Highland
Musculo-Skeletal
Associates, Inc.

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

August 31,1997

Jay S. Hanson
Attorney at Law
918 Terminal Tower
50 Public Square
Cleveland, OH 44113

RE: Dorothy Scott
Case No. 97 P 0209 (Geauga County)

Dear Mr. Hanson:

I evaluated the above plaintiff in my office on August 27, 1997 in reference to alleged residuals of injury sustained in a front-end motor vehicular accident which occurred on December 28, 1995. She was evaluated without friend, family or legal counsel present.

BACKGROUND: As you are aware, Ms. Scott has ongoing severe multiple health problems, including severe polyarticular rheumatoid arthritis for which she has been treated for many years. She has had chronic complaints of neck and low back pain. Even prior to this evaluation she had a rather significant abnormality with instability of the cervical and lumbosacral spine that was diagnosed. Records from a disability evaluation clearly outline the severity of her endstage arthritic symptoms. She is status post bilateral rotator cuff repair with a very poor physical result. None of these areas were normal prior to the accident in question.

ACCIDENT HISTORY: As stated above she was the front seat passenger in a large Dodge dump truck with a snow plow on the front. She was being driven by her part-time employer, Bud Griff. She .was in the floral delivery business. She was not wearing a seat belt. The accident occurred heading eastbound on Chagrin Road in

Bainbridge Township, west of Route 306. She is not quite sure if it was icy or snowy, but a car coming in the opposite direction lost control and came into their lane. The vehicle in which she was traveling broadsided the car that suddenly came into their lane. She believes there may have been some damage to the snow plow and front suspension of the truck, but no physical body damage to the truck that she was aware of.

She did see the accident corning and braced herself. She believes she flew forward and hit her head on the windshield and, in fact, broke the windshield. She believes her knee may have hit the dash. She was somewhat "dazed" but was never unconscious.

The truck was drivable. After making a police report on the scene she was 'taken home. When she was home, shejust sat and relaxed.

Subsequently she returned back to her ongoing family physician, Dr. Fredrick Wilson, who she saw about four days after the accident. She had continuing complaints of neck and low back pain, as well as pain in her hip region. He followed her fairly closely, about every two weeks, and referred her to physical therapy primarily for modalities in Bainbridge, Ohio. The therapy was done about three times a week for two to three months. These are similar areas to where she has had previous complaints. It was felt this was a soft tissue strain or sprain which may have transiently aggravated her rheumatoid arthritis. I do not believe there was any documentation of any worsening of the actual physical arthritic condition.

She did also return to see Dr. George Kellis, her previously treating orthopaedic surgeon. She may have also returned to see Dr. Mandel, her rheumatologist. It appears by the medical records that the bulk of the care and treatment provided after the motor vehicular accident by Dr. Kellis was in reference to her generalized arthritic condition. He did not see her after the accident until February 9, 1996. He believed this was a subjective "exacerbation of her low back, neck and shoulder condition',. She ultimately had one caudal epidural block at the Geauga Hospital which helped her symptoms for about a month. She had had a previous block, that is

earlier in 1995. This block seemed to relieve her back symptoms for a number of months.

Recently she has been referred by Dr. Wilson to Dr. Mark Allen, the Meridia Pain Clinic, at Meridia Hillcrest Hospital. The initial visit, she believes, was approximately three months ago. She had one block and is scheduled for the second block on the day following this evaluation, August 28, 1997. She believes the blocks were essentially for her severe arthritis and spinal problem. She was also placed on Oxycontin, an oral morphine which she takes twice a day. She is also on a hypertensive medication.

I specifically asked her exactly what she felt was worse. She does not believe that there was any substantial new area that was injured. She believes her low back seems to be a little bit more involved in the area of pain, but the pain is about the same type of pain, that is, a deep, dull aching pain that she had prior. She also had a long standing history of neck pain which has not changed substantially. She still has some ongoing discomfort in the posterior shoulder regions bilaterally.

EMPLOYMENT HISTORY: She is retired as a school bus driver from the Kenston School District, retiring in November of 1995. She also had a part-time job which she still maintains in the floral delivery capacity. She also currently works part-time assembling small tools.

CURRENT SYMPTOMS: **As** stated above, she still continues to have off and on pain, primarily in the left and right side neck, as well as across the anterior shoulder regions near where she had her previous surgery. She also has a degree of discomfort in the upper back and trapezius area. She does not believe this is substantially worse than she had prior in the neck and upper back region. She does believe she has a rather poor result from her rotator cuff surgery which was realized **prior** to the motor vehicular accident in question.

The bulk of her ongoing symptoms seems to stem from her low back. She is aware of a severe arthritic condition and the medical records clearly indicate a significant degree of arthritis, disc disease and spinal instability. She has a three level

spondylolisthesis at L4-5 and L5-S 1. This has created intermittent deep aching pain. The low back **pain** seems to be worse with activity and weather, as well as prolonged periods of attempting to stand or walk. The bulk of her low back and lower extremity discomfort is related to her back. She subjectively feels more of her back is painful, although the pain is about the same as it was prior to the motor vehicular accident in question. Occasionally she does have some discomfort in her legs but this is only when the low back pain is at its worst.

PHYSICAL EXAMINATION revealed a very pleasant, 64 year old female who appeared in mild distress. She generally appeared to be suffering from the ravages of her rheumatoid arthritis. She had rather significant joint deformities in her hand and walked in a somewhat stiff protected fashion. There was no limping detected. She could heel and toe **walk,** although this created some joint symptoms in her lower extremities. There did not appear to be any neurological weakness in either her upper and lower extremities by history or by any dissymmetry in the size, shape or consistency of her musculature.

Examination of her cervical spine revealed no spasm, dysmetria, muscular guarding or increased muscle tone, She complained of some deep discomfort in the trapezius muscle. This was not associated; however, with any spasm, dysmetria, muscular guarding or increased muscle tone. There was approximately 15% diminished range of motion in forward flexion, extension, side bending and rotation, compatible with her multiple cervical spinal arthritic condition. This was not associated with any muscular guarding. Protraction, retraction, and elevation of the scapulae were performed normally, No significant disproportional muscle development was noted in the upper back, shoulder or periscapular area.

Examination of both shoulders revealed the bilateral scars compatible with a rotator cuff surgery. She has a very poor functional result, being able to barely forward flex both shoulders actively to 90 degrees and she abducts only to 75 degrees bilaterally. Passively; however, there was much better range of motion. Distinct atrophy of both deltoid muscles, as well as anterior shoulder musculature was noted. This is compatible with her chronic rotator cuff dysfunction. The elbows, wrists, and small

joints of the hand revealed changes of her rheumatoid arthritis. Neurologically, both upper extremities were normal.

Examination of her lumbar spine revealed approximately 25% decreased range of motion in forward flexion, extension, side bending and rotation. Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. No muscular abnormality was noted or any signs of chronic inflammation. The hips, knees, and ankles examined normally. Neurologic examination of both lower extremities was normal.

IMPRESSION: Resolved soft tissue strain or sprain. Probable trapsient aggravation of arthritic **symptoms.** No objective evidence of any worsening of her rheumatoid condition.

DISCUSSION: I have had the opportunity to review quite a bit of records concerning her care and treatment. Extensive records were reviewed from Dr. Frederick Wilson, Drs. Kellis, Shall, and Dr. Mandel. Records from the Geauga Hospital, as well as a letter from Dr. Jeffrey Blood. **A** series of x-rays were also reviewed from Drs. Kellis and Shall's office. These clearly depict the severity of her spinal arthritic disease,

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.

Concerning her preexisting conditions, there is no question there was well documented significantly disabling arthritis and instability of her cervical and lumbosacral spines. It is also clear that her other area of ongoing pain, her shoulder region, was cared for both conservatively and operatively. She had prior to this accident, a very poor result from surgery. She never regained more than 50% of her motion. She is; however, able to tolerate this on a long-term basis. Most of the work capacity that she does is at or below the shoulder level. The shoulders function "just fine" in this orientation.

It is also quite clear that her spinal condition is quite severe. There is documented cervical and lumbosacral instability. There is no objective evidence that this instability was worsened or the accompanying arthritic condition was worsened by this accident. The patient herself does not think her condition has generally worsened although there was more of her low back that is painful now than was prior to the motor vehicular accident. This is entirely subjective in nature. There is no objective evidence of any worsening by x-ray of her lumbar spinal condition.

It is my medical opinion that the ongoing care and treatment, at this point in time, is related solely to the progression of her severe rheumatoid arthritic disease. It is my opinion that the care and treatment rendered for the first three or four months, including all the initial physical therapy, was directly related to the motor vehicular accident in question. In my opinion, there was a subjective transient aggravation of her arthritic symptomatology which seemed to respond quite well to conservative care. There was no new injury, that is a new problem that developed, solely related to this trauma.

The long-term prognosis for the soft tissue component in her neck, lower back and shoulder regions is good. The prognosis for her severe systemic arthritic condition; however, is poor. There was a significant amount of objective physical impairment prior to the accident. This has slightly worsened over the years. In my opinion, no additional new injury was sustained and no preexisting condition was permanently worsened. Her ongoing pain blocks, in my opinion, are solely due to the seventy of her spinal instability and the spinal arthritic condition. She has recovered from any soft tissue residuals involving this motor vehicular accident.

Sincerely,

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

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right arm. There was no specific neurological distributions discussed. X-rays were taken of the neck, right shoulder and low back, and these were essentially normal. She was treated and released.

The accident occurred when she was returning from an office visit with her chiropractor, Dr. Richard Dickson. He had been previously treating her for a work-related low back condition. She did claim that she had off and on symptoms in her cervical spine region and, in fact, in 1992 had a sudden episode of numbness in both of her arms. She believes this was also treated by Dr. Dickson. The records that were forwarded from Dr. Dickson's office did not include any records that preceded the date of injury. These records have been requested.

He stated her on a routine of manipulations, treatments and electrical stimulation. There may have been cervical traction. These treatments were directed toward her neck and back. She also complained of right arm weakness and for this reason an MRI scan was ultimately performed of her cervical spine on November 7, 1994. This revealed a very minimal narrowing of the C5-6 disc space with a mild 2 mm right paramedian defect at C5-6. There was no evidence of cord compression or spinal canal stenosis. This was essentially some mild degenerative disc disease and spondylosis, She continued with Dr. Dickson through the balance of 1994 and early 1995.

Ultimately on May 18, 1995 she was seen by Dr. William Acosta, a neurologist who performed EMG and nerve conduction studies. There was absolutely no evidence of cervical radiculopathy. There was some mild right carpal tunnel syndrome noted. In that there was absolutely no injuries sustained to her hand or upper extremity this was felt to not be related to the car accident. She also saw a dentist about a TMJ complaint. This was not addressed at the time of this evaluation.

The only other physician who treated her was Dr. Norton Winer, a neurologist. She was seen in late July of 1995. This was specifically for dizziness and lightheadedness, and decreased memory and concentration. These are all subjective symptoms that a brain abnormality was rule out. An MRI of her brain on July 28, 1995 was entirely within normal limits. She has continued intermittently under Dr. Dickson's care and treatment.

CURRENT MEDICATIONS: She takes Advil, six per day. This is specifically and primarily for headaches. She claims that her right arm and hand have "never been the same" since the accident. She occasionally wears a right wrist splint which she wore at the time of this evaluation. This tended to relieve some of her hand symptoms.

PAST MEDICAL HISTORY revealed a 1991 work-related incident when she slipped and fell, and twisted her low back. She came under Dr. Dickson's care for this. In 1992 she struck her right hand on a drinking fountain. This was about the time that she began having bilateral hand numbness. No records were available for this injury.

There was also a subsequent motor vehicular accident in January of 1997. She re-injured her neck and back. This was a broadside collision for which Dr. Dickson has still be following her. There was a driver's door impact. She never went to an emergency room for this and only went to Dr. Dickson's office. She clearly states that the exact same areas that were injured in the prior accident were injured in the early 1997 accident as well. Dr. Dickson's records again did not reflect any care and treatment for the second motor vehicular accident.

CURRENT SYMPTOMS: At the time of this evaluation she continued to complain of some fairly typical soft tissue residual symptoms, as well as a number of somewhat unusual symptoms that could not be explained by any neck or back soft tissue strain or sprain.

She continues to complain of headaches. This is associated with numbness in her face, her teeth and her scalp. She has some headaches "most of the time". This is the only reason she takes ongoing medication.

In reference to the **right hand,** she still complains of weakness and some numbness. This occurs with use. The pain is mostly along the radial aspect of her hand in the distribution of the median nerve. She does not have any tingling or is she awakened at night by this. She wears a night splint on her right hand as well.

In reference to her **cervical** spine, she complaints of intermittent **pain** primarily in the right side neck, upper back and trapezius area. It is usually a mild aching pain,

but sometimes a deep aching pain. Activities do not seem to adversely affect it neither do changes in weather. Prolonged sitting and stress seem to aggravate her neck and upper back symptoms. They were more in the right trapezius in a fairly diffuse location above the level of the scapula. She does not have true neck pain. She continues to do her stretching exercises and hot showers seem to relieve these symptoms.

The last area is her lumbar **spine.** Essentially this area "feels better". She is minimally symptomatic.

I specifically asked her from a subjective standpoint how she feels now in relation to the way she felt prior to the second motor vehicular accident. She remarked "I have not quite reached" the level that she was prior to the second accident. She clearly admits that the early 1997 accident aggravated the same areas.

EMPLOYMENT HISTORY: She is currently employed as a school psychologist for the Mentor Board of Education. She lost occasional days here for doctor's visits. She is a salaried employee.

PHYSICAL EXAMINATION revealed a pleasant 41 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. Ascending and descending the exam table was performed normally. She seemed to sit comfortably. She did not appear in any distress.

Examination of her cervical spine revealed a claim of tenderness in the right trapezius area. This was not very sore at the time of this evaluation. There was unrestricted range of motion in forward flexion, extension, side beading and rotation. Left rotation seemed to give her some decreased discomfort. There was no spasm, dysmetria, muscular guarding or increased muscle tone in the neck, back or periscapular area. No muscular atrophy was noted in this areas as well. Despite the pain, she appeared to have normal upper back and neck function.

Examination of both shoulders revealed no areas of tenderness. There was good muscular development bilaterally. 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. Circumferential

measurements of both upper extremities at the axillary, midarm, forearm and wrist level were symmetrical bilaterally. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal. There was no abnormality in two-point tactile discrimination. There was a mildly positive Phalen's sign on the right side at approximately 50 seconds. A positive Tinel's sign was noted just proximal to the wrist flexion crease. This is compatible with mild and/or subclinical carpal tunnel syndrome.

Examination of her lumbar spine revealed no gross abnormality in the form of spasm, dysmetria, muscular guarding or increased muscle tone. There was a full unrestricted range of motion in forward flexion, hyperextension, side bending and rotation. There was good reversal of her lumbar lordosis. Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. Neurologic examination of both lower extremities was normal.

IMPRESSION: Subjective residuals of a recurrent cervical and lumbosacral strain and sprain. She was clearly improving when the second accident occurred. Mild unrelated right carpal tunnel syndrome. Mild cervical spondylosis at the C5-6 level.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from the Lake County Hospital, University MEDNET including the consultation reports, records from Dr. William R. Acosta, results of the MRI scans, as well as limited records from Dr. Richard Dickson.

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.

Initially, according to the records, it was felt that this was primarily a cervical strain or sprain. The EMS and ER personnel were somewhat concerned of the complaints of "tingling" in the right upper extremity. The work-up showed, at worst, paracervical muscular strain or sprain in the neck and back, as well as a possible right shoulder contusion. There was no bruising noted.

She followed up with Dr. Dickson. Reviewing his records and a somewhat verbose report, reveals, at worst, a strain or sprain of the neck and low back. The low back is recurrent. It is difficult to ascertain the exact care and treatment provided by this physician on review of his records. His pre-first motor vehicular accident records were requested.

The neurological evaluation and all diagnostic scans failed to show anything other than some very mild degenerative abnormalities, No significant traumatic lesions were noted.

In summary, at the time of this evaluation she was clearly not subjectively recovered from her second motor vehicle accident. The exact same areas were injured. Despite her ongoing complaints, the objective examination was entirely normal. In my opinion, she has objectively recovered from any soft tissue injuries sustained. She still has a variety of soft tissue complaints in her neck and upper back which she relates to a combination of both motor vehicular accidents. In reality; however, she has objectively recovered. There is no objective evidence of any permanent injury. According to the AMA guidelines, on the basis of this evaluation, there is a permanent physical impairment of 0%. The long-term prognosis is favorable for subjective recovery.

Sincerely,

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

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