Highland
Musculo-Skeletal
Associates, Inc.

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

November 23, 1996

Joyce V. Kimbler
Attorney at Law
Mainplace - Suite 100
121 South Main Street
Akron, OH 44308-1436

RE: Deidre Anne Hanlon
File No. 52630
DOI: 8/8/94

Dear Ms. Kimbler:

I evaluated the above plaintiff, a practicing attorney, Deidre Anne Hanlon, in my office on November 18, 1996. Throughout the history and physical she was accompanied by her attorney, Michael John.

This evaluation was specifically in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on August 8, 1994. She was the driver and solo occupant of a 1991 Corvette heading in a north bound direction on 1-77. She was apparently stopped for traffic on the road. **A** car traveling behind her, braked, lost control, went off to the side of the road and then came back, and struck the rear aspect of her car.

At the moment of impact she felt "an electrical jolt" on her left side and left arm. She was apparently thrown in a **side-to-side** direction, striking her left shoulder on the door or door frame. Her vehicle was towed and she was conveyed by ambulance to the Akron General Medical Center.

In the emergency room her primary complaints were neck, back pain and right shoulder pain. She described the motor vehicular accident and appeared in moderate distress in reference to her low back. There was no true cervical spine bony tenderness. Multiple x-rays were done of her shoulder, thoracolumbar spine, none of which revealed a particular fracture fragment. There was a suggestion of a pars interarticularis defect at the L5 level, but this was not felt to be significant. She was subsequently discharged with a diagnosis of "myofascial strain, shoulder and back, status post MVA."

Subsequently, she came under the care of Dr. Philip Wilcox, who initially evaluated her approximately a week after the accident, on August 16, 1994. His clinical impressions at that time were that of an acute lumbar strain. He recommended physical therapy including modalities, range of motion and strengthening exercises. She was also started on a muscle relaxant.

Approximately three weeks later, in early September, she again had a follow-up visit. Her pain was essentially low back without any leg radiation. She had stiffness, as well as continuing back pain. Routine follow-up examinations were carried out through the bulk of 1994, after she concluded her physical therapy. It was decided in early January of 1995 to try an L5-S1 facet joint injection to be done at the St. Thomas Hospital. This was done on January 11, 1995 and gave her absolutely no relief whatsoever. She claimed to have ongoing "back pain." During this first six months there was extensive physical therapy without resolution of her symptoms.

She sought a second opinion with Dr. Barry Greenberg, a spinal orthopaedic surgeon affiliated with the Crystal Clinic in Akron, Ohio. His initial evaluation was on March 13, 1995, The pain was related by her history to the August of 1994 accident. A diagnostic workup was performed to rule out any "occult fracture, cancer or bone diseases." A bone scan revealed only one kidney and Dr. Flynn, a general surgeon, evaluated her for this. An MRI scan did not reveal any herniated disc, just multiple low lumbar disc disease. On plain x-rays there was some narrowing at the L5-S1 level, but the MRI did not show any herniated discs.

Dr. Greenberg referred her to Dr. Andrew Raynor who initially saw her on April 7, 1995. This was specifically for rheumatological management. A series of blood tests were performed which were essentially normal. X-rays were "negative except for some degenerative changes." She continues to follow with Dr. Raynor on a q6 month basis.

The other care and treatment she had was performed by Dr. Howard Shapiro, a neurologist, who saw her for a consultation. A CT scan without contrast was performed of her spine on August 23,1995, and basically showed some mild scoliosis, but no traumatic abnormalities. He did state her diagnosis was "low back pain, etiology uncertain." Recommendations for pain management was offered and these treatments were carried out at the Cuyahoga Falls General Hospital in October of 1995. The working diagnosis there was "lumbar radiculopathy" and SI joint pain, but there was never any radiculopathy documented by any other musculoskeletal specialists. She underwent a series of lumbar steroid blocks which gave her absolutely no relief. She is essentially being maintained on a pain pill which she never takes and Elavil which she takes at bedtime.

She has had no further therapy or low back conditioning since the original prescription prescribed by Dr. Wilcox. She is on minimal medication.

EMPLOYMENT HISTORY: She is a self-employed attorney. She believes she has lost some billable hours but this was not discussed to any great extent.

PAST MEDICAL HISTORY failed to reveal any previous trauma to her shoulder or low back. She was in a severe motor vehicular accident in 1982 and sustained a fractured right femur, She underwent an open reduction and internal fixation for this. The hardware was removed approximately a year later. There were a number of other hospitalizations but these were unrelated to her motor vehicular accident subjective residuals.

CURRENT SYMPTOMS: At the time of this evaluation she claimed to have back pain virtually on a daily basis. She described the pain as primarily midline low back

pain at the lumbosacral junction **with no radiation.** Occasionally there was some **pain** in the sacroiliac joint in the past, but **this** is not the location of the **pain** now. It **may** be slightly more to the right. When describing the percentages of back **and** leg **pain,** she said that her back was "over 95 percent" of her symptoms. She does wear an elastic binder type of back support. She still has some difficulty **with** ongoing pain necessitating stretching during the course of the day. Prolonged sitting and standing, and maintaining any posture or position for periods of time seems to aggravate her. She is in a regular exercise program using weights, Stairmaster and a Nordic track at home. This tends to keep her somewhat more limber. There is no relation to time of day and the pain, nor certain activities other **than** those described above. Weather changes do not affect her low back. She wears the binder when she is exercising.

PHYSICAL EXAMINATION revealed a pleasant 44 year old female who appeared in no acute distress. She was observed to ambulate normally. She was able to arise from a sitting position without difficulty. Ascending and descending the examining table was performed normally. She was noted to "stretch out" a number of times during the evaluation. This involved mostly hyperextension of the spine and pelvic rotation. She has no ongoing complaints in reference to her shoulder.

Examination of her lumbar spine revealed no spasm, dysmetria, or muscular guarding, or increased muscle tone. There was no tenderness to palpation. She pointed where the **pain** was "deep" at the lumbosacral junction. This band of discomfort was, at the most, 4 cm either side of the midline. She does not consider this radiating and it is not radicular in nature. It is fairly well localized. She maintains excellent flexibilty being able to bend forward to touch below her ankle level. There was good reversal of her lumbar lordosis **with** this maneuver. Hyperextension, side bending and rotation were preformed without limitation. Her straight leg raising both in the sitting and supine positions was performed to 90 degrees bilaterally. Her leg lengths were essentially equal. The right leg may have been about, at the most, 3/8 of an inch shorter **than** the left. (This is probably related to her remote femur fracture.) There was no atrophy noted on gross observation or circumferential measurements of her upper and lower calf level. **A** detailed neurologic examination including sensory, motor and reflex testing of both lower extremities **was** normal.

IMPRESSION: Chronic subjective low back pain by history related to the motor vehicular accident, Mild degenerative arthritis and disc disease, pre-existing. Essentially normal physical examination.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include records from the P&S Ambulance Company, Akron General Medical Center, St. Thomas Medical Center, Cuyahoga Falls General Hospital, Akron City Hospital, as well as records from Drs. Wilcox, Greenberg, Raynor, and Shapiro. A number of other records were reviewed as part of the discovery document packet.

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 apparent that there was no neurological injury and no skeletal injury sustained as a result of this motor vehicular accident. The typical fashion in which disc injuries occur is a flexion injury. This by history was a side-to-side incident. By definition this must be considered a cervical strain or sprain as the original injury. This is what her treating physicians have assumed. She underwent a thorough diagnostic workup which included a bone scan. The bone scan did not reveal any occult fractures of the spine. It did note there was only one kidney.

She was treated by a number of respected physicians including Dr. Wilcox, Dr. Greenberg, Dr. Raynor and Dr. Shapiro. None of these individuals have found anything more than a low back strain or sprain. The neurosurgeon could not determine the etiology of her back pain. She currently is undergoing very conservative medical care and doing exercises on her own. She generally feels that over time the pain has improved.

There is no objective evidence of any ongoing treatable orthopaedic pathology. The mild disc disease, in my opinion was not caused, permanently aggravated or accelerated by this accident. Her primary complaints are that of chronic low back pain

which are most likely soft tissue in origin. On the basis of this evaluation no further orthopaedic testing, care or treatment is necessary or appropriate. She has certainly objectively recovered from any soft tissue injury sustained.

My prognosis for the future would be continuing improvement. I do agree with her ongoing exercise routine and this should be continued in the future. No further formal therapy is indicate. A complete objective recovery has occurred. In the future her subjective symptoms should continue to diminish in intensity and duration. No surgery is anticipated for any traumatic residuals of injury. The care and treatment that has been provided has been appropriate.

Sincerely,

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

RCC/bn

cc: File