Highland
Musculo-Skeletal
Associates, Inc.

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RE: Ruth Renz
DOI: 2/27/93

Dear Ms. Steiber:

I evaluated the above plaintiff in my office on August 28, 1996, in reference to alleged residuals of injury sustained in a somewhat unusually described incident which occurred on February 27,1993.

At that time, she and her husband were leaving the Brecksville Party Center after attending an affair. **As** customary, her husband would go pick up the car and pick her **up** in front of the facility. She was apparently standing on some *carpeting* in front of the party center. Her husband, as he pulled up, apparently caught the carpeting under the wheels and essentially pulled the carpeting out from underneath her feet. Her legs went out from under her and she fell backwards in a somewhat sitting and twisted position.

Initially she felt "shocked." Her husband helped her up and they went home. She claimed to have immediate complaints of **pain** in her low back region and was evaluated at the Marymount Hospital the following day. However, according to the medical records at Marymount Hospital, there was absolutely no complaints of back pain made at that time to her physician. The **primary** injury was tenderness over the left foot and ankle region. As noted by the ER physician "thoracic and lumbosacral

spine non-tender to palpation with full range of motion without any difficulty." This clearly indicates there was no acute trauma to her low back noted at the time of this emergency room visit. Her discharge diagnosis was left ankle and foot strain or sprain.

She stated she subsequently was followed by Dr. John Makley, an orthopaedic surgeon associated with University Hospitals of Cleveland. It was my understanding at the time of the evaluation that she immediately went to this physician. Dr. Makley had been treating her husband for a somewhat unusual bone disease. His initial evaluation was on March 4, 1993. There was absolutely no mention at that time of complaints or problems with her low back. That evaluation was solely for the left ankle. The x-rays were reviewed which were essentially normal. He elected on conservative management.

On follow-up examination on March 29, 1993, this was the first mention of "started complaining of dull aching low back pain.'' Some low back stiffness was noted and she was placed on an anti-innammatory medication.

Because of persistent symptoms she ultimately had an MRI of her lumbar spine performed April 14, 1993. This demonstrated disc narrowing at the L4-5 level with central disc bulging at this level as well. There was some suggestion of a "herniated disc." A conservative approach was followed. Essentially only medication was prescribed until physical therapy was initiated in May of 1993 at the Marymount Hospital. She was given a "weight lifting belt" in order to help protect her low back. Through the summer months of 1993 her symptoms continued without resolution. It was decided to proceed with additional diagnostic studies.

A CT myelogram was performed at the University Hospitals of Cleveland on October 19, 1993. This revealed multiple level disc bulges, as well as facet disease (arthritis). She was evaluated by a second'orthopaedic surgeon, a spinal specialist, Dr. Sanford Emery, on November 11, 1993. It was his impression that this was "mechanical back pain." There was no clinically relevant herniated disc. He did not feel that any surgery was warranted.

She continued to follow with Dr. Makley with some improvement noted with physical therapy. A 'TENS unit was provided for pain control. She continued with complaints of low back pain without any radiating pain into her lower extremities. She still continues to see Dr. Makley on an intermittent basis. Her next appointment is in September of 1996.

CURRENT MEDICATIONS include Relafen which she takes twice a day and Motrin which she takes on an as necessary basis, but can be anywhere from 0 to 3 per day.

THERAPY AND BRACING: There was two sessions of physical therapy, one in 1993 and one in 1994. She wears no low back brace at this time.

EMPLOYMENT HISTORY: She, in the past, had been employed doing cleaning and office work for the Benedictine School. There was no claim of loss of work during this time period at the time of this evaluation. She was essentially terminated in March of 1996 due to "a change in the school policy."

PAST MEDICAL HISTORY revealed no previous low back injuries or problems. She was in a motor vehicular accident a number of years ago and was cared for by Dr. Willis Erwin for a fractured left leg.

CURRENT SYMPTOMS: The plaintiff essentially has pain and ongoing symptoms in two areas, the low back and left leg. The left leg she feels is in the region of her previous fracture site. I carefully questioned her on a repeated basis as to any relationship between her low back pain and her left leg pain. She felt that these symptoms were "totally separate."

In reference to her low back pain, this is primarily a midline lumbosacral pain. She is never comfortable. The pain does not alter with weather changes. Lifting and bending, and any increased activity, tends to subjectively worsen the pain. She also claims to have limited standing and walking ability. When sitting for any periods of time she needs to be in a chair with a back support. This is primarily a midline low back discomfort that does not radiate laterally past two or three inches. It is well

confined to the lumbosacral spin There is no complaints of radiation into the buttock, posterior thigh, or lower extremity.

In reference to her left leg discomfort, she feels this is, as noted above, a "totally separate problem." She complains of some intermittent localized numbness along the lateral aspect of her foot with intermittent swelling. She was wearing an anti-embolic elastic stocking at the time of this evaluation. She claims to wear this on a daily basis. She feels this is related to the ankle portion of her injury.

PHYSICAL EXAMINATION revealed a somewhat apprehensive appearing 58 year old female who appeared in no acute distress. She appeared to sit comfortably through the bulk of the examination. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally.

Specific examination of her lumbar spine revealed no objective signs of injury or abnormality. She claimed to have diffuse pain in the midline low back region. There was no spasm, dysmetria, or muscular guarding. There was some tenderness noted but no objective correlation. She claimed to have a decreased range of motion of her lumbar spine being able to bend forward only to the knee level. There was; however, good reversal of her lumbar lordosis with this maneuver. Hyperextension, side bending, and rotation showed approximately 20 to 30 percent restriction of motion that was due to complaints of low back pain. There was objective correlation with these restrictions. The range of motion; however, in the sitting position, she was clearly able to bend forward to touch just above her ankle level.

In the sitting position her straight leg raising was performed to 90 degrees bilaterally. When asked to point to the level of ankle pain she clearly was able to flex, as noted above, to the ankle level. There was a full range of motion of her hips in flexion. No atrophy was noted in either lower extremity on circumferential measuremens of the upper and lower thigh, and upper and lower calf level. Her straight leg raising in the supine position; however, was limited to approximately 45 degrees with complaints of "severe back pain." She tended to go from a sitting to lying position and vice versa using her upper extremities for support.

Examination of her lower extremities revealed essentially a normal knee and ankle exam bilaterally. There was no objective abnormalities noted on range of motion of her foot and ankle, or inspection and circumferential measurements of her ankle and feet.

IMPRESSION: Related to this injury, left ankle strain or sprain. Origin of low back pain documented approximately one month post injury. MRI evidence of multiple level early degenerative disc disease with some degenerative bulging. No clinical evidence of a herniated disc.

DISCUSSION: I have had the opportunity to review medical records associated with her care and treatment. These include records from the Marymount Hospital, University Hospitals of Cleveland and Dr. John Makley, Dr. George Topalsky (family medical doctor), Dr, Willis Erwin, MagnaTech (MRI scan), and records from Dr. Thomas and Associates.

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 my opinion, based on a reasonable degree of medical certainty and probability, that the **primary** injury sustained, according to the medical records, was a sprained left ankle. There was no documentation of any low back pain initially and, in fact, according to the emergency room records, the thoracolumbar spine examined normally and there were no complaints. This story differs greatly from the patient's recollection of the events. It was not until a second visit with Dr. Makley that there was any mention of complaints of low back **pain.** In my opinion, her low back is related only to the incident in question by her history. There was clearly evidence of long-standing degenerative disc disease including degenerative bulging. There was never any documentation of any clinically significant disc herniation. **As** also noted above, there has never been any complaints of radiculopathy. She clearly states the left leg symptoms are totally unrelated from her back discomfort. This has generally been the impression of her treating orthopaedic surgeons.

There are a number of discrepancies noted at the time of this evaluation. From the history standpoint, there was a significant difference between the "immediate low back pain" noted by the plaintiff and that noted in the medical records. There was no explanation from an orthopaedic basis for an acute low back injury not manifesting itself with a 72-hour period. There was absolutely no mention of her back when she saw Dr. Makley. She was clearly concerned about her injury but documented only an ankle problem. The low back pain was not documented to have started until later that month, primarily in the form of stiffness. This seemed to worsen from this point on.

At the time of the physical examination there was also discrepancies noted. These included the difference between the sitting and supine straight leg raising and the difference in flexibility of the lumbar spine in the standing and sitting position. These tests essentially evaluate the same anatomic areas and should be equivalent. The discrepancy, in my opinion, is either due to the patient's attempt at exaggerating her injuries or an issue of malingering.

There is clear evidence in the medical records of ongoing objective abnormalities in her lumbar spine in the form of degenerative disc disease and arthritis. There is no documented clinically significant herniated disc, that is an MRI correlation between her symptoms and physical examination. She has solely low back pain. In my opinion, this is due only to her degenerative condition. Within a reasonable degree of medical certainty, if a severe low back injury did occur at the time of this slip and fall, there would have been immediate symptoms in her low back or at least some abnormality within the first 12 to 24 hours. There were no complaints registered at the time of Dr. Makley's evaluation a number of days after. In my opinion, the back complaints, care and treatment, scans and consultation were unrelated to the slip and fall which occurred on February 27,1993.

The long-term prognosis is favorable. There is a degenerative condition which will likely worsen with age. In my opinion, there was no permanent aggravation or acceleration of a pre-existing condition. The only historical reference between her current back complaints and the incident in question is by her history. She has

objectively recovered from any soft tissue injury sustained to her lower extremity. The long-term prognosis, in my opinion, is favorable.

If any additional records become available including the MRI scans, I would be glad to review these for you.

Sincerely,

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

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