Highland
Musculo-Skeletal
Associates, Inc.

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October 28, 1996

Patrick Roche
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1700 Midland Building
101 Prospect Avenue, West
Cleveland, OH 44115-1027

RE: Jennifer Osborn
Case No. 95 CIV 0733 (Medina Co.)
File No. V-5155

Dear Mr. Roche:

I evaluated the above plaintiff, Jennifer Osborn in my office on October 22, 1996. This was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on July 14, 1994. Throughout the history she was accompanied by her attorney, Mr. Dean Steigerwald. Her attorney was not present for the physical examination.

MEDICAL **HISTORY:** She was the driver and solo occupant of a Ford Escort vehicle involved in a front end impact on July 14, 1994. She was traveling approximately 45 miles per hour when a car pulled out in front of her. She was unable to avoid the collision. According to the medical records, she claimed to hit the steering wheel with her chest and abdomen. She was ambulatory at the scene, walked approximately 200 yards and sat down, and then walked another 200 yards at which time she called 911. She was evaluated on the scene by paramedics and conveyed to the Akron General Hospital Medical Center where she had an emergency evaluation. There was a claim of lower extremity paralysis. It was not

known at that time whether this was due to "hysteria versus cord contusion." She was admitted to the Medical Center for observation and diagnostic workup by Dr. Michelle Heatherill. During this hospitalization she complained of not being able to move and severe headaches Multiple MRI scans were performed which showed no evidence of abnormality. Neurological service was consulted and no anatomic reason was discovered why she was unable to move her legs. Ultimately she was able to get up and walk, had physical therapy, and was discharged from the Medical Center on July 19, 1994. She was scheduled for outpatient physical therapy, as well as follow-up with a psychologist in Medina, Ohio.

She was referred to the Medina General Hospital physical therapy department with a diagnosis of soft tissue strains and sprains. She was noted to limp on her left side, complaining of anterior knee **pain** and low back **pain.** She was treated during the summer of 1994 complaining of intennittent knee pain and occasional numbness and weakness in her lower extremities. Ultimately she was started on weight machines and a treadmill, and then in a brief work conditioning program, lifting boxes repetitively, and doing some work simulation.

Ultimately she did return to her previous type of work, working as a wheelchair van driver for the same company that she had previously worked for. She apparently, prior to this accident, had gone through an EMT training program, but felt she could no longer lift or carry stretchers. When she did receive her EMT certification, she did not pursue an occupation with this, but returned to her job working as a nurse's assistant.

She was subsequently referred to the Westside Rehabilitation and Dr. Jeera Hayden, being initially evaluated on November 9, 1994. She was treated for "strain of the cervical dorsal spine, lumbosacral spine, and left knee. There was some complaints of intermittent severe pain and locking of the left knee. Because of ongoing symptoms she was referred to Dr. Sheldon Kaffen, an orthopaedic surgeon, who evaluated her on December 21, 1994. He recommended continuation of conservative treatment, as well as some additional exercises for her left knee. 'There

was a recommendation that if her left knee symptoms did not improve, an MRI scan of the knee would be appropriate. She was ultimately discharge from Westside Rehabilitation on December 14, 1994.

There did not appear to be any care or treatment rendered for the entire first half of 1995. The next medical evaluation was on July 13, 1995, approximately one year after the accident. This was a referral to Beachwood Orthopaedics and she was evaluated by Dr. Richard Kaufman at that time. A history was presented with the initial working diagnosis of a cervical neck and back strain, and a sprain of the left knee.

Dr. Kaufman referred the patient to Dr. Edward Gabelman who initially evaluated the patient on August 14, 1995, approximately 13 months after the accident. This was specifically for her left knee. An MRI scan was done in the unit in Dr. Gabelman's suite. This study reported some chondromalacia and no other abnormality. These findings will be discussed below. Because of a failure to improve with the conservative care to date, arthroscopy was recommended and carried out later that month on August 30, 1995. The initial reason for the surgery was a loose body in the knee but what was discovered was a giant cell tumor (ganglion cyst) in the subcutaneous tissue of the left knee and some chondromalacia of the left patella. On arthroscopy there was some cracking and fissuring of the undersurface of the patella, but absolutely no damage or problem with the intercondylar notch. This will be discussed below.

Postoperatively she continued to have great difficulty using her knee despite an exercise and physical therapy program. She was followed on a routine basis by Dr. Gabelman through the balance of 1995. Follow-up x-rays revealed no additional clinically significant abnormality. She states she is still under Dr. Gabelman's care but cannot recall the last visit.

CURRENT SYMPTOMS: At the time of this evaluation she continues to wear a knee brace on a daily basis. There is continuing symptoms in the neck, low back and left lower extremity. The patient claims she has not worked since May of 1995. In reference to her cervical spine, she complained of an aching pain between the shoulder blades that occurs primarily when trying to sit up straight for too long a period of time or in cold and damp weather. This pain tends to radiate along the spine into the thoracolumbar region without any radiations from the midline. It seems *to* stop approximately four inches above her beltline. This is in the low thoracolumbar junction. It should be noted that there has been absolutely no care or treatment of her neck and back complaints since her treatment ended in 1994. The treatments were supplied by the Medina General Hospital and the Westside Therapy Group.

In reference to her lees and knee, she complains of a stabbing pain and numbness which occurs on an intennittent and unpredictable basis. This is a numbness and tingling which seems to radiate from the Heels all the way up the posterior aspect of her legs to her buttock region. This does not follow any neurological pattern and is not reproduced by any particular body posturing, positioning or activity.

In reference to her left knee, she wears a hinged knee brace virtually all the time. She claims this supports her knee from buckling or giving out. It does not seem to help the pain. She complains of pain along the anterior aspect of the knee, both medially and laterally. There is off and on swelling of the left knee. Stair climbing, walking "excessively" seems to bother her. In the care of her young child, she does a fair amount of squatting, kneeling and bending. She has difficulty arising from this position. She also has difficulty sitting with her legs crossed.

PAST MEDICAL HISTORY failed to reveal any previous or subsequent injuries to her spine or knee. She did become pregnant in November of 1995, and approximately two months ago delivered a healthy baby boy.

PHYSICAL EXAMINATION revealed a somewhat heavyset 35 year old female who appeared in no acute distress. Her gait pattern was normal. She was observed easily lifting and bending to care for her young child. There was no limping detected on ambulation. She was able to heel and toe walk without difficulty.

Examination of her cervical spine revealed no spasm, dysmetria or muscular guarding. She claimed to have some minimal tenderness below the C7 vertebral prominence and in the mid scapular region. There was a full range of motion of her cervical spine in forward flexion, extension, side bending and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was no observable atrophy in the neck, upper back, or periscapular musculature. A full range of motion of both shoulders was noted. 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 revealed a mild claim of tenderness to palpation at the thoracolumbar junction. She was able to easily bend forward to touch just above her ankle level. There was good reversal of her lumbar lordosis. Hyperextension, side bending and rotation were performed normally. Her straight leg raising in both the sitting and supine positions was performed to 90 degrees bilaterally. There was a fiill range of motion of both kips. Her leg lengths were equal. A detailed neurologic examination including sensory, motor and reflex testing of both lower extremities was normal.

Examination of both knees revealed no effusion bilaterally. Circumferential measurements of both lower extremities at the upper and lower thigh, upper and lower calf, and at the knee joint level were equal and symmetrical bilaterally. There was some retropatellar crepitance noted on the right knee. This was somewhat more prominent on the left knee.

Specific examination of her left knee revealed multiple scars. These included the small arthroscopic incisions, as well as the small incision for the removal of the ganglion cyst. There was also a number of other incisions from childhood injuries. There was full range of motion of the knee from complete extension to 140 degrees of flexion. Her medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no rotational instability detected. Patellofemoral examination showed no patellar subluxation. There was tenderness about the patellar retinaculum. No other objective abnormalities were noted.

IMPRESSION: By history, soft tissue strain or sprain of the neck and back, Strain of the knee with subsequent diagnosis of chondromalacia. Minimal ongoing objective findings.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from the Akron General Hospital Medical Center, Medina Community Hospital Medical Center, Westside Rehabilitation and Dr. Hayden, Beachwood Orthopaedics and Dr. Gabelman, Dr. Sheldon Kaffen, and the actual MRI scans from Beachwood Orthopaedics.

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 clear that there is a functional component to her initial clinical presentation. She was claiming to have weakness of both lower extremities to the point that she could not walk. A thorough diagnostic evaluation, including multiple MRI scans, failed to show any anatomic lesion to explain this. A neurological consultation also failed to explain her reaction and symptomatology. She was discharged from Akron General Hospital Medical Center with a diagnosis of "trauma - motor vehicular accident." There was no specific mention of any bruising or abnormality to the left knee that would indicate direct impact type of trauma.

The only physical therapy she had for her back and her left knee in 1994 ended after the Medina General Hospital and Westside Rehabilitation sessions. There was six month period of time where absolutely no medical care was documented until she was referred to Dr. Kaufman and Beachwood Orthopaedics. Within a month of her evaluation with Dr. Gabelman, an MRI scan was performed. The scan, to my review, was of very poor quality. The machine that is owned by the physician is somewhat primitive, having a very low magnetic field potential. The current state of the art scanners are a minimum of 10 times more powerful. I reviewed the actual scans would not have proceeded with a surgical procedure on the basis of the quality of the scan.

Review of the arthroscopic findings surprisingly show only some cracking and fissuring compatible with chondromalacia of the left patella. I do not believe these were "chondral fractures." There seemed to be mild advance chondromalacia picture without any damage to the intercondylar notch. In my medical opinion, based on a reasonable degree of medical certainty, had this chondromalacia been caused by a direct impact type of trauma 'there would have been an equal amount of damage to the other compressive side of d e joint, that is the intercondylar notch. In that there is solely damage to the undersurface of the patella, in my opinion, this was not due to an impact type of trauma. She clearly has chondromalacia symptoms bilaterally, left worse than right. Her symptoms are related only by her history to the motor vehicular accident in question . If the arthroscopic pictures or video are available, I will be glad to review these.

It is difficult to ascertain whether the small ganglion cyst was related to trauma. It was never mentioned prior to Dr. Gabelman's records. Usually traumatic ganglions appear within a number of weeks after injury. The etiology of this benign mass remains obscure,

On the basis of this evaluation, she has objectively recovered from any soft tissue injury sustained. In my opinion, the chondromalacia "damage" noted on the arthroscopy was unrelated to singular traumatic event. The reasons are discussed

above, that is no "kissing lesion" on the intercondylar notch. If anterior trauma is severe enough to cause cartilage damage to the patella, in my opinion, there would have equally been some damage caused by the other side of the impact on the distal femur.

On the basis of this evaluation, no further orthopaedic care or treatment is necessary or appropriate. She has objectively recovered from her spinal injury. She still has ongoing symptoms in reference to her left knee. In my opinion, the chondromalacia symptoms are related to a developmental abnormality and her weight, and unrelated to a specific traumatic event. If additional medical records become available, including the arthroscopic pictures and/or video, I will be glad to review these in the future.

The long term prognosis is favorable. She has objectively recovered.

Sincerely,

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

RCC/bn

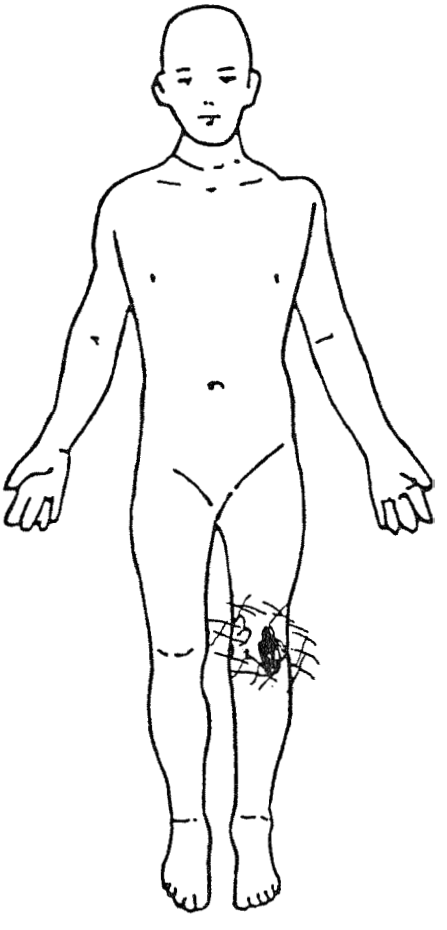
cc: File

HIGHLAND MUSCULO-SKELETAL ASSOC., INC.

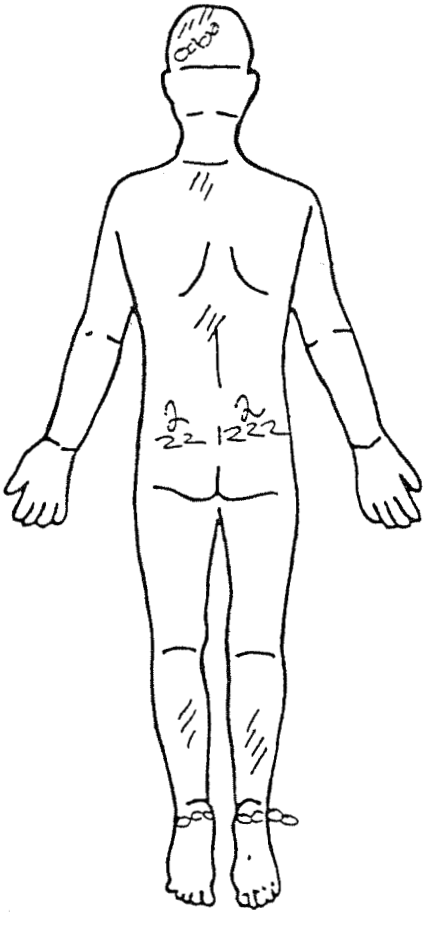
PAIN PATTERN DRAWING

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: