Highland
Musculo-Skeletal
Associates, Inc.

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

November 16, 1997

Molly A. Steiber
Attorney at Law
633 The Leader Building
526 Superior Avenue, NT
Cleveland, OH 44114

RE: Deborah Olszanski
Case No. 326400

Dear Ms. Steiber:

I evaluated the above the plaintiff in my office on November 12, 1997 in reference to alleged residuals of injury sustained in a motor vehicular accident that occurred on April 16, 1996. She was evaluated without friend, family or legal counsel present.

She was the driver and solo occupant of a 1995 Buick Rivera heading southbound on 1-271 near the 480 construction. The accident occurred at approximately 7:30 in the morning. The traffic was described as "stop and go". The vehicle in front of her suddenly stopped and she halted her vehicle. The vehicle traveling immediately behind her, however, did not stop and a rear-end collision occurred. The force of the impact forced her car into the vehicle in front of her. After making the appropriate reports her vehicle was drivable and she went on to work She is employed as a banker for the National City Bank Company, at that time working at the Twinsburg office.

Later that day she was evaluated at the University Primary Urgent Care Center in Twinsburg complaining of neck pain, a small abrasion over the right upper eye and some neck aching. X-rays at that time of the cervical spine were normal and she was discharged with the diagnosis of cervical strain and abrasions.

She then re-consulted her family physician, Dr. Christine Hudak. Dr. Hudak treated her for a previous neck injury and is her current family physician. Near the same time, she also consulted with Dr, *Gary* Estadt, a chiropractor in Mentor, Ohio. Chiropractic treatments were initiated approximately two days after the accident on April 18, 1996. This has been her primary method of treatment during the early months of post injury. Dr. Estadt did an evaluation and a chiropractic examination. It was felt that she essentially had cervical strain with cervical myositis. There was reference to a "right cervical radiculitis" although on careful questioning there was never any **neurological** type of radiating pain. She was out of work approximately three days.

Her initial course of treatments were primarily that of modalities, primarily toward the right side of her cervical spine. There was some transient relief of her symptoms. By late August of 1996 her symptoms did not resolve and Dr. Estadt ordered an MRI scan at the Regional Diagnostic Imaging Center in Mentor, Ohio. This showed a mild focal abnormality at the CS-6 level which measured, at worst, 1-1/2 mm. The actual x-rays were reviewed and this was a very minor disc aberration which certainly could not be considered to be a "disc herniation". It did not cause any type of pressure on the neurological system and could not have been the source of her pain.

The plaintiff obtained a neurological consultation from Dr. Norton Winer, affiliated with University MedNet. This initial consultation was on or about October 5, 1996. He reviewed the records and did a thorough examination. EMGs and nerve conduction studies were also performed which was consistent with "bilateral C6 radiculopathy". This was more on the right than the left. This, of course, did not correspond with any of her symptomatology. He treated her with some muscle relaxants. She believes she saw this physician four or five times. This was the last physician that she saw. No further care or treatment was recommended other than a home cervical traction unit which tended to help her neck initially but then caused headaches. She continues to take the Flexeril on an as necessary basis.

EMPLOYMENT HISTORY: **As** noted above, she is a commercial lending office for the National City Bank. She has worked for that company since she got out of school, now for about five years. She lost about three days from work. Initially she was at the Twinsburg office and now she is at a downtown office.

PAST MEDICAL HISTORY did reveal a prior motor vehicular accident. This was an injury to her neck. She had a series of exercises and some equipment, including a Theraband unit, and was told to "use these" as part of her rehabilitation for this more recent accident.

CURRENT SYMPTOMS: She was carefully questioned as to her level of symptoms. She clearly never had any neurological symptoms whatsoever. Her symptoms never radiated into her forearm. At worst the symptoms were described as an aching pain. There were never any neurological complaints such as numbness, tingling, muscular weakness or a "electricity"like pain. The bulk of her symptoms "greater than 80%' have always been in the right side neck with some very minimal contribution of aching type pain radiating into her right upper arm. Despite the abnormal EMGs and nerve conduction study reports, those abnormalities never corresponded with her symptoms.

Currently she has a dull, occasionally noticeable, aching pain which bothers her two to three days a week. Strenuous activities such as pushing or lifting while doing her grocery shopping, or stress and tension at work, seem to aggravate her discomfort. The bulk of her discomfort, now greater than 90%, is in the right trapezius muscle area. She has no problem with recurrent headaches. As noted above, there is absolutely no neurological complaints radiating into her right upper extremity. She has no sought any medical care and treatment since her final visit with Dr. Winer.

She developed some reaction to medications and was evaluated by a gastroenterologist. Those records were reviewed as well.

PHYSICAL EXAMINATION revealed a pleasant, articulate, 27-year-old female who appeared in no acute distress. She was noted to sit, stand, and move about the examination room normally. She was able to arise from a sitting position without difficulty. Ascending and descending the exam table was performed normally.

Examination of her cervical spine revealed no objective findings of muscle irritation in the form of spasm, dysmetria, muscular guarding or increased muscular tone. She claimed to have pain only to deep palpation in the right trapezius muscle at the base of the neck. There was full unrestricted 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 a full range of motion of both shoulders in forward flexion, extension, abduction, internal and external rotation. The elbows, wrists, and small joints of the hand examined normally. There was negative Tinel sign at the elbow and wrist level. A detailed neurologic examination including sensory, motor and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level showed the very slight increase in size of her right upper extremity compatible with her right side neuromuscular dominance.

In essence, the cervical, upper back, and shoulder exam was entirely within normal limits. She complained only of some subjective tenderness on occasion in the right trapezius muscle area. There were never any neurological complaints.

IMPRESSION: Resolving subjective symptoms of a cervical strain or sprain. MRI and EMG evidence of minor abnormalities which are unexplained on the basis of a clinical examination and by the patient's history.

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 University Urgent Care Center, University MedNet, and Dr. Gary Estadt. Records were also reviewed from the Regional Diagnosis Imaging Center and Northcoast Endoscopy. The actual MRI scans and x-ray films were reviewed. These, as noted above, were essentially 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 the plaintiffs ongoing level of physical impairment.

In my opinion, the injury in question was, at worst, a cervical strain with facia1 abrasions. The only care and treatment that was provided was chiropractic in nature. This was totally passive and was not associated with any active exercise program. The only exercises the patient has performed has been on her own as instructed from her prior neck injury. The findings on the MRI scan were discussed above and were minimally significant at best.

I have no explanation for the mild abnormalities seen on the EMGs and nerve conduction studies. They clearly match the level of the disc abnormality but do not match the level of symptoms or the quality of the symptoms that were complained of. As stated above, she clearly **never** had any neurological complaints and never had any radiating **aching pain** below the level of the right arm. There was never any forearm symptoms nor was there any weakness or radiating of pain into her right hand. Clearly, these are abnormal objective findings but do not pertain to any particular injury or to the patient's level of symptoms. In my opinion, they are clinically irrelevant and do not match the type of symptoms that the patient demonstrates. She clearly, on careful questioning, never had any neurological symptoms that would account for these abnormal findings. As stated above, the MRI findings also were not attributable to a singular incident of trauma and are within normal limits for the general population.

As noted above, over the course of the months, the patient's symptoms have slowly improved. In my opinion, at worst, she sustained a cervical strain which is resolving. There was no permanent injury sustained. The disc abnormality on the MRI and the EMG findings were not associated with any traumatic incident. The long-term prognosis is favorable. On the basis of this evaluation no further care or treatment is necessary or appropriate. She has objectively recovered and her remaining diminishing subjective symptoms should continue to improve. No permanent injury was sustained.

Sincerely,

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

RCC/bn

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