Highland
Musculo-Skeletal
Associates, Inc.

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November 12, 1996

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RE: Bonnie J. Maki
File No. 51503
DOI: 9/24/93

Dear Mr. Spetrino:

I evaluated Bonnie Maki in my office on November 4, 1996, in the presence of Elisa Raicevich, a paralegal from the plaintiff's law firm. This evaluation was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on September 24, 1993.

The history, as you know, was somewhat complex. She has been seen by quite a few caregivers. The bulk of all of their findings were primarily subjective in nature. I will present the history given by the patient and also with the corresponding medical records.

On the above date at approximately 11:30 in the evening she was the driver and solo occupant of a Chevrolet Celebrity vehicle. This occurred in Akron, Ohio, on the Wolf Ledges entrance ramp on 1-77. She was approaching the highway and stopped at a yield sign when her vehicle sustained a rear end impact. The force of the impact threw her forward and backwards. Apparently the seat broke. She struck her chin on the

dashboard. She heard the tires screeching, clenched the steering wheel with her hands and bit down hard with her jaw. Her vehicle was towed from the scene.

She was able to get out of the car, exchange information, and wait for the police.

She was subsequently evaluated at the Akron City Hospital Emergency Room with complaints of pain in both shoulders and neck region. There was also some complaints of back pain. She had some pain along the anterior aspect of her knees and shin where it struck the dashboard. There was apparently no damage to the windshield of the car or steering wheel. Physical examination was essentially normal. No significant objective findmgs were noted. **A** series of x-rays were also performed including the right tibia and fibula, and cervical spine, both of which were normal. She was discharged with a diagnosis of a cervical strain related to the motor vehicular accident.

Subsequently she was evaluated by Dr. Zouhair Yassine, an orthopaedic surgeon at the Crystal Clinic. This initial evaluation was on October **5,** 1993 and he treated her on an intermittent basis through January of 1995. The initial visit revealed pain in the neck and back. It was felt to be a minor soft tissue strain or sprain. Physical therapy was recommended. By the second visit on November 2, 1993 there was marked improvement. No muscle spasm was noted. Her motion was good. He did not see her again until April of 1994, approximately five months later, still improving, and in June of 1994 there was some recurrence of neck pain and left shoulder pain. All of the **pain** seemed to be subjectively aggravated by activity. The last time he saw her was in June of 1994. He only saw her on four occasions.

She consulted for a one-time basis with her family physician, Dr. Barbara Lohmeyer, on December *7*, 1993, primarily about her headaches. She was given a variety of medications for the headaches and dizziness.

She then came under the care of Dr. Steven Oyakawa. She treated with this physician for about seven months, July **24,** 1994 to February 17, 1995. He recommended a series of physical therapy treatments including hot packs, ultrasound, cervical traction

and stretching. He followed her primarily for pain in the neck and back region. Progressive improvement was noted with each and every physical therapy session. The MRI scan revealed a small disc protrusion at the C5-6 level which was not felt to be a surgical problem.

She was seen at the Altman Hospital on May 31, 1995, complaining essentially of right rib pain. She claimed at the time of this evaluation that this had been bothering her since the accident but it was never mentioned in any of her other doctors records. She was essentially treated and released.

She then came under the care of Dr. Norman Lefkowitz, a neurologist, who followed her for a short period time, June 6, 1995 through July 27, 1995. The MRI scans were reviewed but his evaluation was primarily for her lumbar spine. An MRI scan was performed which was entirely within normal limits, done at the Ohio Neuro Center in Fairlawn, Ohio. EMG and nerve conduction studies were performed which did not show any surgically treatable abnormalities.

She then came under the care of her current treating physician, Dr. Robert Crawford, who initially saw her on June 13, 1995. It was uncertain at the time he initially saw this individual whether she wanted further treatment or whether she was, in fact, only sent for an evaluation by her lawyer. Pain management was suggested and she was evaluated by Dr. Bharati Desai for a one-time evaluation on November 8, 1995. She also saw a dentist during the summer of 1995 for her ongoing jaw problems.

Earlier this year, from late February of 1996 to July 5, 1996, she was cared for by Parker Chiropractic Life Center and Dr. Kenneth Parker. Apparently she was referred by her attorney for chiropractic care and treatment. He saw her on an intermittent basis with again some transient relief of her symptoms. She also underwent massotherapy on one occasion by Ms. Debra Phelps. This helped to ease some of her pain.

CURRENT MEDICATIONS includes Norflex, Naprosyn, and Flexeril which she obtains from Dr. Crawford.

EMPLOYMENT HISTORY: She has been trained as a physical therapy aide and also in a secretarial capacity. She last worked in 1995 as a receptionist. She was somewhat vague as to her inability to work.

PAST MEDICAL HISTORY revealed no previous accidents or trauma to her neck, upper back or low back.

CURRENT SYMPTOMS: She described a litany of subjective symptoms in the neck, upper and lower back. She also complained of discomfort in her knees and both feet, although she, in fact, has never been seen or been treated for any of her lower extremity complaints.

In reference to her cervical spine she complains of diffuse pain "in the C5-6 area." The left side was worse than the right side. This seemed to be relieved with rest and therapy treatments, but increased with activity, stress and reaching or maintaining one position, such as doing needlepoint. This "C5-6" area was really the C7-T1 area and is really at the base of the neck and not in the mid cervical spinal area as stated by the patient.

She complains of an intermittent aching pain in the posterior aspect of her left arm and elbow. She also claims to have aching pain and occasional numbness, and a tight achy feeling in all of the fingers. This did not follow any particular dermatomal pattern. This is worse by activity and when she walks for long periods of time.

In the thoracic spinal area she complains of some discomfort primarily that initiates in the left scapular region below the level of the bra line. When it gets worse it then radiates to the right side.

Her lumbar spinal area, she complains of an aching pain that radiates up and down the midline, but primarily at the thoracolumbar junction.

In reference to her lower extremities, that is her shin, knees and feet, she complains of discomfort, the right side worse than the left, when walking or stair climbing. She has

difficulty wearing high heels which actually creates some low back pain. It bothers her when she stands and walks. As stated above, she has never had any care or treatment.

In general, she rated her pain as a "7" which is moderately severe by the scale described.

PHYSICAL EXAMINATION revealed a somewhat apprehensive **43** year old female who appeared in no acute distress. She appeared to be somewhat overweight. She was observed ambulating into the office normally. She was able to arise from a sitting position, as well as ascend and descend the examining table normally. She was able to stand up on her heels and toes without difficulty.

Examination of her cervical spine revealed no spasm, dysmetria or muscular guarding. As noted, the "C5-6 area" was really the lower cervical upper thoracic area. There was a claim of tenderness but no objective abnormalities in the form of spasm, dysmetria, guarding or increased muscular tone was noted. There was a full range of motion of her cervical spine in forward flexion, extension, side bending and rotation. No restrictions were noted in movement of the scapulae in elevation, protraction or retraction. There was excellent muscle development in the sternocleidomastoid, scalene, upper back, neck and periscapular muscles. No atrophy was noted.

A full range of motion of both shoulders was noted in forward flexion, extension, abduction, 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. **A** detailed neurologic examination includmg sensory, motor and reflex testing of both upper extremities was noted. There was a negative Tinel and Phalen sign.

In essence, the neck, upper back and shoulder examination, includmg the scapular examination, other than subjective tenderness, was entirely within normal limits.

Examination of her lumbar spine revealed no specific area of tenderness to palpation. There was good muscular development in the paraspinal muscles. There was excellent

flexibility bendmg able to bend forward to, in fact, touch the ground on forward flexion. **A** good reversal of her lumbar lordosis was noted. Hyperextension, side bending and rotation were performed within normal limits. Her straight leg raising in the sitting position was performed to 90 degrees bilaterally. There was a full range of motion of both hips and knees. The knee examinations were normal with no effusion or any signs of trauma or ongoing objective abnormalities. The ankles and feet examined normally. Excellent muscular development was noted in the thigh and calf, and circumferential measurements failed to reveal any atrophy. **A** detailed neurological examination including sensory, motor and reflex testing of both lower extremities was normal.

IMPRESSION: Subjective residuals of a neck and back strain or sprain. No significant objective findings noted in review of the medical records. Very **minor** MRI abnormality at the C5-6 level. This was non-traumatic in origin.

DISCUSSION: I have had the opportunity to review a fair amount of medical records associated with her care and treatment. These included records both prior to and subsequent to the motor vehicular accident in question. The records reviewed included the Ohio Traffic Crash report, Dr. Theresa Matty, Dr. Glenn Barrett, Akron City Hospital, Dr. Zouhair Yassine, Rehabilitation Health Center Inc., Dr. Barbara Lohmeyer, Dr. Steven Byakawa, Professional Therapy Associates, Health South Rehab (RK Physical Therapy), Akron General Medical Center (MRI scan), Altman Hospital, Dr. Normal Lefkowitz, Dr. Robert Crawford, Dr. James Felix, Dr. Desai, and the Parker Chiropractic records.

After careful questioning of the patient's history and physical limitations, as well as after a careful physical examination and review of detailed medical records, I have come to some conclusions concerning her ongoing level of physical impairment.

At worst, this was a minor soft tissue injury that has created a fair amount of subjective symptoms over the years. She has been seen by a number of excellent physicians, including Dr. Yassine, who is a well-respected orthopaedic surgeon. He did not feel

any diagnostic studies or scans were necessary or appropriate. This was felt to be a soft tissue strain or sprain. She only saw this physician on a number of occasions.

As well documented above, she has seen numerous caregivers for short periods of time. Essentially, other than the diagnostic testing, no significant organic pathology was present, and she was treated on the basis of her symptoms only. No one has ever made a mention of any more significant injury than a soft tissue strain or sprain. She continues to explore different physician's opinion. Virtually every treatment that was given to her improved her symptoms in the form of modality physical therapy. It appears that any time she increases her activity the pain reoccurs. These recurrent episodes are purely subjective in nature. No significant objective findings were noted by any of the specialists physicians.

In my opinion, there is no objective findings to support her ongoing subjective complaints. Her examination, as noted, was essentially within normal limits. Despite this, she complained of a level "7" pain. There is no medical explanation for her level of pain without any objective abnormalities noted. She continues to have a variety of complaints without objective treatable findings.

The only abnormality noted in all the diagnostic work-ups was this minor disc abnormality at the C5-6 level. This? in my opinion, is developmental in origin or related to early degenerative disc disease. There have been numerous prospective randomized studies done using MRI in the normal population. It is estimated that anywhere from one-third to two-thirds of all normal uninjured individuals will have minor MRI abnormalities without symptoms. In my opinion, the symptoms presented are not referable to this minor disc abnormality. This is not traumatic in origin and represents a normal variant.

At the time of this evaluation she has objectively recovered from any soft tissue injury sustained. There were absolutely no objective findings to support her ongoing subjective complaints. There was rarely anything other than stiffness and soreness noted in the medical records. In my opinion, she has objectively recovered from any

soft tissue injuries sustained. No further care or treatment is necessary or appropriate for ber alleged ongoing complaints. She has objectively recovered and the long-term prognosis is favorable.

Sincerely,

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

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