Highland
Musculo-Skeletal
Associates, Inc.

October 29, 1997

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5333 Meadow Lane Court
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RE: Mary Lloyd
Case No. 97 CV 117751
File No. 17,681

Dear Mr. Gallagher:

I evaluated Mary Lloyd in my office on October 24, 1997 for the purpose of an Independent Medical Evaluation, This was in reference to an injury that occurred on November 11, 1995. Present throughout the history and physical was Mr. James Ash, a legal assistance from the Miraldi and Barrett Law firm.

The injury occurred in Lorain County. She was attending a Pioneer Festival at the Mill Hollow reservation. The accident occurred approximately noontime when she was walking along a road heading toward the festival. She was walking with a group of people although she was here by herself

A converted van/bus approached her from the rear. Apparently the back of her head was struck by the passenger side rearview mirror. She was knocked forward to the ground. The bus passenger side rear wheels apparently rolled over her left foot. She sustained primarily a crush and soft tissue injury. There may have been a short-term loss of consciousness. Apparently the driver stopped the vehicle with the wheels still on her ankle. The van driver then backed up to release Ms. Lloyd's left leg.

She was conveyed by ambulance to Lorain Community St. Joe's Regional Medical [illegible] room. At that time it was felt to be [illegible] contusions and abrasions. She was admitted to the hospital under the care of Dr. John Wright, who observed her for four days. Some debridement was performed and cleansing of her superficial left leg wounds. There were multiple areas of full thickness abrasions. X-rays failed to reveal any fracture. She was admitted to rule out compartment syndrome. Fortunately this complication never developed. She was ultimately discharged with a diagnosis of crush injury to left foot and ankle with superficial skin loss, scalp laceration and cerebral concussion. She was discharged on September 14, 1995 to be followed by Dr. Wright in his private office.

Dr. Wright followed her with a series of dressing changes. Some of the skin areas, in fact, did heal. She followed up with Dr. Wright on a number of occasions and ultimately was referred to a plastic surgeon, Dr. John Payne.

Dr. Payne saw her initially on October 12, 1995. There were two wounds, one measured 7.5 x 2 cm, and the other 5 x 1.5 cm. There was healthy granulation tissue noted and **minimal** necrotic tissue. This description was somewhat less intense than the description given by the plaintiff at the time of this evaluation. Due to the amount of pain and the likelihood of scar and slow healing, it was decided to perform a split thickness skin graft taken from the lateral left thigh onto the foot. This was done on [illegible] 1995. He followed her postoperatively and essentially discharged her [illegible] on November 6, 1995. The site appeared to be doing well, as was the graft site. She did not apparently, according to the plastic surgeon, have any significant complications develop. She continued with local antibiotic care and ultimately the skin did heal.

Due to the fact that there was an inordinate amount of pain along the lateral aspect of the leg and foot, she was referred to a second orthopaedic specialist, Dr. Vernon Patterson. His initial evaluation was on December 11, 1995, about three months after the accident. She reported a great deal of pain along the lateral aspect of the foot, especially in the third, fourth, and fifth digits, as well as hyperesthesia (increased

sensation) along the lateral aspect of the foot. X-ray examination failed to show any fracture abnormality and he began treating her for what he suspected was a reflex sympathetic dystrophy secondary to the crush trauma. He also recommended physical therapy and started her on Klonopin to be taken at bedtime. She was also managed with some short courses of oral steroids which also tended to improve her symptoms on a temporary basis.

A pain management consultation was obtained from Dr. V. Joshi at the Lutheran Medical Center. She had a series of lumbar sympathetic blocks which did seem to help her symptoms. It was felt that this somewhat confirmed the diagnosis of reflex sympathetic dystrophy. She has had a total of five injections to date. She has an appointment with Dr. Kumar in Toledo, Ohio. A chemical sympathectomy was contemplated, injecting the sympathetic chain with Phenalt to give a more permanent relief.

CURRENT MEDICATIONS included only Klonopin h.s.

EMPLOYMENT HISTORY: She is employed as a histologist in the clinical laboratories at the Fireland's Hospital. She did lose some time from work. The exact loss could not be recalled at the time of the evaluation.

CURRENT SYMPTOMS: The bulk of her symptoms include an inability to walk due to a "bad sensation" along the lateral aspect of her left leg, ankle and foot. She claims to have some localized breakdown along the skin graft sites. These; however, did appear on clinical examination fairly normal in appearance. She also claimed some stiffness in the ankle and limited ability to stand and walk. She also has difficulty sleeping due to the **pain.** The pain she describes as a variety of sensations including a deep aching pain, burning, and numbness along certain aspects of her leg. Symptoms have not changed to a great extent from those originally described in December 1995 to Dr. Patterson.

PHYSICAL EXAMINATION revealed a pleasant **44** year old female who appeared in no acute distress despite her level of symptoms. Her gait pattern was mildly

antalgic on the left side. It was difficult to interpret where the discomfort was coming from. This may have been just from a habit.

Specific examination of her left foot and ankle revealed the healed abrasions and skin graft sites. These appeared to be supple and mature in appearance. There was no excessive redness or swelling about this area. She did claim to have "neuroma" type pain along the superior aspect of the large graft site along the proximal aspect of the ankle, but there was no associated mass or lesion noted. There was the typical appearance of a mature skin graft. This appeared to be very well healed. It was very benign in appearance.

Range of motion of the knee, ankle, and foot joints appeared to be normal. There was no pitting edema. Although she claims to not use the ankle or foot in the maximum capacity there was no measurable a trophy in the upper and lower thigh or upper and lower calf on circumferential measurements with a tape measurer.

Specifically looking for **objective** signs of reflex sympathetic dystrophy there was none. There was no diffuse atrophy of the skin or any excessive bluing or cyanosis. No vascular abnormalities could be-detected on this examination.

IMPRESSION: Healed abrasions about the forehead and knee. Status post crush injury with superficial skin loss. Status post very satisfactory skin grafts. Subjective symptoms of reflex sympathetic dystrophy.

DISCUSSION: I have had the opportunity to review medical records from a variety of sources. These included records from the Lorain Community St. Joe's Regional Health Center, Rehabilitation Consultants, the Lutheran Medical Center, and Fireland's Hospital. Records were also reviewed from Dr. Vernon Patterson, Dr. John Wright, and Dr. John Payne. Included with these were some Xerox pictures of the ankle shortly after the time of the injury.

M e r 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 she sustained are very well defined. These included, as noted above, a resolved cerebral concussion and a crush injury to the ankle. The initial appearance was much more significant than the clinical appearance is today. This is not atypical for injuries of this nature. The injury was primarily soft tissue in nature and was not severe enough to cause a bony fracture. Undoubtedly there was some damage to the deep skin layers which necessitated the debridement and the skin graft.

Specifically on an appearance basis, the skin grafting was extremely successful. There are no residual areas that would necessitate any further operative intervention. She has an excellent result. There are very few objective residuals of injury noted at the time of this evaluation that would necessitate any ongoing care or treatment from an orthopaedic or plastic surgical standpoint. She has objectively recovered from her traumatic skin and soft tissue injuries.

The area that she has also received care for was in the realm of reflex sympathetic dystrophy. This is a neurological abnormality in which abnormal pain pathways are set up. These are typical with crush injuries and with severe bony trauma as well. She did get satisfactory results from the sympathetic blocks. A more permanent type of block has been recommended and she is scheduled for this. In my opinion, the RSD is directly and causally related to the original accident and does demand the further treatment that is described.

The long-term prognosis, however, is favorable. She has returned to active gainful employment. Hopefully the sympathetic blocks will give her more than transient relief of her pain problems. From an orthopaedic and plastic surgical standpoint no further procedures, will be necessary in the lower extremity. She has objectively recovered from her soft tissue injury. She still continues to have soft tissue complaints that are compatible with reflex sympathetic dystrophy. In my opinion, the care and treatment provided in the medical records discussed was directly and

causally related to the accident in question. The long-term prognosis is favorable and I am optimistic that more complete pain relief will be obtained in the future.

Sincerely,

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

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