give her any long standing relief. There were financial reasons why she did not pursue physical therapy according to her history. In my opinion, she would have greatly benefited from an appropriate physical therapy program, including active rehabilitation,

including muscular strengthening and condition. She has still yet to date gone through this type of program.

In reference to the mild right scapular winging this is a definite objective finding. This was never reported in any of the medical records and was not discussed in Dr. Zaas' evaluation of April 1997. It is unknown exactly when this winging occurred. The plaintiff herself cannot remember exactly when this developed. When caused by trauma, there is usually a history of blunt trauma to the **lateral** aspect of the chest. This would mean that she would have struck the right side of her chest wall in a very severe fashion in order to have caused this type of injury. There is absolutely no history of this type of trauma related to the January 1994 incident. The etiology of this findingremains obscure.

On the basis of this evaluation, she has objectively recovered from any soft tissue injury sustained. She is actively gainfully employed on a full time basis. There is minimal objective findings associated with her soft tissue complaints. The precise etiology of the scapular winging is somewhat obscure. The long term prognosis is favorable. On the basis of this evaluation, no further orthopaedic care or treatment is necessary or appropriate.

Sincerely,

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

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

June 4,1995

Thomas **A.** Barni
Attorney at Law
5885 Landerbrook Drive
Suite 205
Mayfield Heights, OH 4-4124

RE: Roland Pepin
Case No, 311991
DOI: 4/4/95
PRELIMINARY REPORT

Dear Mr. Barni:

I evaluated the above plaintiff in my office on May 30, 1997, in the presence of his attorney, . L. James Martin. This evaluation was previously scheduled for earlier in the week and the plaintiff failed to show for that evaluation. Conversations between the plaintiff attorney's office and my office allowed the examination to proceed on May 30, 1997.

The history presented was of a somewhat unusual incident that occurred at a Cleveland Cavaliers basketball game at the Downtown Gund Arena on Tuesday, **April** 4, 1995. The plaintiff was sitting in an aisle seat when a lid from a hot dog vendor struck his left shoulder. The best that he could recall the incident was that the enhre hinged top flew off and struck him along the superior aspect of the shoulder. The vendor was a number of rows behind the plaintiff. There **was** immediate pain in the left shoulder and an incident report was filed. He did not seek medical attention until the following day.

On April 5,1995, he was evaluated at the MedCenter on Darrow Road in Stow, Ohio. He presented with a history of **pain,** swelling and discomfort in the superior aspect of the left anterior shoulder. **A** mass had developed of approximately 2 x 2 cm. Some photographs were produced at the time of this evaluation which showed the approximate locations of the mass. It was felt at that time that he had a contusion of the left shoulder. X-rays were performed which were entirely within normal limits. He was seen on April 18, 1995 for a follow-up examination. The shoulder was still tender at that time. Pain was noted in placing his arm in certain positions, primarily in overhead positions. Initially this was felt to be a contusion and the diagnosis was changed to a bursitis of the left shoulder and/or a possible early impingement syndrome.

The MedCenter referred the plaintiff to Dr. Howard Pinsky, who initially saw him on **April** 21, 1995, less than three weeks after the injury. The history was presented and the x-rays were reviewed. No bony pathology was noted. Examination showed a small abraded area on the superior aspect of the shoulder, just lateral to the AC joint. There was an ill-defined soft tissue swelling there, again noticing this post traumatic condition. Impingement sign at that time was negative. The diagnostic impression **was** contusion with possible hematoma of the left shoulder.

He was evaluated 10 days after that. The "bump" was still present. Dr. Pinsky was not sure of the exact etiology of this. On a follow-up visit on May 15, 1995, about six weeks after the injury, an MRI scan was ordered. This fortunately was normal. On May 31, 1995, the scans were reviewed. The doctor still believed this was a contusion of the shoulder.

During the balance of the 1995 year, he continued having difficulty with his left shoulder. He is in the vending business and organizes amateur bowling tournaments. Repetitive lifting, especially overhead lifting, seemed to bother his left shoulder symptoms.

Ultimately he was taken to surgery at the Cuyahoga Falls Hospital on November 12, 1996. This was an arthroscopy of the left shoulder. This showed essentially no pathology in the glenohumeral joint and only some synovitis in the subacromial area. A subacromial decompression was performed.

Postoperatively the patient underwent two series of physical therapy treatment sessions, initially at the Marden Rehabilitation Associates, and then follow-up at the Cuyahoga Falls General Hospital. The symptoms in the shoulder essentially completely resolved. He is unable to recall the last day of physician treatment. He continues on a home exercise program with weight, stretching, and the use of a Theraband. He is currently on no medications.

CURRENT SYMPTOMS: As stated above, the surgery tremendously relieved his left shoulder problems. He has only complaints of "weakness" in the left upper extremity. He has not returned to sports, although this has not been a physician recommendation to avoid these activities. He feels weak, not only in strength, but also in endurance. There is occasionally a diffuse discomfort which is not well localized. The plaintiff is right handed.

EMPLOYMENT HISTORY: As noted above, he is a self-employed organizer of amateur bowling tournaments. He also is in the vending machine business. The time out of work or work reduction was not discussed at the time of this evaluation.

PHYSICAL EXAMINATION revealed a pleasant 40 year old male who appeared in no acute distress. He appeared to sit, stand, and move about the exam room without difficulty

Examination of his left shoulder revealed no residuals of a "bump". There were three well-healed arthroscopic incisions. Examination of the neck, upper back and periscapular area failed to show any musculature atrophy. Circumferential measurements at the axillary, midarm, forearm and wrist level showed the right upper

extremity just slightly larger than the left, comparable with the right-left dominance. There was no objective finding to support his complaint of "weakness".

Examination of his left shoulder revealed a full range of motion in forward flexion, extension, abduction, internal and external rotation. This was noted both actively and passively. The elbows, wrists and small joints of the hand examined normally. Neurological examination of both upper extremities was normal.

IMPRESSION: By history, contusion of the left shoulder. Synovitis of the subacromial region. Resolved soft tissue swelling which, by history, was related to this incident at the Gund Arena. Completely normal physical examination.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These include records from the MedCenter, North Hill Orthopaedic Surgery and partial records from Dr. Howard Pinsky. I have also reviewed records from the Cuyahoga Falls General Hospital and Marden Rehabilitation Associates.

After careful questioning of the patient's history and physical impairment, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning his ongoing level of physical impairment.

It is my opinion, within a reasonable degree of medical certainty, that the primary injury was solely a contusion of the left shoulder. This manifested itself with the development of a soft tissue mass within a very short period of time. This was well documented in the medical records, By the history presented, this was related to the incident at the Gund Arena. No ecchymosis was documented. The evaluation by his orthopaedic surgeon clearly noted an obscure abnormality. This failed to improve with conservative care, rest and an aspiration. I have not had the opportunity to review all the records from Dr. Pinsky. The exact date of the shoulder aspiration and what was noted, was not available for review at this time.

At the time of surgery, no traumatic abnormalities were noted. There was some synovitis in the subacromial area. The surgical procedure and physical therapy significantly reduced the level of pain. There is minimal subjective symptoms at this point in time other than that of occasional **pain** and "weakness". The physical examination was entirely within normal limits. **As** expressed by his treating physician, he has objectively recovered from his injury and surgery. No permanent residuals of injury were noted. He does not appear to have had any medical care for over a year.

On the basis of this evaluation, the long term prognosis is favorable. No permanent injury was sustained. By history, the care and treatment provided was causally related to the incident in question. However, impingement syndrome is a fairly common entity seen in a general orthopaedic surgeon's practice. I cannot state within a reasonable degree of medical certainty that the findings at the time of the arthroscopic surgery were solely related to the incident in question. There was; however, complete resolution of his subjective pain in response to the surgical procedure performed.

In *summary,* he has objectively recovered from the injury sustained and the subsequent surgery. The long term prognosis is favorable. On the basis of this evaluation, no further care or treatment is necessary or appropriate.

Sincerely,

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

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