Highland
Musculo-Skeletal
Associates, Inc.

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

October 27. 1996

Mary E. Cook
Attorney at Law
The Superior Building, 21st Floor
815 Superior Avenue, NE
Cleveland, OH 44114-2701

RE: Darla Marinelly
DOI: 7/5/95

Dear Ms. Cook:

I am writing to you in reference to the above claimant who was evaluated in my office on October 25, 1996. This was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on July 5, 1995.

Ms. Marinelly reported at that time she was a front seat passenger in a Ford Taurus 4-door vehicle being driven by her fiance. Two individuals, including the fiancé's daughter, were in the rear seat. They were traveling, she believes, in an east bound direction on Granger Road, going though the intersection at Transportation Boulevard. It was raining when the accident occurred at approximately eleven o'clock in the evening. They were traveling approximately 30 to 40 miles per hour. She noticed a car approaching which did not appear to be stopping. Her fiance turned the car to the right in order to reduce the level of the impact, but a passenger side impact occurred. The force of the impact pushed in the door and she was struck in the right hip region by part of the interior of the car. She was wearing a seat belt.

EMS was on the scene and conveyed both her fiancé's daughter with a head concussion and herself to the Marymount Hospital Emergency Room. She had x-rays and an examination, and was essentially treated arid released. The x-rays were

essentially normal. She does not believe any bruising was noted at the time of the injury. She essentially went home.

She claimed to be in shock for a while. There was difficulty extricating her from the car in that the door was too damaged to open. The window apparently broke and she could not move her right leg initially. She stayed home for about three or four days and then subsequently contacted her family physician, Dr. John Thomas. She saw Dr. Thomas initially in mid-July of 1995 (July 13, 1995) where x-rays were performed. She was referred to Fairview Hospital for physical therapy which was done three times a week for a three week period of time. A CT scan was also performed which was reported as negative. She was treated for back and radiating leg pain which gradually began to subside. The leg **pain** was tingling dong the lateral aspect of her foot and ankle. What prompted her visit to the doctor initially was that her right leg gave out.

She gradually improved with the exercises that were provided. In late October or early November of 1995 she had an episode in which she was walking, turned quickly and had a sharp pain, which sounds like a recurrence of virtually identical symptoms. Dr. Thomas recommended an orthopaedic surgeon. She contacted her attorney and she was ultimately referred to her attorney's cousin, Dr. Robert Mark Fumich. Dr. Fumich evaluated her initially on November 16, 1995 and because of a slightly abnormal x-ray in the form of a slight decrease in the L5-S1 disc space, as well as some associated arthritis, and with her clinical presentation, EMG and nerve conduction studies were recommended. These were slightly abnormal and necessitated an MRI scan to rule out a herniated disc. The scan was ultimately performed at the Meridia Hillcrest Hospital on November 22, 1995. This was normal. Dr. Fumich had her go through another course of physical therapy at the Ohio Physical Therapy group. That concluded the formal treatment for this injury.

She did well for the bulk of 1996 until July of 1996, when similar **type** of symptoms occurred. She tried to downhill ski last winter and had difficulty doing that She also had some ongoing problems when riding her bike. The episode in July of 1996 was of less intensity and of shorter duration. She did not seek any medical attention for this.

EMPLOYMENT HISTORY: She lost a few days of work, being employed as a rehabilitation nurse. She was employed by Medbridge Nursing Home with inpatient rehabilitation at the time of the accident. She recently switched jobs and now works for an outpatient therapy organization.

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

CURRENT **SYMPTOMS:** At the time of this evaluation she was essentially asymptomatic. Her better days continue to improve. She has not had a severe episode since July. What she notices on occasions is a popping sensation around the level of her iliotibial band on the lateral aspect of her right thigh with certain abduction and adduction maneuvers. The pain actually in July was relieved after the right hip "popped." She basically has had no significant symptoms since then and basically is asymptomatic at the time of this evaluation.

PHYSICAL EXAMINATION revealed a pleasant 40 year old female who appeared in no acute distress. Her gait pattern was normal. She was able to arise from a sitting position without difficulty. Ascending 'and descending the examining table was performed normally.

Examination of her lumbar spine revealed a full range of motion in forward flexion, extension, side bending, and rotation. When asked where the area was sore she pointed in the vicinity of this sciatic notch and the sacroiliac joint on the right side. There was also some Iocalized tenderness in the region of the greater trochanter of the right proximal femur. Range of motion of the lumbar spine was performed in an unrestricted fashion. There was a full range of motion of both hips and knees. Neurologic examination of both lower extremities was entirely within normal limits. She was able to heel and toe walk without difficulty. Essentially, the examination was within normal limits.

IMPRESSION: Resolved contusion and/or strain or sprain of the right hip and right low back.

DISCUSSION: I have had the opportunity to review a number of medical records. These include medical reports from Drs. Thomas and Fumich, as well as records from Fairview Hospital Physical Therapy and Ohio Physical Therapy. The MRI scan results were reviewed as well and the actual x-rays from Dr. Fumich's office were reviewed.

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, within a reasonable degree of medical certainty, that the nature and extent of the injuries was essentially a contusion and/or strain or sprain of the right low back and hip. She did not have any intense medical care other than the visits as noted to Dr. Thomas' office, the appropriate physical therapy and the CT scan, which was negative, These symptoms seemed to have resolved with the physical therapy and she had a good period of time in the late summer or early fall of 1995, with continuing improvement.

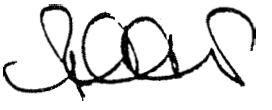
I have no explanation retrospectively for what exactly happened with the flare in October of 1995. I do believe, on the basis of the ongoing level of symptoms that an orthopaedic consultation was appropriate. The neurological evaluation was also appropriate and revealed some minor EMG and nerve conduction studies. I do think, on the basis of these abnormalities, that the MRI scan was appropriate. This fortunately was normal. She has improved tremendously with the physical therapy and exercises. She is essentially asymptomatic.

The flare-up that occurred in the summer of 1996 was handled "on my own" indicating the patient was able to resolve this with simple stretching exercises and the continuation of her therapy program.

In conclusion, it is my medical opinion, that the soft tissue injury has resolved to a great extent. I do not anticipate any need for further medical care. I have no explanation for the minor EMG and nerve conduction study changes with the balance of the testing being normal. At worst, this was a contusing type of trauma and may

have involved some soft tissue muscular straining. The long-term prognosis is favorable. She has objectively recovered. I do not anticipate any needed for further orthopaedic care or treatment. I do believe the care and treatment provided was appropriate for the symptoms and the findings noted.

Sincerely,



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

RCC/bn

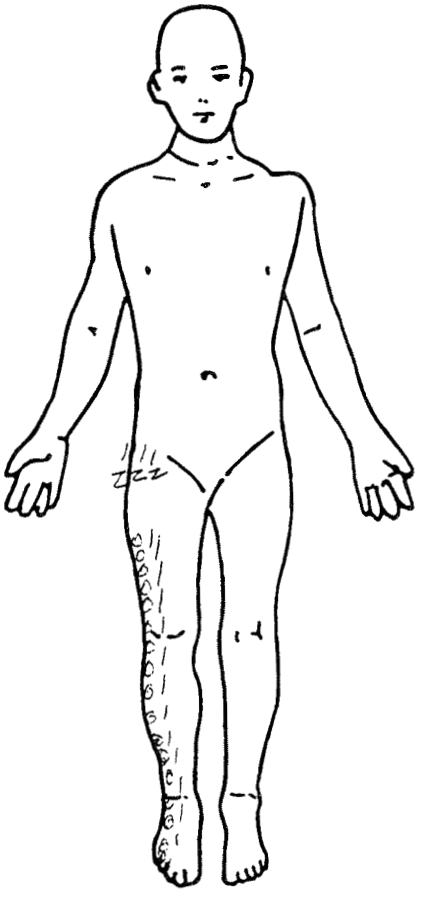
cc: File

HIGHLAND MUSCULO-SKELETAL ASSOC., INC.

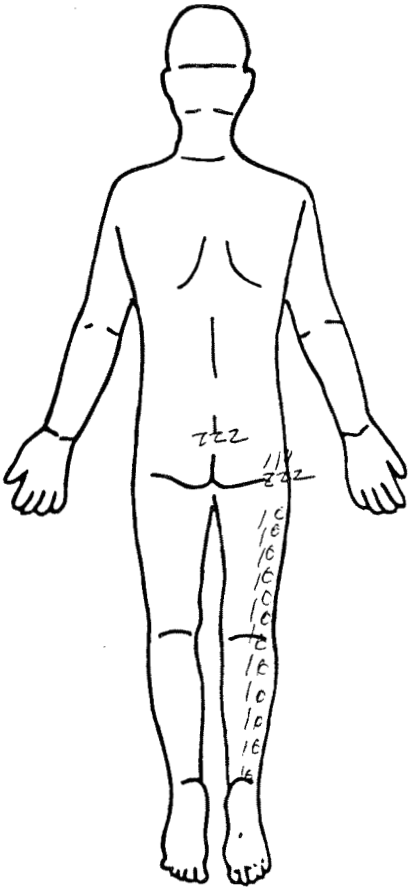
PAIN PATTERN DRAWING

PLEASE INDICATE ON DRAWING TYPE AND LOCATION OF PAIN USING CHOICES BELOW:

PINS AND NEEDLES = OOOO BURNING = XXXX STABBING = //// DEEP ACHE = ZZZZ



FRONT VIEW



BACK VIEW

RATE YOUR PAIN 0 = No Pain ⟶ 10 = Extremely Intense

1. Right now	(0)	1	2	**3**	**4**	5	6	7	8	9	10
2. At its worst	0	1	2	3	4	5	6	7	(8)	9	10
3. At its best	(0)	1	2	3	**4**	5	6	7	8	9	10

PATIENT NAME: M. Darla Marinelly