Highland
Musculo-Skeletal
Associates, Inc.

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

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Stephen C. Merriam
Attorney at Law
126 West Streetsboro St., Suite 4
Hudson, OH 44236

RE: Dixie Johnson
Case No. 295020
File No. 2565 AS

Dear Mr. Merriam:

I evaluated the above plaintiff in my office on August 9, 1996, in the presence of her attorney, Mr. Michael Shapiro. This was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on December 21, 1993.

The accident as described occurred at approximately 3:30 in the afternoon in the vicinity of Villa View and Neff Road in Cleveland near the Euclid border. She was the driver and solo occupant of a late model Cadillac. She was the fifth or sixth car back at this intersection, and a rear-end collision occurred. The impact did not force her into the car in front of her. She did not know what happened at that time and heard a "loud explosion." She thought she was shot at and did not feel initially that she was in a motor vehicular accident. She noticed in her rearview mirror that a pickup truck was behind her. It appeared to be a distance from the rear of her car and she didn't think that she was initially hit. She does not recall being thrown forward or backwards. This was a work-related injury in that she was on her way home from the bank. She was able to drive back to work, being employed as a buyer for the George Whalley Company on South Waterloo in Cleveland.

Overnight and the next day she developed sharp stabbing pains, primarily in her low back region radiating down into her lower extremities. She returned to Dr. Bruce Bond, a chiropractor that had been previously treating her for her spinal complaints. New x-rays were taken and she was started on a treatment regimen of heat, electrical stimulation and manipulation. He has been her sole treating physician and has treated her intermittently since that time. According to the medical records, the treatments were not altered in anyway, shape or form, consisting of a brief office visit and attended ultrasound session, as well as electrical muscle stimulation. Reviewing the chiropractor's records indicate the exact same treatment was provided with some slight alterations in the use of infrared and intermittent traction throughout this entire time period. Treatment records were reviewed from late 1993 through 1994, and intermittently through 1995. She went for chiropractic treatments on a regular basis. The working diagnosis was a soft tissue strain or sprain of the neck, chest, and low back area.

On or about May 23, 1996 she was evaluated by Dr. Harold Mars. The history and physical was presented, and a series or neurodiagnostic tests were performed. These included an EMG and nerve conduction study which suggested carpal tunnel syndrome bilaterally with no evidence of acute cervical radiculopathy. There was a normal neurodiagnostic study of the lower extremities. An EEG was performed on June 4, 1996, and was interpreted as normal. An MRI scan was ordered by Dr. Mars on July 15, 1996 and showed a small central disc herniation associated with osteophytes obliterating the ventral subarachnoid space at C5-6. There was a bulge at the C6-7 level as well, secondary to degenerative disc disease (osteophytosis). Flexion, extension laterals did not suggest any instability. The last time she saw Dr. Mars was in early August of 1996. It was recommended that she continue with the same treatment.

EMPLOYMENT HISTORY: She took 10 days of vacation around the time of the accident and has been working since that time. The type of work she does is primarily clerical office work, working with inventories and computers for this tool company.

She has not had any substantial loss of work. A Workers' Compensation claim for this injury has been filed.

BRACING AND MEDICATIONS: She was provided a soft cervical collar by the chiropractor which she wore for approximately two weeks. She occasionally wears this when the neck aches a great deal. She is on no prescription medicine and takes Tylenol, two tablets a day.

PAST MEDICAL HISTORY is significant. In the late 1960s or early 1970s she was involved in a motor vehicular accident with treatment at the St. Vincent Charity Hospital. She started having back pain about three months after this. She has had intermittent chronic back and neck pain since that time. For the past 20 years she has had off and on treatments for this. At one point in time she was hospitalized for x-rays at the Richmond Heights General Hospital and has also been evaluated at the Cleveland Clinic for osteoarthritis which was subsequently noted. During the late 1980s and early 90s, there were periodic flare-ups. She has been under Dr. Bond's care on an intermittent basis since 1990.

Two additional injuries occurred; on December 31, 1991, she fell off a ladder while taking down Christmas ornaments and exacerbated her back problems. She resumed treatments which lasted for six to seven months, presumably into 1992. A third incident occurred on June 28, 1993, when she fell down some steps at home. She went directly to Dr. Bond's office and returned to therapy. She was also treated for three or four months for this.

CURRENT SYMPTOMS: The bulk of her symptoms are in her cervical, thoracic and lumbar spine. There are no true complaints of radiculopathy although she does complain of some radiating numbness which does not follow any particular dermatomal pattern. At best, she has no symptoms which is how she felt at the time of this evaluation. At worst, she rates her level as an extremely intense pain.

In reference to her cervical spine, she describes a diffuse aching pain, primarily in the base of the neck at the C7 region. There is an increased discomfort with stress, housekeeping and especially with wallpapering which she has had to give up. The pain is described as throbbing when it is severe. It is very well localized in this area and does not radiate from this area into the upper extremities. She also complains of intermittent headaches, the last one was approximately three weeks ago. These are headaches that she essentially wakes up with and that are unrelated to activity.

In reference to her upper extremities, she complains of diffuse numbness and pins and needles sensation. These occur on an intermittent basis and radiate in a non-anatomic fashion in her upper extremities. She has minor complaints which could be described as carpal tunnel syndrome. These did not appear to be cervical radiculopathy.

In reference to her thoracic and lumbosacral spine, the pain is primarily in the midline at the lumbosacral junction and in the medial scapular region. This is described as an aching pain which is related to posture, position, and activity. There is also some leg numbness and tingling which follows the same distribution, that is "the whole leg goes numb." The bulk of her symptoms occur with prolonged standing in the midline lumbosacral region.

PHYSICAL EXAMINATION revealed a pleasant, somewhat heavyset, 57 year old female who appeared in no acute distress. She was able to sit, stand and move around the examining room normally. Her gait pattern was normal. She was able to heel and toe stand without difficulty.

Examination of her cervical spine revealed a claim of tenderness around the C7 region. There was; however, no spasm, dysmetria or muscular guarding noted. There was no signs of chronic or subacute inflammation. A full range of motion of her cervical spine was noted in forward flexion, extension, side bending and rotation. This did not provoke any discomfort at the time of this evaluation. Protraction, retraction, and elevation of the scapulae were also noted to be normal. 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. Neurologic examination was entirely within normal limits.

Examination of her thoracolumbar spine revealed no objective abnormalities. There was no spasm, dysmetria or muscular guarding. A full range of motion was noted in forward flexion, extension, lateral bending and rotation. Her straight leg raising was performed to 90 degrees bilaterally. Her leg lengths were equal. Circumferential measurements of both lower extremities was normal at the mid and upper thigh, and mid and lower calf region. A detailed neurologic examination was normal.

IMPRESSION: By history, resolving cervical, thoracic and lumbar soft tissue strain or sprain. These are **recurrent** injuries as she has had similar symptoms in the past that were quiescent. There was no evidence of neurological impingement or injury despite her symptoms.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from Dr. Bruce Bond and records from Dr. Harold Mars including the electrodiagnostic studies and the scan results.

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, at worst, she sustained a minor soft tissue strain or sprain. However, with this injury she claims to have had the ongoing need for care of a similar capacity. It does not appear that her chiropractor significantly altered the care and treatment. She would come in for treatment multiple times during a week and this was slowly diminished. A significant number of chiropractic treatments were administered. Through August of 1995, these total in

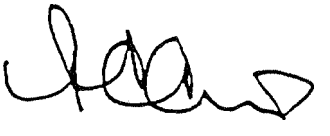
excess of $8400. In my opinion, this is somewhat excessive in that the treatments were not altered significantly. There was no notation of any comprehensive rehabilitation program including flexibility, strengthening, or conditioning. She just continued to receive passive therapy and manipulation.

Records reviewed from Dr. Mars clearly show some objective degenerative findings on the MRI scan as will be discussed below. The electrodiagnostic studies showed only a carpal tunnel syndrome with a suggestion of ulnar neuropathy. These did not correspond with the MRI abnormalities.

Review of the MRI scan indicates multiple level minor disc disease. This was most apparent at the C5-C6 and C6-C7 level. There are minor disc bulges, as well as what appears to be an anterior disc bulge. There was no significant spinal cord impingement. These abnormalities are those associated with early degenerative disc disease and are not associated with trauma. These studies were done on July 15, 1996.

In conclusion, it is my medical opinion, at worst, the claimant sustained a soft tissue injury. She was totally asymptomatic on the day of this evaluation. Her symptoms seemed to vary as noted above. In my opinion, based on this evaluation, no permanent injury was sustained. There was no permanent aggravation of her osteoarthritis. This is a recurrent injury in that she has had similar symptoms in the past. On the basis of this evaluation, she has objectively recovered from any soft tissue injury sustained. The long-term prognosis is favorable.

Sincerely,



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

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