Highland
Musculo-Skeletal
Associates, Inc.

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

October 12, 1997

Jan L. Roller
Attorney at Law
1700 Midland Building
101 Prospect Avenue, West
Cleveland, OH 44115-1027

RE: Adelaide Robertson
Case No. 322477
File No. V6250/851886

Dear Attorney Roller:

I evaluated the above plaintiff in my office on September 18, 1997 in reference to alleged residuals of injury sustained in a motor vehicular – pedestrian accident which occurred on or about June 17, 1996. She was evaluated without friend, family or legal counsel present.

She was in Solon, Ohio. crossing the street at the corner or Solon and SOM Center Road. A motor vehicle impacted her left knee. She was then thrown to the roof of the car and she sustained a closed head injury as well. The right leg may have been traumatized too and felt "a little numb" for a long time.

Initially she was conveyed to the St. Luke's Hospital Solon Urgent Care Center and then transferred to the St. Luke's Hospital. She underwent a number of x-rays, as well as a CT scan of the head. The CT scan was normal. X-rays of the knee did reveal the tibia plateau fracture, but this was not recognized initially. She was discharged home and not given a knee immobilizer.

The following day she had exquisite pain in the knee and could not move about at all. She notified Dr. Benes, her family medical doctor affiliated with University Hospitals of Cleveland, due to the severe pain. She was conveyed to the Meridia Hillcrest Hospital Emergency Room where she was placed in an immobilizer and referred to an orthopaedic surgeon, Dr. Paul Forcier.

Surgery was delayed due to her continuing vertigo and control of her diabetes. Ultimately an open reduction and internal fixation of her left lateral tibial plateau was carried out. Bone graft material was added to the procedure.

After her discharge from Hillcrest she was referred to the Heather Hill Extended Care Rehab facility for about 21 days. Following this she was hospitalized for a period of time, approximately one month at the Anna Maria facility. She then was followed by Meridia Home Health Care and followed up also by Dr. Forcier. She was able to bear weight by the end of September of 1996. She saw Dr. Forcier periodically and the last visit was on or about July 9, 1997.

She has not seen any other physicians. She still has some ongoing complaints.

CURRENT SYMPTOMS: At the time of this evaluation she still had intermittent complaints of vertigo. This would cause a spinning and a somewhat unsteadiness on her feet. She continued to use a cane outside of the house mostly because of the vertigo. She claimed to walk with a slight limp, which seemed to improve after being up and about on her feet for a period of time. The cane was not for the left knee, but as stated above, for balance. There was a generalized aching pain about the left knee. It does not seem to be progressive. She feels a generalized slow improvement over the year since her accident.

PHYSICAL EXAMINATION revealed a very pleasant 76 year old female who appeared in no acute distress. Her gait pattern favored her left side. The first few steps were somewhat unsteady but then they gradually improved. She was able to walk up and down the hallway without difficulty.

Examination of her left knee revealed a well-healed scar compatible with her surgical history. There still remains some stiffness in the knee going from full extension to just past 90 degrees of flexion. Her medial and lateral, as well as anterior and posterior ligamenta1 complexes were intact. There was no rotational instability detected. No significant atrophy was noted in the upper and lower thigh or upper and lower calf level. Neurologic examination of both lower extremities was normal.

X-rays were performed here in my office and did reveal a healed lateral tibial plateau fracture in excellent position. No s i p s of post traumatic arthritis were identified.

IMPRESSION: Healed left lateral tibial plateau fracture. Closed head injury with subjective vertigo. Residual stiffness in flexion of the left knee.

DISCUSSION: **A** series of medical records were reviewed. Rather extensive records were reviewed from her care including those from Heather Will, Outreach Professional Services, NovaCare, Meridia Home Healthcare, and the Anna Maria Nursing Home. Medical records were reviewed from Dr. Bruce Morganstern, a neurologist, who evaluated her for her vertigo, and Dr. Paul Forcier her treating orthopaedic surgeon. Records were also reviewed from the MedNet Urgent Care Center, Columbia St. Luke's Medical Center, including the original CT scan of the head. X-rays were also reviewed from Meridia Hillcrest Hospital which showed the original fracture films and the surgical repair.

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 injuries seem to be quite clear and are well documented. These included a closed head injury, a mild strain of the right knee and a definite impacted left lateral tibial plateau fracture. The care and treatment provided was necessary and appropriate at the St. Luke's Hospital, as well as the Meridia Hillcrest Hospital. Because of her age and the slow progress of the physical therapy, the rehab that she received was also quite appropriate, On the surface it seems somewhat extensive but considering the balance problem with the vertigo and the difficulty with range of motion of the left

knee, in my opinion, there were no other choices from a medical management standpoint.

At the time of this evaluation, x-rays were performed and there were no s i p s of post traumatic arthritis. The fear of this occurring in the future is minimal. There was excellent reconstitution of the knee joint and the surgical procedure was performed quite well. There is no indication that the "hardware" needs to be removed in the future. She has no symptoms whatsoever from this.

The only objective residual there is from her injury and surgery is incomplete flexion of the knee. Her right knee flexes to about 130 degrees, her left knee to only 95 degrees. It is likely that the range of motion will improve in the future. She should continue with her range of motion and stretching exercises as she was instructed as part of her rehabilitation. Review of the x-rays do show a healed lateral tibial plateau fracture. The **risk** of post traumatic arthritis and total knee replacement is low. Considering her age and the level of activity, it is doubtful that any further orthopaedic care or treatment will be necessary.

The long-term prognosis in general is favorable. Her major physical impairment is the subjective vertigo. There has been an excellent recovery from her left knee injury and surgery. Her home exercises should be continued. At the time of this evaluation it is my opinion that no further orthopaedic care or treatment is necessary or appropriate. She has a functional range of motion of her left knee similar to that seen after total knee replacements. It is doubtful she will need joint arthroplasty in the future.

Sincerely,

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

RCC/bn

cc: File

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Orthopaedic Surgeons

October 12, 1997

Mr. Lawrence E. Gawell
Associate Counsel
Greater Cleveland Regional Transit Authority
615 Superior Avenue, West
Cleveland, OH 44113-1878

RE: Eli Gohagen
Case No. 318220
File No. 644907

Dear Mr. Gawell:

I evaluated the above plaintiff in my office on October 9, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on or about December 18, 1995. He was evaluated without fiend, family, or legal counsel present.

He was the driver of a 1992 Toyota Camry vehicle at a traffic light in the vicinity of East 87th Street and Union Street on the eastside of Cleveland. A RTA bus allegedly rearended a school bus which rearended his vehicle. At the moment of impact he was thrown forward and backwards. We did not believe he struck his head nor was there any loss of consciousness. However, according to the medical records, he did claim to have a 10 minute loss of consciousness. He was extricated from his vehicle and conveyed to the St. Luke's Hospital Emergency Room. X-ray and an examination were done at that time. A CT scan of the head was done as well and all of these were normal. He was discharged with a diagnosis of neck and back strain. There was absolutely no mention of a right knee injury at that time.

Subsequently his attorney referred him to Dr. Terence Isakov who evaluated him at his Lyndhurst office. The initial examination was on December 20, 1995, about two days after the accident in question. At that time again there was no mention of any injury to his right knee. After the initial exam it was felt that he had a neck and back strain, as well as a strain of the left shoulder. Dr. Isakov was somewhat concerned as there was some weakness on a subjective basis noted in his left ann. Physical therapy was initiated to the neck and back region. The medical records reviewed from Dr. Isakov's office show that he was seen on a follow-up basis with continuing neck and back pain. The last visit to his office was on April 10, 1996 and the last therapy session was on May 21, 1996. He had a normal range of motion and strength in his neck and back. Throughout this entire record during the first five months of treatment there was absolutely no mention of any problems with his right knee. His general symptoms seemed to improve under the care of Dr. Isakov. He was discharged on April 10, 1996 with no plans for follow-up.

He was subsequently referred to Dr. Ahmed Elghazawi of the Regional Spine Center. Although no specific referral was noted in Dr. Isakov's notes, Dr. Elghazawi states that Dr. Isakov made the referral. It is unknown as to what caused the pain to increase from its much improved condition in early April. Dr. Elghazawi saw him but elected not to treat his neck or back symptoms according to the plaintiff. He was more concerned with his right knee. An MRI scan was performed on or about November 12, 1996, almost 11 months after the motor vehicular accident. The radiologist reports were suspicious of a focal tear of the anterior horn of the lateral meniscus, as well as a small joint effusion. I reviewed these scans and there was absolutely no full thickness tear identified. There was an area in which there was some increased signal uptake which was suspected. There was no structural tear noted. According to the plaintiff Dr. Elghazawi injected the knee on a few occasions. Recently he was referred to Dr. Jeffrey Shall, an orthopaedic surgeon. Surgery was discussed according to the plaintiff but no records were available for review. On the basis of the review of the scan there is no direct clinical correlation between his location of ongoing symptoms and the minor non-traumatic MRI abnormality noted. Dr. Elghazawi last saw him in August of 1997.

He was also referred to Dr. John Nickels, an anesthesiologist who runs the Cleveland Back and Pain Management Center. He was evaluated at Grace Hospital and has received a number of trigger point injections. There was never any neurological abnormality noted in the medical records. He last saw Dr. Nickels for more **"pain** pills" in September of 1997. Dr. Nickels also gave him a left wrist splint, low back brace, as well as a car seat brace.

He is currently on only the **"pain** pills" given by Dr. Nickels, the identity of which he could not recall.

EMPLOYMENT HISTORY: He is "laid off" from the MTD Company as an assembler. He was laid off on May 22, 1997. He was somewhat evasive as to how much time he missed from work. Apparently he had a previous job in which some additional time was lost.

PAST MEDICAL HISTORY failed to reveal any previous or subsequent problems in the above areas.

CURRENT SYMPTOMS: **At** the time of this evaluation he still has some ongoing complaints in his neck, low back, and right knee.

In reference to his **cervical spine,** he is virtually pain free except when there is cold and damp weather, He feels he can tell when it is going to rain. The pain seems to be primarily midline right paraspinal and right trapezius area. He was asymptomatic at the time of this evaluation. There was absolutely no complaints referred into his upper extremities that could be even vaguely considered neurologic in nature. He had essentially no complaints in his shoulders or upper extremities.

Concerning his lumbar **spine,** his discomfort is more constant. It bothers him when he is sitting, driving, or standing too long. It is a deep muscle aching type of discomfort that is in the suprailiac region. This does not follow any known neuromuscular patterns and represents a generalized muscle strain in the low back. There is no radiation of **pain** into his buttocks or lower extremities.

In reference to his right knee, in my opinion, there was no mention of any injury sustained until he saw Dr. Elghazawi over five months after the motor vehicular accident in question. In my many years of orthopaedic experience, if **there was** an acute knee injury that was competent to sustain a meniscal tear, there would have been well localized pain immediately. The **pain** would be quite specific. Again review of the records showed absolutely no mention of a knee complaint prior to him see Dr. Elghazawi. There was nothing mentioned specifically of a right knee injury or right knee complaints in the emergency room records, Dr. Isakov, or the physical therapist that saw him over the first five months post injury.

Specific symptoms now are some supralateral knee pain that occurs with certain movements. Kneeling for too long seems to bother him. He has no specific lateral joint line complaints. The bulk of his complaints are in the lateral suprapatellar region. He wears the brace and basically feels he is not able to do any jumping because of pain along the anterolateral superior aspect of the knee joint region. He has never had any specific physical therapy for this right knee complaints.

PHYSICAL EXAMINATION revealed a pleasant 33 year old male who appeared in no acute distress. His pattern was normal. He was able to arise from a sitting position without difficulty. Ascending and descending the exam table was performed normally.

Examination of his cervical spine revealed no spasm, dysmetria, and muscular guarding or increased muscle tone. There was a full range of motion in forward flexion, extension, side bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was no atrophy in the neck, upper back, or periscapular muscles. Ranee of motion of both shoulders was performed normally in forward flexion, extension, abduction, and 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. The detailed neurological examination including sensory, motor and reflex testing of both upper extremities was normal.

Examination of his lumbar spine area revealed the area of pain to be specifically in the suprailiac area. This was not confined to the low lumbar area it was mainly in the L1-L2 area. He showed me the regions that he received the blocks and these were clearly in the paraspinal musculature. There was full flexibility of the lumbar spine being able to bend forward to touch his toes. Hyperextension, side bending, and rotation showed no restriction of predicted normal motion. His straight leg raising in the sitting position was performed to 90 degrees bilaterally. There was a full range of motion of both hips. His leg lengths were equal. Circumferential measurements of both lower extremities at the upper and lower thigh and upper and lower calf levels were equal and symmetrical bilaterally.

Examination of both knees revealed no effusions bilaterally. His right knee examined absolutely the same as his normal left knee. There was a full range of motion from full extension to 140 degrees of flexion. His medial and lateral, as well as anterior and posterior ligamenta1 complexes were intact. There was a negative Lachman and negative pivot shift sign. There was no rotational instability noted. Patellofernoral examination was normal. The only area of tenderness was in the supralateral to the upper portion of the patella in the distal thigh area. This he claimed was the area of impact. This area was at least 8 cm away from the anterolateral joint line. Specifically, there was absolutely no tenderness or soreness along the joint line. This would have been the area of discomfort related to the meniscal abnormalities seen on the MR scan. Apley and McMurray testing was normal.

IMPRESSION: Subjective residuals of a low back strain. Resolved neck strain. Alleged contusion of the right knee with absolutely no mention in the medical records.

DISCUSSION: I have had the opportunity to review a number of medical records associated with his care and treatment. These included records from the St. Luke's Emergency Room, Dr. Isakov and his physical therapist, Dr. Elghazawi, and Dr. John Nickels. I have also had the opportunity to review the actual MRI scan of the right knee, as well as the records from the St. Luke's Hospital.

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 his ongoing level of physical impairment.

The injury as described would have caused the soft tissue strain or sprain, more to the neck than to the low back. There was a report of loss of consciousness, but a negative workup was noted. His only care and treatment to date was conservative in nature. During the first five months there was absolutely no mention of his knee being involved as a point of injury. There was clear improvement noted throughout the care and treatment by Dr. Isakov.

There is no clear understanding of why he underwent further care or treatment in that this initial five months cleared up his back problem. Dr. Elghazawi followed him primarily for his knee complaints. For some reason he was referred to an orthopaedic surgeon in reference to the MRI abnormality. There is clearly no clinical conelation at the time of this evaluation as to the area of his maximum discomfort and the minor abnormalities seen in the MR scan. As noted above, this was not a tear of the lateral meniscus, only an increase in signal in the anterior horn that was suspicious of anterior horn tkar. No physical structural tear was noted.

At the time of this evaluation, despite his ongoing level of symptoms, he had completely recovered objectively. No ongoing objective residuals of injury were noted. The long-term prognosis is favorable. There is no indication for any further care or treatment. In my opinion, all care and treatment for his knee, both in the past and in the future, are unrelated to the motor vehicular accident in question. The long-term prognosis is good.

Sincerely,

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

RCC/bn
cc: File

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

October 12, 1997

Richard Hoenigman
Attorney at Law
800 Leader Building
526 Superior Avenue, East
Cleveland, OH 44114-1460

RE: Debra Leuchtag
Case No. 324669
DOI: 11/17/95

Dear Mi-. Hoenigman:

I evaluated the above plaintiff in my office on October 8, 1997 in the presence of a paralegal, Maria Shinn, from Mr. Turoff s office. 'This evaluation was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident, which occurred on or about November 17,1995.

On the above date, which was a Friday, at approximately 5:20 in the afternoon, she was the driver and solo occupant of a late model Chevrolet Cavalier vehicle. Her vehicle was heading northbound on Richmond Road, south of Mayfield and north of Cedar Road. She could not remember a cross street. **A** car stopped suddenly in front of her, and she was able to stop her vehicle. **A** rear-end collision as the car behind her did not stop, The force of the impact allegedly caused her to bump the car in front of her. The driver of the other vehicle left the scene but came back later: There was no apparent damage or injury to the vehicle in front of her. The plaintiff was wearing a seatbelt.

At the moment of impact she stated she was thrown forward and backwards. There was some "stuff" behind her visor, which hit her. She developed some pain in the

right ann and shoulder region. Police came on the scene, her family was notified, and she drove herself home. Her family subsequently took her to the Richmond Heights General Hospital for her initial evaluation.

At that time she complained to the ER staff of right shoulder, neck and head pain. She complained of pain in the entire right side of her body initially. A number of x-rays were performed including a chest x-ray which were essentially normal. A urinalysis was also normal. She was discharged with a diagnosis of "muscle strain" and referred back to her family physician.

She subsequently returned back to the care of Dr. Sandra Cobb who saw her initially a few days after the accident on November 20, 1995. Examination at that time was compatible with a neck and upper back muscle strain. Muscle relaxants were recommended and physical therapy was considered. She underwent therapy at the Mt. Sinai Sports Medicine facility, which started a number of weeks after the accident. Again the bulk of her ongoing symptoms were that of a cervical strain and that is what she received treatment for. This was given to her both in the neck and back region with electrical stimulation, massage, exercise on a station bike. She believed this went on for a number of months. According to the records she had a total of 19 treatments that concluded on or about February 22, 1996. There was good subjective and objective recovery at that point in time. She; however, remains somewhat symptomatic.

She was referred to Dr. Harold Mars over a year post injury. His evaluation was on October 3, 1996. A thorough diagnostic neurological workup was essentially normal. A "rotator cuff injury" was suspected but this was never pursued. It was felt that she had cervical and lumbar myofascitis. Electroencephalogram was normal. EMG and nerve conduction study "suggested some mild degree of sciatica". This basically did not show any level of pain (which is what sciatica actually is) it just showed some abnormal muscle responses.

She has not had any medical care or treatment since she was evaluated by Dr. Mars. No shoulder problem was ever explored. She is currently on no medications. She continues to work on a full-time basis working as a dispatcher for a local heating,

ventilation, and air conditioning company. She has worked for this company for about 13 years. She did lose some time from work for therapy and doctors appointments.

PAST MEDICAL HISTORY failed to reveal previous trauma to the above-described areas.

CURRENT SYMPTOMS: At the time of this evaluation she still continues to complain of right posterior and lateral shoulder pain, as well as some intermittent neck pain particularly with cold weather. Occasionally damp weather bothers her, as well as some activity. Lifting and carrying, if she "overdoes it," can give her some aching symptoms. There is also a pain along the right posterior deltoid area. She does not have true rotator cuff pain. When she moves her shoulder in a forward/backward direction, she tends to feel some vague discomfort. No weakness was mentioned in her complaints.

In reference to her low back, this has improved over the months post injury. She has occasional low back pain but never had any leg pain consistently. There was no clinical subjective conelation with the minor EMG and nerve conduction findings.

PHYSICAL EXAMINATION revealed a pleasant 38 year old female who appeared in no acute distress. Her gait pattern appeared to be normal. She was able to go up on heels and toes without difficulty.

Examination of her cervical spine revealed a claim of tenderness in the right trapezius and upper scapular region. She claimed to have some intennittent swelling in this area but this in fact was directly in the shoulder blade area. Range of motion of the cervical spine was performed without limitations in forward flexion, extension, side bending, and rotation. The extremes of motion gave her some discomfort. Protraction, retraction, and elevation of the scapular were also performed normally. There were no objective signs of ongoing muscular irritation in the form of spasm, dysmetria, and muscular guarding or increased muscle tone. There was no atrophy noted in the neck, upper back, or periscapular muscles.

Examination of her shoulders revealed full range of motion in forward flexion, extension, abduction, and internal and external rotation. She did claim to have some discomfort that was localized in the posterior shoulder and trapezius area (the same area that her neck was bothering her) at the extremes of motion. The elbows, wrists, and small joints of the hand examined normally. Objective neurologic examination including motor strength testing and reflexes were symmetrical bilaterally. She claimed to have a decreased sensation throughout all the fingers of her right hand. This did not follow any particular neurological pattern. In essence, the objective exam was normal.

Examination of her lumbar spine failed to reveal any deficiency in range of motion, Her straight leg raising in the sitting position was performed to 90 degrees bilaterally. Neurologic exam of both lower extremities was normal.

IMPRESSION: Subjective residuals of a cervical sprain. Resolving lumbar strain.

DISCUSSION: I have had the opportunity to review a number of records associated with her medical care and treatment. These included records from the Richmond Heights General Hospital, Dr. Sandra Cobb, Dr. Harold Mars, and the Mt. Sinai Physical Therapy organization.

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 examination, in my opinion, at worst, she sustained a soft tissue strain or sprain of the cervical spine. This was essentially the same opinion given by her physicians. No neurological complaints were ever voiced as consistent symptoms. EMG and nerve conduction studies were performed although not terrible well indicated. These revealed some minor muscular abnormalities. These, as noted, did not correspond with any **physical** findings or consistent subjective symptoms. In my opinion, she does not have sciatica nor was this condition created on the basis of this accident. She may have had some irritation of the muscles associated with the

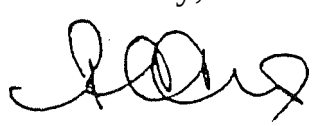
resolution of her muscle inflammation. This is not existent at the time of this evaluation and certainly not permanent.

The physical examination revealed no significant objective abnormalities. Her complaints are that of a muscle strain or sprain. There is still some subjective symptoms although there are no a great deal of objective findings to correlate. In my opinion, she sustained no permanent injury. There was, at worst, a soft tissue pulling or stretching injury associated with this collision.

The long-term prognosis is favorable. She has objectively recovered for any soft tissue injury sustained. Although there is still some continuing symptoms in the neck, upper back, and posterior shoulder region, in my opinion, these are soft tissue in nature and are related by the history to the original injury. I do not believe there is any objective evidence of any rotator cuff injury nor do I believe any diagnostic workup is necessary to look more closely at her right shoulder symptoms.

She has objectively recovered. No permanent injury was sustained. The long-term prognosis is favorable.

Sincerely,



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

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