Highland
Musculo·Skeletal
Associates,Inc.

August 16, 1996

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RE: Jennifer J. Stein
Case No. CV 95 08 2686 (Summit Co)
File No. 51208

Dear Mi. Spetrino:

I evaluated the above plaintiff in my office on August 15, 1996, in the presence of her attorney, Tim Conway. This was specifically in reference to a motor vehicular accident which occurred on August 14,1993.

This motor vehicular accident occurred in an office building parking lot in the Iate morning of August 14, 1993. She was the driver and solo occupant of a late model Maxima vehicle. She was driving through the parking lot and a car backed up suddenly in front of her. She could not stop and the driver's side of her vehicle was impacted. She stated that she was thrown in a side-side direction. There was no head injury. She was wearing her seat belt.

She was able to drive her vehicle home, but this was later towed. That night she began having onset of **hip** and leg **pain.** As will be discussed below, the history presented was not entirely accurate in that she has had ongoing symptoms in virtually the same areas as she was claiming injuries as **part** of this motor vehicular accident, in the past.

IC
6 wks
6 months
Hips Back.
In 2.1.

She waited approximately two weeks to see her orthopaedic surgeon, Dr. Green, with complaints of both neck and back pain. There was no initial treatment. She also claimed her neck was bothering her. He recommended a cervical collar, anti-inflammatory medications, and physical therapy primarily for her neck only. She had some constant neck pain at that time, but received some relief with the physical therapy prescribed. According to the medical records the only complaint she had in reference to this motor vehicular accident was some neck discomfort in the paraspinal muscles. She had normal range of motion and *only* medications were recommended. There was no indication that physical therapy was specifically prescribed for this. Follow-up examination with this physician approximately a month later revealed some cervical spinal tenderness. X-rays were obtained which showed some increased motion at the C5-6 level, but this was not felt to be any significant trauma. Her working diagnosis was a cervical strain.

According to the records she was seen again approximately a month later on November 16, 1993, with minor neck complaints but mostly complaints of her back at that time. A bone scan was ultimately performed which was normal.

Her history is somewhat complex and this evaluation was made somewhat more difficult in the fact that the patient had no memory of the doctor's visits. It was difficult to correlate all visits with the medical records provided.

Suffice it to say, there were definite problems with her neck and low back in the past. Careful review of her medical doctors records indicate a previous motor vehicular accident in October of 1988. She complained of a back injury, as well as a neck injury at that time. It was felt to be mostly muscular in nature. This was not recalled at all at the time of this evaluation.

As far back as September 27, 1990, according to her medical records, she had problems with "back and leg pains." X-rays were done and, in fact, she was referred to a spinal specialist, Dr. Barry Greenberg, later in 1990. Physical therapy was

prescribed for both her back and her "snapping hips" which has been well documented for many years.

In February of 1994, she was evaluated in consultation by Dr. Bacha. She was referred by Dr. Ken Green, as well as Dr. Chung. This evaluation was primarily for her right hip. The primary problem was felt to be stemming from her snapping hips, but because of her chronic symptoms, an MRI scan was ultimately performed. This revealed a bulging and slightly herniated L4-5 disc.

A second opinion was recommended by a University Hospitals spinal physician, Dr. Sanford Emery. This evaluation was carried out on April 4, 1994. At that time she presented with a history of bilateral hip and thigh pain which has troubled her "all her life." He evaluated her for a number of reasons. According to the records, she was evaluated for the bulging L4-5 disc with just a slightly abnormal MRI scan and normal EMGs. The rheumatologist's, Dr. Bacha, records were also reviewed.

Dr. Emery did not believe her ongoing symptoms were coming from her low back but more from her hips. He recommended a number of diagnostic studies, including an MRI scan of her hips and pelvis. These were done on April 18, 1994. These clearly showed an abnormality in the iliotibial band. No M e r recommendations were made. It is my opinion that this entire workup at University Hospitals, including the second set of MRI scans, was unrelated to the accident in question.

Since her evaluation with Dr. Emery she has not had any treatment. She does not believe she had much treatment in 1995, only perhaps physical therapy. There has been no treatment so far in 1996. She is currently on no medications other than Premarin which she takes for her GYN problems.

PAST MEDICAL HISTORY revealed "no previous problems" with her neck and back. She did not discuss any of the previous injuries or previous significant problems that she has had. These are very well documented in the Crystal Clinic records, including intermittent neck and low back pain for many years, as well as the snapping

hip problem. There was never any true radiculopathy. It is doubtful that the MRI abnormalities had anything to do with this low velocity motor vehicular accident. Her basic. ongoing problem is trochanteric bursitis due to the ''snapping hips."

Other aspects of the past medical history, unrelated to this trauma, were reviewed including her rapid heart rate problem, notations of an intestinal disorder, laparoscopic surgery for endometriosis and a notation in the record of previous chemical dependency (alcoholism).

CURRENT SYMPTOMS were expressed on an intermittent basis in both the neck, thoracic and low back region.

In reference to her cervical spine, she complained of intermittent stiffness in the back of the head radiating parallel to the midline. There was a separate type of discomfort which she developed of a "sharp pinching sensation" in the trapezius areas. This is usually bilateral and occurs with prolonged driving. She, in general, appears to more restricted in motion and movement related to her cervical spine flare-ups.

In her thoracolumbar spine, she has "periodic soreness." There is intermittent soreness with prolonged sitting, She tends to limit her activities in relation to how her hips and low back feel. There are no radicular symptoms in either upper or lower extremities,

PHYSICAL EXAMINATION revealed a pleasant 29 year old female who appeared in no acute distress. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally.

Examination of her cervical spine revealed no spasm, dysmetria or muscular guarding. There was a full unrestricted range of motion in forward flexion, extension, side bending and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was no atrophy noted in the neck, upper back, shoulder or periscapular region. A full range of motion of both shoulders was noted in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and

small joints of the hand examined normally. Neurologic examination 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.

Examination of her thoracolumbar spine was objectively normal. She claimed to have some tenderness in the low lumbar region, but no objective abnormality was noted. There was no spasm, dysmetria or muscular guarding noted. A full unrestricted range of motion was noted in forward flexion, limited only by "tight hamstrings." Hyperextension, side bending and rotation were performed without limitations. There was a full range of motion of both hips. No abnormality was noted on testing of the sacroiliac joints. Her leg lengths were equal. Circumferential measurements of both upper extremities at the thigh and calf level were equal and symmetrical bilaterally. A detailed neurologic examination including sensory, motor and reflex testing revealed only slightly diminished ankle jerks bilaterally. This was clearly noted as far back as 1990, according to the medical records.

IMPRESSION: Subjective residuals of a soft tissue neck strain. Minor disc abnormality at the LA-5 level by MRI scan. Long history of chronic neck and back complaints. It appears on review of the medical records, her primary problem related to this accident was a cervical strain.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from her family physician, Dr. Chung; records from the Akron City Hospital, Crystal Clinic including the orthopaedic surgeon's, Dr. Green and Dr. Greenberg; records from the rheumatologist, Dr. Bacha; records from Associated X-rays at the St. Thomas Hospital, as well as records from University Hospitals of Cleveland.

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.

At the time of this evaluation my impression was that the plaintiff was somewhat evasive in discussing her prior medical conditions. I was left with an impression at the time of the exam that there was really no significant previous problem other than the snapping hips. However, review of the medical records clearly indicated a previous motor vehicular accident, in which there was a neck and back injury, in 1988, as well as medical treatment for orthopaedic complaints in the earlier 1990s. She, in fact, was under the care of an orthopaedic surgeon at the time of this accident and did not seek medical attention until two to three weeks after the accident in question. According to the records this was, at worst, only a neck injury.

There was ongoing symptoms related to her low back, which according to the records, precipitated the MRI scan of her lumbar spine. The primary purpose for the rheumatological evaluation was to more clearly evaluate her chronic trochanteric type of discomfort. It was only in relation to this symptom that the lumbar disc herniation arose. I do not believe any of her treating physicians have felt that this disc abnormality was directly related to this motor vehicular accident.

It is my opinion that the MRI scan of her lumbar spine was not precipitated by the accident in question. It is, therefore, my opinion that the entire evaluation at the University Hospitals of Cleveland, including the MRI scan, was unrelated to the accident as well. Certainly the second MRI scan at University Hospitals was unrelated. It appears that most of this workup was due to her chronic problem and the somewhat serendipitous discovery of a minor disc abnormality.

On the basis of this evaluation, the long-term prognosis is favorable. There are no objective findings to support her subjective complaints. There is clearly a complex history in which there were multiple complaints prior to this motor vehicular accident in question. It appears that it was only a minor neck injury that was sustained. In my opinion, all of the diagnostic workup, care and treatment by the various physicians involving her low back and "snapping hips" was unrelated to the accident in question. On the basis of this evaluation no further care or treatment is necessary or appropriate, As stated there has been no care rendered for at least the past 18 months. The

long-term prognosis is favorable. She has objectively recovered from any soft tissue injury sustained.

Sincerely,

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

RCC/bn

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