Highland
Musculo-Skeletal
Associates, Inc.

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

November 2, 1997

Thomas M. Coughlin, Jr.
Attorney at Law
330 Hanna Building
1422 Euclid Avenue
Cleveland, OH 44115-1901

RE: Bethany Minner
Case No. 97 CV 000229 (Lake Cty.)
File No. 1138/15199-V

Dear Mr. Coughlin:

I evaluated the above plaintiff in my office on August 14, 1997, in reference to alleged residuals of injury sustained to her left knee. She recalled a somewhat unusual event occurring on July 3, 1995. This was a work-related accident in which she was employed by Ken's Beverage on Walnut Street in Painesville, Ohio.

Her employment at that time was a cashier and "runner". She was stocking an upright cooler in the driver through area. She was kneeling with her weight on her right leg on the ground with her left knee bent. A vehicle came into the store, struck the door of the cooler and the door, in fact, struck her along the medial aspect of the right knee. There was no pain initially but over the course of the next day she had difficulty standing and walking, and had a sharp pain along the medial aspect of her knee and in and about the left patella.

Initially she was evaluated at the Lake County East Hospital in Painesville, Ohio. X-rays were performed of the left knee. This was felt to be a soft tissue injury and an infrapatellar tendon strain. The x-rays of the knee were normal and she was given a

knee immobilizer and crutches. She was also told to rest the leg and wear her Ace bandages. Follow-up was recommended.

The initial physician that saw her after the accident was Dr. Jack Battersby, a chiropractor in Mentor, Ohio. Dr. Battersby followed her for a period of time for her neck and low back strain. The treatment consisted primarily of electrical stimulation, and other modalities. There may have been some manipulation as well as repetitive ultrasound treatments. These symptoms completely resolved. An MRI scan of her right knee was ordered and performed on July 19, 1995. There was some evidence of "mild chondromalacia". There was a small effusion noted. This study was done at the Meridia Hillcrest Hospital.

Subsequently she was referred to Dr. George Kellis, an orthopaedic surgeon. She really had minimal care and treatment by this physician. She "did not care" for the way he treated her. Essentially an examination was performed and it was felt after review of the MRI that she may have sustained a contusion to the medial femoral condyle. He saw her on a number of occasions throughout the summer and early fall of 1995. There was improvement noted during this time period with the recommended exercises. He clearly states that she was not following his recommendations. The last recorded visit was on April 24, 1996 with continuing knee pain. Her symptoms and examination were that of patellofemoral syndrome. He states that he again "pushed her to do the proper exercises for her knee". This physician rendered no further care or treatment.

She subsequently returned back to her previously treating orthopaedic surgeon, Dr. Robert Baker, in Greenville, Pennsylvania. The plaintiff had undergone patellofemoral alignment surgeries of the left knee a number of years before. According Dr. Baker's records, there was a diagnosis of carpal tunnel syndrome, as well as patellar malalignment syndrome noted. Patellar subluxation was noted on the left side and on October 11, 1991, she underwent arthroscopic surgery of her left knee.

She returned to Dr. Baker on or about February 24, 1997 with discomfort in her left knee. He notes at the time of his initial evaluation a very high Q-angle of 20 to 25 degrees with full motion and no effusion. He also felt there was definite hypermobile patella on the right side. He also believed that this was a subluxing patellar problem.

An MRI scan was performed which was normal. .There was no effusion. Arthroscopic surgery was discussed and approximately performed on June 2, 1997 on her left knee. This showed chondromalacia of the patella and a lateral retinacular release was performed. This was the identical procedure that was performed back in 1991. In Dr. Baker's opinion later, dated August 11, 1997, he clearly states that, by the patient's history, the present conditions are directly related to the July **3,** 1995 incident although the condition he treated her for was identical treated in the early 1990's.

CURRENT SYMPTOMS: She is now about two and one-half months status post surgery. She is walking independently and walks without a limp. Periodically the left knee gives way. There is still a fair amount of atrophy in the knee and she has not been on any exercise program as of yet. There seems to be some problems with the Bureau of Workers' Compensation and getting the appropriate therapy allowed in that Dr. Baker is an out-of-state physician. She has a diffuse aching pain intermittently and difficulty sleeping. She still plays volleyball but with a hinged brace. The pain is worse with kneeling. She essentially has patellofemoral abnormalities.

There is absolutely no complaint of pain in her neck, mid or low back region.

PHYSICAL EXAMINATION revealed a pleasant, somewhat evasive 23 year old female who appeared in no acute distress. As noted above, there were no residua1 spinal complaints and no spinal examination was performed.

Examination of her left knee revealed the three recent arthroscopic incisions. There was no effusion and a full range of motion was noted. She still had approximately

1-1/2 cm of atrophy in the left thigh as compared to the right thigh. The Q-angle was significant measuring 23 degrees bilaterally.

IMPRESSION: Chronic patellofemoral malalignment syndrome. This was subjectively aggravated by the incident in question. Status post arthroscopic surgery with incomplete rehabilitation to date.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These records included those from the Lake County Hospital, Dr. Jack Battersby, Dr. George Kellis, and Dr. Robert Baker. A series of x-rays were also reviewed that were taken at the Lake County East Hospital on the date of injury. The MRI scans have not been reviewed, but these were interpreted as normal.

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 evaluation, in my opinion, there was a significant pre-existing condition. This was previously operated on and a lateral retinacular release was performed. Subjectively, the patient had complete relief of her symptoms after the 1991 surgery. It is unknown what physical condition the left lower extremity was in from a muscle rehabilitation standpoint. There is no question that a soft tissue injury occurred. This, but the history, aggravated her pre-existing condition. It is clearly apparent that she was not compliant initially. She did not seem to follow the initial orthopaedic surgeon's recommendations.

The only finding at the time of the second arthroscopy (post-injury) was identical to the findings at the 1991 surgery. No acute traumatic lesion was created. A re-operation was performed, that is the identical procedure that was done in 1991. This clearly did not change the malalignment syndrome which will be discussed below. She has a good relief of her pain after the surgery but still needs to do a rehabilitation program.

In my opinion the patellofemoral malalignment syndrome is a congenital and/or developmental abnormality. She has a very high Q-angle which is a fairly significant predisposing factor in this syndrome. The quadriceps mechanism with its insertion onto the proximal tibia by the patellar tendon is somewhat more laterally than anatomically neutral position. This causes lateral stresses, as well as rotatory stresses on the patella through **normal** activity. **A** retinacular release frequently helps this condition but doesn't "cure" this condition. It does not appear that this condition was at worst subjectively aggravated by this traumatic incident. I have no criticisms on the care and treatment she received for her pre-existing condition.

The only other objective finding noted at the time of the evaluation was a mild degree of atrophy in the left thigh. This is totally **reversible.** With appropriate rehabilitation, including progressive resistance exercises, the atrophy can be eliminated. I doubt whether she was doing her exercises on a regular basis between her recovery after the 1991 surgery and the 1995 accident. The actual true condition of her knee is unknown although she clearly states it was asymptomatic.

The long-term prognosis is favorable. She received the appropriate level of care and treatment. The second arthroscopy was, by her history, related to the motor vehicular collision. At worst, this **transiently** aggravated a pre-existing condition. The long-term prognosis is favorable. If she is compliant with her exercises, **complete** resolution of her symptoms can be realized. In my opinion, the long-term prognosis is favorable. No permanent injury was sustained.

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

Timothy X. McGrail
Attorney at Law
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55 Public Square
Cleveland, OH 44113

RE: Robert Armstrong
Case No. 327329 (Cuyahoga County)
File No. 6.210

Dear Mr. McGrail:

I evaluated the above plaintiff, Robert Armstrong, in my office on October 29, 1997 for the purpose of an independent medical evaluation. This was specifically in reference to alleged residuals of injury sustained in a motor vehicle/bicycle accident which occurred on October 7, 1996. He was evaluated without friend, family, or legal counsel present. Liability issues were not discussed.

He was operating a standard bicycle on Detroit Avenue in Rocky fiver on October 7, 1996. Allegedly a vehicle turned suddenly in front of him, he couldn't stop, and his bike struck the passenger side of the automobile. He was not wearing a helmet. He was traveling at approximately 10 miles per hour and fell on his left side. He was somewhat "stunned". He landed on his bicycle and injured the left neck shoulder, elbow, and left foot region. He was able to ambulate at that time and walked his bike home. Apparently the front tire rim was bent. He did not seek any medical attention at the time of the accident.

The following day on October 8, 1996, he was evaluated at the Fairview General Hospital Emergency Room. Essentially his complaints at that time were that he fell

on his left side. He had complaints in the left shoulder, left forearm, and the top of his left foot. Multiple x-rays were performed at that time. No fractures were identified. X-ray examination of his .foot revealed "degenerative changes with osteophytic spurring seen in the first metatarsal phalangeal joint. **A** tiny heterotopic ossification likely related to degenerative changes was seen immediately lateral to the first metatarsal phalangeal joint." In other words, this gentleman had a rather significant osteoarthritis of his base of toe joint prior to the time of the accident.

He was referred by the emergency room to the first treating physician, Dr. George Essig. He was evaluated one-time only, on October 11, 1996. Dr. Essig's opinion was that he sustained a contusion of the left foot and bursitis of the left shoulder. He saw this physician on one and only one occasion.

His attorney referred him to Dr. Jeffrey Moms. Again, this physician saw him on one and only one occasion, October 31, 1996. This was shortly after the accident in question. Dr. Moms did a complete examination and felt that he essentially sustained a neck strain, a strain of the left shoulder, contusion of the left forearm, contusion of the left foot and ankle, and right great toe. He also felt that the degenerative changes that were noted at the time of the evaluation were not due to the incident in question.

Physical therapy was carried out for 10 visits in early 1997. He did not have any follow-up for his orthopaedic injuries. The only care and treatment he had by an orthopaedic surgeon was with Dr. George Essig on one occasion and Dr. Jeffrey Moms on one occasion,

He subsequently came under the care of Dr. Stanley Beekman. The initial visit was on February 11, 1997. The chief complaint at that time was a painful left first toe. The plaintiff believed that this was due to 'jamming his foot on the bicycle". Conservative care and treatment was discussed but ultimately on June 4, 1997 the plaintiff underwent a joint replacement of the first metatarsal phalangeal joint. The prognosis for this was good. The surgery was performed at the St. John and Westshore Hospital. According to the operative report and medical records, the reason for the surgery was "hallux limitus left foot" indicating a degenerative

condition. There was no indication that this surgical procedure was caused in any way, shape, or form, to be related, other than the patient's history, to the incident in question.

CURRENT SYMPTOMS: The bulk of his complaints have dissipated. His left shoulder is "okay". He has only an occasional discomfort in the cervical spine. As you are aware, he does a fair amount of weight training and has a very well developed upper body. The only left arm symptom he has is when he does reverse curls. There is some aching discomfort in the region of the lateral elbow.

His only residual symptoms are in his left foot. Again these are related to the hallux limitus that he has, He has this to a similar degree in the right foot although he does no admit to have any symptoms. This will be discussed below. Certain types of shoes bother him, especially a tight dress shoe. When he is running and running and lateral cutting, he seems to have some additional discomfort in the left great toe region. He has no other symptoms.

He is currently on no medications.

EMPLOYMENT HISTORY: He is a hill-time employee for Fitworks. He is essentially a service manager at the Rocky River gym.

PAST MEDICAL HISTORY failed to reveal any previous problems in the above-described area, He does not admit to having any foot symptomatology prior to this incident.

PHYSICAL EXAMINATION revealed a very fit appearing 36 year old male who appeared in no acute distress. He was observed walking in and out of the examining room and office building. His gait pattern was normal and no limping was detected.

Examination of his cervical spine was essentially normal. There were no signs of diminished range of motion or ongoing muscular inflammation. No spasm, dysmetria, muscular guarding, or increased muscle tone was noted. A full range of

motion was noted of the cervical spine in forward flexion, extension, lateral bending, and rotation. Protraction, retraction, and elevation of the scapulae were performed normally. There was a full range of motion of both shoulders, elbows, wrists, and small joints of the hand. He claimed to have a slight degree of tenderness along the lateral aspect of the elbow. His overall physical condition was deemed to be excellent. He had excellent muscular development and no objective findings of an injury.

The only abnormalities at the time of the examination were noted in both feet. He was born or developed a congenitally short first metatarsal. Although the surgery caused the great toe ray to be shorter, there is a short first ray on the **right** foot as well. There was a well-healed scar along the dorsal aspect of the left great toe compatible with the surgical history. He had 10 degrees of dorsi- to about 30 degrees of plantar flexion at the MP joint of the left great toe. The right great toe was much more limited in range of motion. There were very large palpable osteophytes. He barely had 5 degrees of dorsi- and 10 degrees of plantar flexion. He clearly is developing the same syndrome, that is a hallux rigidus, due to degenerative arthritis. This is undoubtedly due to the short first metatarsal that he has developed congenitally. None of these abnormalities are traumatic in origin. **A** neurovascular examination was normal. No atrophy was detected in either upper or lower extremity. Neurologic examination of both upper and lower extremities was normal.

IMPRESSION: Resolved cervical strain, shoulder strain, and contusions. Subjective aggravation of his left first metatarsal phalangeal joint.

DISCUSSION: I have had the opportunity to review a number of medical records. These included the records from the Fairview Hospital, Drs. George Essig, Jeffrey Morris, and Stanley Beekman. Records were also reviewed from the Rebound Physical Therapy, as well as the St. John and Westshore Hospital surgical records. No x-rays were reviewed. It was suggested that he obtain bilateral x-rays of both feet to ascertain the degree of pre-existing arthritis in his left foot and current arthritis in his right foot. The patient did not want to have these done at the time of this evaluation. It was offered to him at "no charge".

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.

It is clear that he sustained soft tissue injuries to his neck, left shoulder, and left arm. These have virtually completely recovered from a subjective standpoint and are objectively recovered. The care and treatment with the doctor in the emergency room and Drs. Essig and Morris were appropriate. I have no criticisms on their evaluation or their findings. It is clear that there was a preexisting degenerative condition in his first metatarsal phalangeal joint. These were present on the initial x-rays. No right foot films were done for comparison.

There appeared, at least by the history presented to his various physicians, that the arthritic condition in his left great toe was aggravated by the accident in question. He clearly had an endstage problem with "hallux rigidus". This indicates that the arthritis has progressed to such a degree that there is absolutely no range of motion. He is almost at that level on his right foot, and clearly there was no history of injury of his right foot. It is my opinion, within a reasonable degree of medical certainty, that a surgical procedure was likely to occur within the two years after the accident on his left foot. If his symptoms develop in the right foot, a similar type of surgery would be indicated. The surgery was performed strictly for a degenerative condition. It was subjectively aggravated by the motor vehicular/bicycle accident in question. This is a very common finding in the general population. This condition does not need a great deal of trauma to subjectively make the arthritic condition symptomatic. The care and treatment that he received was for his arthritic condition. The symptoms of the arthritis are related to the accident in question.

The long-term prognosis is favorable. He has objectively recovered from his soft tissue injuries. The joint implant was successful. No further care or treatment is necessary or appropriate. Other than the care and treatment for his foot, he has had minimal orthopaedic care to date. In my opinion, this level of care was appropriate for his level of injury. The left foot surgery was done strictly for the symptomatic

arthritis. The exact etiology of the symptoms are unclear. It is related by the patient's history to be the motor vehicular incident in question. The long-term prognosis is favorable. No further care or treatment is indicated.

Sincerely,

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

RCC/bn

cc: File