Highland
Musculo·Skeletal
Associates, Inc.

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

September 20, 1997

Phillip A. Kuri
Attorney at Law
920 Key Building
159 South Main Street
Akron, OH 44308

RE: Evelyn Valentin
Case No. 96 CV 0658 (Mahoning Co)
File No. 1072/13966-NAS
DOI: 10/14/94

Dear Mr. Kuri:

I evaluated the above plaintiff in my office on September 10, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on October 14, 1994. The patient was evaluated without friend, family or legal counsel present. She was an extremely poor historian, not being able to recall much of the details in her care and treatment.

She did recall a motor vehicular accident that occurred on the above date, October 14, 1994. At that time she was the driver of a motor vehicle with no additional occupants. She was not wearing a seat belt. There was a history of a head injury with mild neck pain, as well as initial complaints of severe headaches and blurry vision.

She was conveyed by ambulance to the St. Elizabeth Hospital in Youngstown, Ohio, where she had her initial evaluation. The main concerns at that time were mild neck pain, severs headache, and blurred vision. Physical examination revealed a normal range of motion of her cervical spine. She did have x-rays done of her cervical spine

which were essentially normal, other than some mild disc space narrowing at the C3-4 levels. These were not felt to be traumatic. The major treatable injuries were two lacerations of the forehead, which were repaired in layers. Multiple x-rays were performed and these were all essentially within normal limits.

As you are aware, she has not had a great deal of care or treatment since that time. She reported to her family physician, Dr. Benjamin Hayek, on October 18, 1994. She followed with this physician on an intermittent basis for muscular tightness in her neck, upper back and paraspinal area. Physical therapy was initiated with active and passive modalities. She was treated conservative. The therapy in the doctor's office was not terribly successful and she had some hospital-based physical therapy as well. She followed with this doctor through the end of 1994 on a fairly regular basis . Dr. Hayek felt that she was disabled from her job during this period of time from October 14, 1994 until his last visit in late November of 1994.

Physical therapy was carried out at the St. Elizabeth's Hospital in Youngstown, Ohio, through the latter months of 1994. According to the records, the last visit was OR January 31, 1995. She was treated essentially for a soft tissue neck injury.

One additional physician saw her, Dr. Lynn Mikolich. This evaluation was carried out on or about November 23, 1994. It was felt that she had traumatic headaches and residuals of a cervical muscle strain or sprain. An MRI scan was performed of her cervical spine on November 16, 1994. This showed a small disc protrusion on the right paracentral at C4-5 without neurological impingement. Some spondylosis was noted at the C4-5 and *C5-6* level.

It did not appear that she has had any significant medical care or treatment since late January of 1995. She did have several bouts prior to this time of frequent epigastric and abdominal problems. She did have a previous motor vehicular accident in which her forehead was injured. The exact date could not be recalled.

At the time of this evaluation she stated she was on no current medication. She has had a number of jobs since the accident but was unemployed when the accident

occurred. She currently works as a packer. The bulk of her symptoms are a deep, dull aching pain, primarily in the right trapezius and intrascapular area. She also has occasional aching sensations which go into her right shoulder, right elbow and right wrist region. She complains of the pain being moderately severe on occasions. This seems to be most severe with repetitive bending and lifting, or when she is maintaining her posture and position for any period of time. There are absolutely no neurological symptoms. The bulk of her pain is in the left upper back and trapezius area.

PHYSICAL EXAMINATION revealed a very pleasant, somewhat soft spoken 40 year old female who appeared in no acute distress. Her ability to walk was normal, She was able to stand, sit, and move about the exam room without difficulty. Her gait pattern was normal.

Examination of her cervical spine revealed no midline tenderness. There was some soreness in the right upper back and trapezius area. On range of motion there was very minimal restriction of motion at the extremes of forward flexion and hyperextension with over 90% of her predicted range of motion. Full motion was noted in lateral bending and rotation. Protraction, retraction, and elevation of the scapular were performed within normal limits. There was some discomfort at the extremes of these motions but no objective findings in the form of spasm, dysmetria, muscular guarding or increased muscle tone. 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 equal and symmetrical bilaterally. **A** detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

Examination of her lumbar spine showed full lumbar flexibility. There were no objective signs of injury. There were no complaints in this area at the point of this examination. Lower extremity exam was normal.

IMPRESSION.: Subjective residuals of a cervical strain. Healed forehead lacerations.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These records included those from St. Elizabeth Hospital in Youngstown, Dr. Hayek and Dr. Mikolich.

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.

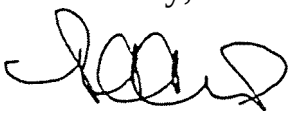
On the basis of this evaluation, in my opinion, she sustained the lacerations of the forehead, as well as a soft tissue strain or sprain of the cervical spine. The initial emergency room care and treatment was appropriate. The care and treatment provided during the balance of 1994 and early 1995 were also appropriate for a cervical strain or sprain. She still continues to have intermittent symptoms of a similar nature. These symptoms are, by history, related to the motor vehicular accident in question.

As noted above, on the physical examination, there was very little in the way of objective abnormalities. There was some very minor stiffness in her cervical spine, certainly compatible with two-level cervical disc disease. Review of the MRI results clearly show disc abnormalities at the C4-5 and C5-6 level. There was a small degenerative type herniation at the C4-5 level. There was no impingement; however, of the spinal cord or spinal nerve roots. In my opinion, her symptoms are not stemming from this minor x-ray abnormality.

The long-term prognosis is favorable. She has not sought any medical care or attention for 18 months, On the basis of this evaluation, she has objectively recovered. She still continues to have a variety of subjective complaints which are historically related to the motor vehicular accident. There are minimal long-term objective findings and there are no treatable abnormalities noted at the time of this evaluation. In general, the long-term prognosis is favorable. No further care or

treatment is necessary or appropriate. **At** worst, she sustained a soft tissue strain or sprain of her neck and upper **back.** She has objectively recovered.

Sincerely,



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

RCC/bn

cc: File

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Timothy L. Cordon, M.D.
Orthopaedic Surgeons

:September 20, 1997

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

RE: Nadine Pajor
Case No. 97 CV 118292 (Lorain Co)
DOI: 8/3/96

Dear Mr. Hanson:

I evaluated the above plaintiff in my office on September 16, 1997 in reference to residuals of injury sustained to her right leg. Throughout the history and physical, she was accompanied by her daughter, Chris Stempowski.

She described the injury as occurring at her place of residence, The Westwood Mobile Home Park. On that day she was assisting a neighbor with a problem. Apparently the Mom fell asleep while food was cooking and a small pan fire developed. The unit smoke detector went off, it woke the neighbor's children, but did not wake the neighbor. The children went next door to get Mrs. Pajor. She entered the mobile home but could not see anything due to the fact that there was a great deal of smoke. As she exited she fell off the steps onto a concrete slab, sustaining any injury to her right tibia and fibula.

Initially she was conveyed to the Amherst Hospital where the initial x-rays and examinations were performed. She was placed in a splint and then transferred to the Elyria Memorial Hospital. She came under the care of Dr. Purohit, an orthopaedic

surgeon, who ultimately performed a closed intermedullary nailing (internal fixation) using a non-locked tibial nail. She was hospitalized until August 6, 1996 and then discharged to her daughter's home.

Since that time she had follow-up care with her treating orthopaedic surgeon. Periodic x-rays were taken and ultimately the fracture completely healed. She was started on gradual weight bearing after approximately a month. Her cast was switched to a brace and she was gradually mobilized. Her last visit with her physician was in July of 1997.

At the time of this evaluation her fracture site still remained sensitive. She had difficulty kneeling and doing some of her housework because of some aching pain in her right leg and knee. Walking for long periods of time seemed to bother her. She continued with a cold sensitivity. She tends to wear high socks all year round in order to keep the leg "warm". Her doctor did mention at the time of the last visit that he was considering taking out the internal fixation nail.

PHYSICAL EXAMINATION revealed a pleasant 55 year old female who appeared somewhat older than her stated age. Her gait pattern was normal. There was a very mild limp for the first two to three steps and then the limp disappeared. There was a well-healed scar anteriorly over her patellar tendon compatible with the insertion point for the nail. There was some uncomfortable swelling around the side of the fracture site which appeared to be bony to palpation. The overall alignment of her leg was excellent. It appeared to be quite stable. There was full function of her knee and ankle joints. She did also complain of having some pain in her right foot where she had previous' reconstructive foot surgery. This area was also somewhat uncomfortable for her.

Examination of her muscles revealed a very slight degree of muscle wasting in the right calf. She had not been on an ongoing rehabilitation.

The plaintiff permitted me to have x-rays done of her right tibia and fibula. This showed the intermedullary nail in excellent position and the fracture had completely healed.

IMPRESSION: Healed fracture, right distal third tibia and fibula.

DISCUSSION: I have had the opportunity to review' a number of medical records associated with her ,care and treatment. These records included those from the Amherst Hospital, as well as the Elyria Memorial Hospital Medical Center. Records were also reviewed from her surgical procedure.

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.

The diagnosis is quite clear in that she sustained a closed fracture of the distal third of the tibia and fibula. This was appropriately managed with an intermedullary nailing: It went on to anatomic healing and no significant objective orthopaedic residuals by x-ray. The intermedullary nail appeared to be in normal position. It was not protruding through the bone and would not be a source of ongoing discomfort. The choice to remove the nail is solely up to the patient and the physician. It is doing absolutely no harm in its present condition. If it is elected to remove the internal fixation device, then this second surgery would obviously be related to the original injury.

The only abnormality noted was the palpable fracture site which is typical for this type of injury. She did have a slight degree of right calf atrophy. She has clearly not been on any rehabilitation and this typically is 100% reversible. With appropriate ongoing mild exercise, including walking, complete objective recovery is typically realized.

The long-term prognosis is favorable. There is no signs of post-traumatic arthritis and it would be highly unusual for that to develop. The only care and treatment that would be necessary in the future would be for extraction of the intermedullary rod. This is typically done as an outpatient without any hospitalization. The cost would be in the realm of $1500 to $2500, including both surgeon and the hospital fees.

The long-term prognosis is favorable. She is recovering quite nicely.

Sincerely,

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

RCC/bn

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