Highland
Musculo-Skeletal
Associates, Inc.

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September 22, 1997

John A. Neville
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The 113th St. Clair Building
Cleveland, OH 44114

RE: Christine Corbo
Case No. 326162 (Cuyahoga County)
File No. 1380-05-31997-96

Dear Mr. Neville:

I evaluated the above plaintiff on two occasions, as you are aware. The initial evaluation was on August 8, 1997. During that time an independent medical evaluation was attempted. **A** complex medical history was performed which took approximately 30 minutes, The patient then refiised to be examined. **A** second examination was scheduled in which the history was again taken and ultimately a complete physician examination performed. The date of the second visit was on September 16, 1997. The history was taken by myself. **A** female office assistant was present for the actual physical examination.

As you are aware, the plaintiff still complains of significant ongoing pain and an inability to work. There has been a fair amount of very sophisticated diagnostic testing that has been performed. Very little of these abnormalities follow the patient's complaints.

ACCIDENT HISTORY: The accident occurred on April 25, 1995. She was the driver and solo occupant of a Pontiac SSEi vehicle in the vicinity of Prospect and Holiday Drive. She was moving approximately 35 miles per hour when a car allegedly came out from a side street. This car lost control and, in fact, two impacts

occurred on the driver's side of her vehicle. She described the first impact occurring with the car spinning and a second impact happening. This occurred at about two o'clock in the afternoon on a Saturday.

A coworker who was following her home, in fact, took her home. She complained in a very short period of time, of neck, upper back, and shoulder pain, as well as diffuse headaches.

Her initial evaluation was at the Kaiser Foundation Hospital two days after the accident, on or about April 24, 1995. Complaints at that time were an injury to her head, back, and shoulder area. Diagnostic tests were performed, including a cervical spinal x-ray, which was normal. They gave her a cervical collar and their clinical impression was cervical thoracic strain secondary to a motor vehicular accident, per the patient's history. This was essentially a muscle stretching type of injury.

She subsequently returned to her previous treating physician, Dr. Kenneth Klak. He has been her primary physician through most of this postop period. The initial evaluation was by one of his associates, Dr. Goekel. She was started on a series of physical therapy treatments which were essentially passive in nature. These included massage and manipulation. She was also seen at Southwest Therapy, a chiropractic center, for machine treatments twice a week for over a year. She did claim to have some relief of these symptoms, but it lasted only a very short period of time. She still continued with passive type of therapeutic approach.

Ultimately she was referred to Dr. Harold Mars, a medical neurologist, referred from Dr. Klak. He performed a number of diagnostic tests on her. He again felt, at worst, her injury was a cervical and lumbosacral strain or sprain, musculoskeletal headaches, a minor tremor, as well as carpal tunnel syndrome, which was probably unrelated. There was absolutely no history of any hand injuries. She still complained of a constant headache, neck and back pain. There were a total of three EMG and nerve conduction studies performed. To her knowledge, the only thing that showed was a carpal tunnel syndrome.

She also was seen by Dr. Medling, a clinical psychologist, who stated that she appeared anxious and tense on the day of the evaluation. It was felt that she had a depression which, by history, was related to this accident. She has been treated on Paxil, 20 mg daily. She also takes hypertensive medication and Tylenol.

Her primary physician still remains Dr. Klak. She still gets manipulations from his office from time to time. The only other abnormality that was noted was some very mild degenerative abnormalities in her cervical spine at the C5-6 level which was not felt to be specifically traumatic in nature. No disc herniations were noted and no neurological compromise was noted. She still wears her cervical collar "off an on."

At the time of the accident she was employed as a customer service representative for Ohio Savings. She has not worked since the time of the accident. This is due to the fact that she can no longer be on her feet for any length of time. She also has some subjective symptoms of lightheadedness and weakness. Prior to this job she worked in the catering department for Continental Airlines essentially doing kitchen work.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries to her neck and back.

CURRENT SYMPTOMS: As you are aware, she continues with a vast amount of subjective symptoms. These include problems in her neck, both left and right shoulders, arms, mid and low back region.

In reference to her **cervical** spine she complains of pain bilaterally in both trapezius muscles, the right slightly greater than the left. This is a deep aching pain which is sometimes "very intense." She also feels her neck is "clicking". She has these sensations on both the left and the right side. The pain in her neck and upper back seems to increase with any attempt at sitting or standing for more than a short period of time. She has this **pain** every day and all day. "Nothing has every helped". She has to change positions frequently while sitting, but in reality "nothing helps it". It has been at this level essentially since the time of the accident. Any increase in activity seems to worsen her symptoms. She described her pain as, at best, a level

"7," a moderately severe level, and at the time of the evaluation an 8 or a 9. **A** level "10" is a **pain** that is so severe that no human on earth can stand'the pain for more than five seconds. She did claim at the time to have a level "10" pain as well.

In reference to her arms and upper extremities, 'she complains of pain in the lateral aspect of both forearms. All her fingers are numb and tingly. The arm intermittently gets "so weak and so stiff I can't hold anything". The right side is usually worse than the left and it is in a "glove" distribution. Although the EMG's stated that she has carpal tunnel syndrome, the symptoms that she has seem to include many more anatomical areas.

There is a constant aching mid and low **back** pain. Again this has been all the time, every day since the time of the accident. It is primarily in the midline in the thoracolumbar junction and low in the lumbosacral region. Any increase in activity aggravates the pain. It is virtually her "entire back". When the back is at its worst, she has "pain traveling into my thighs and knees". There is also an aching pain in her legs which does not ever go below her knee level.

In addition, she complains of headaches every day. There was a history of filing a Bureau of Workers' Compensation claim for her carpal tunnel syndrome.

PHYSICAL EXAMINATION, as stated above, was carried out on the date of the second evaluation, September 16, 1997. I have been a practicing orthopaedic surgeon for over 18 years and I cannot recall a more unusual examination that that demonstrated by Ms. Corbo. Virtually every area that was touched, looked at, felt or pressed caused complaints of severe pain. She had an extremely bizarre robotic fashion of moving. There were; however, no signs of objective residuals of injury.

Examination of her cervical spine and upper back revealed tenderness virtually every area that was touched. There was; however, no detection of spasm, dysmetria, muscular guarding or increased muscle tone. There was only the complaint of pain (i.e., tenderness) to touch. There was a full and complete range of motion of her cervical spine in forward flexion, extension, side bending and rotation. She claimed

to have pain with virtually every movement. There was no abnormality in the muscles in the neck, upper back, or penscapular area in the form of spasm, dysmetria, muscular guarding, or increased muscle tone. No atrophy was noted in the neck, upper back or periscapular musculature. Range of motion of her scapulae was performed normally, and protraction, retraction and elevation with a significant amount of claimed pain. Range of motion of both shoulders was also performed normally with severe pain in the neck, upper back and shoulder region. The elbows, wrists, and small joints of the hand examined normally. There was a negative Tinel and Phalen sign. No atrophy was noted on circumferential measurements of either upper extremity at the axillary, midarm, forearm and wrist level. **A** detailed neurological examination was entirely within normal limits from an objective standpoint. The "numbness" that was felt did not follow any known nerve root pattern.

Examination of her thoracolumbar spine was also quite unusual. Again, virtually every area that was touched caused severe pain. She; however, was able to maintain over 90% of her predicted range of motion in forward flexion, extension, side bending and rotation. There was normal proportional muscle development in the paraspinal area. A full range of motion of both hips and knees were noted. **A** detailed neurologic examination of both lower extremities including sensory, motor and reflex testing failed to show any objective abnormality. No atrophy was detected in circumferential measurements of the upper and lower thigh or upper and lower calf level.

A number of discrepancies were noted during the examination. In the sitting position she could barely bend forward to touch her mid thigh level; however, in the sitting position she could bend forward to touch to her ankle level without difficulty. There was also a significant difference in the sitting and supine straight leg raise. This test essentially examines the same structures, that is the lower portion of the lumbosacral nerve roots and the sciatic nerve in particular. **A** stretch is deliberately placed on this nerve. She could maintain a 90-degree straight leg raising with a negative Lesague's sign while sitting. However, in the supine position I could barely lift her legs off the table 20 degrees.

The balance of the examination was normal.

IMPRESSION: By history, a soft tissue cervical and lumbosacral strain or sprain. Significant functional component to her pain with no objective abnormalities.

DISCUSSION: I have had the opportunity to review some medical records associated with her care and treatment. These include some records from Dr. James Medling, Dr. Harold Mars, Dr. Kenneth Klak, Dr. Nicholas Hadzima (chiropractor), and the Social Security Administration.

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.

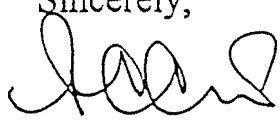
It is my opinion, based on a reasonable degree of medical certainty, that she had, at worst, a soft tissue strain or sprain of the neck and back region. These injuries typically heal within a six to eight week period of time and with conservative care and treatment, most of the symptoms are usually resolved by two to three months. This, of course, was not the history given by the patient who complains of a significant continuation of her pain despite any modality that was every prescribed. She also claims to be significantly physically impaired to the point that she is unable to work.

In reality; however, the examination was entirely within normal limits. She had a very bizarre physical examination as discussed above, which was not physiological in nature. There are some conflicting signs which were discussed above. This clearly indicates a degree of malingering or at least an attempt to exaggerate the level of symptoms. It was a most unusual examination. The soft tissues of the back and the extremities were painstakingly examined. I was unable to find any objective correlation with her symptomatology. In my opinion, there is a significant functional component to her complaints. That is, she feels the pain but there was no objective correlation.

On the basis of this evaluation, I have no orthopaedic explanation why she is unable to work. She has objectively recovered from any injury sustained. Despite this, she still has a fair amount of ongoing pain and dysfunction which were unexplained from a medical standpoint. There was no clear correlation other than by her history of the car accident being the source of her abnormalities. There is a substantial psychological component to her current clinical presentation.

On the basis of this evaluation, she should have been able to return to her previous employment many months ago. There is no clear explanation why this has not been done. She has recovered from any soft tissue injury sustained on the basis of the objective evaluation. Despite her level of pain, the physical examination was within normal limits. There is no medical explanation for this severe amount of ongoing symptoms without any correlating objective findings.

Sincerely,



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

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