Highland
Musculo-Skeletal
Associates, Inc.

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September 18, 1997

Ronald A. Margolis
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The Superior Building, 21st Floor
815 Superior Avenue, NE
Cleveland, OH 44114-2701

RE: Rebecca Thompson
Case No. 320330
File No. 1700-13993

Dear Mr. Margolis:

I evaluated the above plaintiff in my office on September 15, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident, which occurred on December 13, 1993. She was evaluated in the office without friend, family, or legal counsel present.

She was a rear-seat passenger side occupant of a late model Nissan vehicle at approximately seven or eight o'clock in the evening on December 13, 1993. There were two people in the front seat and she was in the rear seat with a dog. The accident occurred on 1-480 heading in a westbound direction, past Great Northern Boulevard. According to her history, the driver lost control of her vehicle and struck the concrete median. She was not wearing a seatbelt.

At the moment of impact she was thrown in a somewhat twisting fashion, striking both knees on the back of the front passenger seat. She was thrown forward and, in fact, hit the headrest. She believes she may have lost consciousness. She also believes that her knees may have damaged a plastic portion of the rear of the seat.

There was a laceration under her nose and a "chipped tooth". Her nose was bleeding. Her left knee hurt more than her right knee.

She was conveyed by ambulance to the St. Johns and Westshore Hospital Emergency Room where she had her initial evaluation. It was felt that she had a laceration to the inner upper lip about 1/2 cm long, which was, I believe, repaired. She also was felt to have a contusion of her left knee and left ankle. Facial x-rays were normal as were x-rays of her left ankle and left knee. She was placed in a knee immobilizing device and discharged from the hospital.

She believes she saw Dr. Nabil Angley as the initial orthopaedic consult. This evaluation, according to the records, was on December 17, 1993. He felt that her knee injury was a sprain of medial collateral ligament and recommended a knee immobilizer. There was no gross instability note. No abnormality in patellar tracking was noted. There were no signs of cruciate ligament injury. Both she and her mother were not "happy" with Dr. Angley and they sought a second orthopaedic opinion with Dr. Robert Blankfield, associated with Ohio City Orthopaedics, Dr. Blankfield, according to the records, tried a variety of treatments including a number of injections into her trochanteric hip area, as well as therapy, initially at Lutheran Hospital and then through his company sports medicine clinic, Initially she was seen twice a week through therapy and then as needed. Treatments consisted of modalities and stretching for her "whole back". She was complaining of pain in the neck, upper back, periscapular and shoulder region all the way down to her tailbone. Sitting for periods of time bothered her. She continued to have poorly localized diffuse aching pain in her knee.

The primary diagnosis that she underwent treatment for was a lumbosacral muscular strain and a cervical muscle strain. Dr. Blankfield also treated her for left trochanteric bursitis. Ultimately she was referred to one of his associates, Dr. William Bohl, for her knee problems. Dr. Bohl's conclusion was that this was "anterior knee pain" but no specific diagnosis was made. She also had transient symptoms and impingement syndrome of the shoulder area but this resolved. There

were numerous injections given both in her hips and knees with some overall improvement.

The only physician she had contact with was in late 1995, Dr. Patrick Sziraki, in Medina, Ohio. An MRI scan was ultimately performed of her left knee, which was entirely within normal limits. He saw her initially on or about October 23, 1995. He was suspicious of an internal derangement. He also felt that this was "anterior knee pain" with no other diagnostic impression. There was no remarkable patellofemoral instability, a suspicion of chondromalacia or any structural abnormality. He provided her with an elastic knee brace.

She has had absolutely no care or treatment for her symptoms since late 1995. She still continues to have symptoms, taking over-the-counter Ibuprofen. She was taken 800 mg four times a day but this never really helped her. The accident occurred when she was in the 11th Grade. She never finished high school 'for .this and a number of social reasons. She has been working and has lost no time from work, now holding down two jobs.

EMPLOYMENT HISTORY: She is currently working full-time as a server for the Macaroni Grill Restaurant in North Olmsted, Ohio. She also has a part-time job working as a cashier.

PAST MEDICAL HISTORY failed to reveal any previous or subsequent injuries.

CURRENT SYMPTOMS: At the time of this evaluation she had a variety of continuing soft tissue complaints. Most of her pain was in the midline and paraspinal muscles from the base of her neck down to her tailbone. Her low back seemed to be worse with prolonged sitting and standing. This was described as a severe, deep and sometimes sharp pain. Sitting for long periods of time was one of the worst things that she could for herself The symptoms she felt were on a daily basis. She significantly limits the amount of times she spends sitting.

Specifically in reference to her neck, she complains of intermittent stiffness. She has to move her neck and "crack it" about every half-hour. Rotational movements seem to bother her in the past. Her neck would "stick" if she repeatedly moved her neck in a rotatory fashion. This happens occasionally at this point.

In reference to her low back and lower extremities, she develops a deep dull aching pain primarily in the midline. There is no true radiating or radicular type of pain. The trochanteric area at the hip, right worse than the left, sometimes "snaps and cracks". She was unaware of any direct trauma sustained to the hip area.

In reference to her knees, she has a generalized aching anterior knee pain. She has the sensation of the knee wanting to give out and buckling after climbing four sets of steps. She cannot walk up and down hills and has difficulty riding a bike. Her knees "feel bruised all the time". Driving sometimes bothers her left knee, maintaining one position for long periods of time.

Her worst areas are her right hip and left knee, as well as a generalized back discomfort.

PHYSICAL EXAMINATION revealed a pleasant, very articulate, 20 year-old female who appear in no acute distress. From an objective standpoint, there was very little abnormality detectable. She was able to sit, stand, and move about the exam room normally. She did not appear in any acute distress. Her gait was normal. She was able to walk on her heels and toes without difficulty. Arising from a sitting position was performed normally, as was ascending and descending the exam table.

Examination of her cervical, mid thoracic and lumbar spine failed to reveal spasm, dysmetria, muscular guarding or increased muscle tone. She claimed to have tenderness to palpation about the mid thoracic level at the lower border of her scapula, just below her bra line. There; however, was no objective correlation with her tenderness. There was full flexibility of her cervical spine in forward flexion, extension, side bending and rotation. Her thoracolumbar spine also examined normally in mobility, being able to be forward to touch just above her ankle levels.

Hyperextension, side bending and rotation were performed normally. There was a full motion of her shoulders, elbows, wrists, and small joints of the hand. Range of motion of both hips and knees was normal.

Her straight leg raising both in the sitting and supine positions were performed to 90 degrees bilaterally. He leg lengths were equal. There was no atrophy noted in circumferential measurements of her upper and lower thigh and upper and lower calf level. A detailed neurologic examination of both upper and lower extremities was normal.

IMPRESSION: Subjective residuals of a back strain and knee contusions. No ongoing objective evidence of treatable abnormality. She has objectively recovered.

DISCUSSION: I have reviewed some medical records associated with her care and treatment. These included records from the St. John's and Westshore Hospital, Dr. Angley, Ohio City Orthopaedics, as well as the records from Dr. Sszirаki.

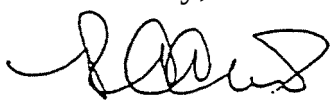
After careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of medical records, I have come to some conclusions concerning her ongoing level of physical impairment.

On review of the records, her injuries were, at worst, a muscular pulling or stretching injury involving her neck, mid and lower back. She may have sustained a knee contusion. There was a slow response with physical therapy and she continued to have a "excessive," in her words, amount of pain. She still continues to have pain on a daily basis despite the normal physical examination. She had a great deal of physical therapy related to her level of symptoms. This, I believe, was appropriate for at least three or four months after the motor vehicular accident. Fortunately no significant muscular or neurological injury was every noted. On the basis of this evaluation she has objectively recovered from any soft tissue injury sustained.

The long-term prognosis is favorable. Although she still complains of a fair amount of discomfort, she is fully active and holding down two jobs. On the basis of this

exam, I have no clear explanation for the ongoing source of her symptoms. Typically soft tissue injuries in her age group resolve within a short period of time with appropriate therapy the symptoms are usually gone by two and one-half to three and one-half months. On the basis of a normal objective evaluation, in my opinion, she has recovered. She still continues to have a variety of complaints of pain without objective findings. On the basis of this evaluation, no further care or treatment is necessary or appropriate. Despite her level of discomfort she has recovered.

Sincerely,



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

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