Highland
Musculo·Skeletal
Associates, Inc.

November 24, 1997

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RE: Ann Meyers
Case No. 323353
DOI: 1/16/95

Dear **Mr.** Neubert:

I evaluated the above plaintiff in my office on November 19, 1997 in reference to residuals of injury sustained in a motor vehicle accident which occurred on the above date. She was evaluated without a friend, family or legal counsel present.

The history presented was that she was the driver and solo occupant of a motor vehicle described as a 1989 Ford Taurus that was proceeding through the intersection of Clague Road and Brookpark Road. **A** motor vehicle coming in the opposite direction made a left hand turn suddenly in front of her. She was unable to stop her vehicle and a front-end impact occurred, primarily along the front passenger side of the car.

At the moment of impact some of the internal objects in the car flew around. She was struck in the head by either her car phone or the garage door opener. She was not rendered unconscious. The bulk of her discomfort, however, was in the region of her right ankle. She was conveyed by EMS to the Fairview Hospital Emergency Room where she had the appropriate x-rays and evaluation performed. The head laceration

was repaired and multiple x-rays were performed. The x-rays of the right ankle were positive for a fracture of the distal fibula. Multiple x-rays of the right knee, right foot, and tib-fib were negative for acute fracture. The head wounds were actually stapled shut and a sterile dressing applied. She was given some pain medication and referred to Dr. Duret Smith, an orthopaedic surgeon.

The initial evaluation was, in fact, the following day. Repeat x-rays at that time did show widening of the ankle mortise. He attempted to do a closed reduction to close the medial gap but, unfortunately, on follow-up x-rays the anatomic position of the fracture was lost. Due to the instability a surgical repair was contemplated and ultimately carried out at the Fairview Hospital. This was done on a 23-hour observation status, being admitted and discharged on January 24, 1995. The diagnosis was a severely comminuted distal fibula and lateral malleolar fracture. She underwent an open reduction and internal fixation, as well as removal of the staples in her head.

He followed her on a routine basis through January and February of 1995. The cast was ultimately discontinued and physical therapy initiated in mid-March of 1995. The last routine follow-up was on May 26, 1995 and she was "doing nicely". X-rays looked "super" and no traumatic arthritis was noted.

She was followed in **April** of 1996, about 15 months after her open reduction and internal fixation. It was decided at that point to remove her hardware, and this was done on an ambulatory basis on June 18, 1996. Three additional postop visits were carried out, the last visit was on July 22, 1996. At that time she was doing well, had no complaints. Her wound had healed. He restricted her activity for another month to protect the residual fracture site. She has had no further care or treatment for these injuries.

EMPLOYMENT HISTORY: At the time of the accident she was self-employed as a florist, operating Vaughan's Florist. She subsequently sold the business and then went into work at a Dillard's department store in customer service. She then

subsequently got a job as a bank teller in September of 1997. She did not lose a great deal of time out of work.

PAST MEDICAL HISTORY failed to reveal previous or subsequent injuries.

CURRENT SYMPTOMS: At the time of this evaluation she still had some residual symptoms that seemed to be on an intermittent basis and related to certain activity or weather conditions. She did claim to have some episodes of recurrent swelling, primarily in the anterior and anterolateral aspect of the ankle. She still tries to keep the foot elevated when she is sitting for any period of time. Cold weather and damp weather seem to give her an aching pain. There is occasional burning and cracking sensation in the ankle. She does some of her stretching exercises and this seems to dissipate. Her fourth child was born in April of 1996. She cares for this 18-month-old active child in addition to her job as a "full-time mom". There are no other residual symptoms.

PHYSICAL EXAMINATION revealed a very pleasant **43** year old female who appeared in no acute distress. Her gait pattern was extremely minimally abnormal. I noticed a very slight limp when she first got **up** from a sitting position and walked out of the **exam** room. By the time she had her x-rays and left the building, there was almost no discernible **limp.** Examination of her right ankle revealed a well-healed scar along the lateral aspect of the ankle, compatible with her surgical history. This appeared to be well healed. She complained of some decreased sensation about the ankle and the deep peroneal nerve distribution along the dorsal aspect of the foot. There **was,** however, no edema or swelling noted. There was full range of motion of the subtalar and midfoot joints.

Range of motion of the ankle was very minimally limited **with** less **than** 10% restriction of motion in dorsiflexion. There was full plantar flexion. No other abnormalities were noted and neurovascular examination was normal other **than** this area of decreased sensation mentioned above.

X-rays were performed in the office. These included AP, lateral and mortise views of the **right** ankle. This showed the healed fracture with an absolutely pristine joint space. There is absolutely no evidence of posttraumatic arthritis. If this. was to develop solely related to this injury it would have appeared by this point in time.

IMPRESSION: Healed scalp lacerations, status post open reduction and internal fixation for displaced lateral malleolar fracture. Excellent clinical result. No evidence of posttraumatic arthritis.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These included records from the police and accident report, the EMS run. Records from Fairview Hospital, Dr. Duret Smith, and records of her two ankle surgeries.

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.

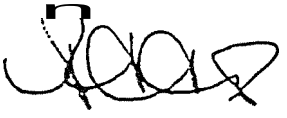
The actual physical injuries are fairly clear cut. The scalp lacerations necessitated the emergency room care and treatment, as well as the staple removal. Her ankle fracture was a direct result of the accident and necessitated the care and treatment provided by **Dr.** Smith. This did include the attempt at conservative care and the operative repair of the fracture. The decision to remove the hardware is optional. I have no criticisms on the decision to remove the previously placed plates and screws, although I do not do this on a routine basis for my patients with similar injuries.

There was no mention of any posttraumatic arthritis in the records of Dr. Smith. There was none that was apparent on a clinical basis at the time of this evaluation.

The long-term prognosis is favorable. She still had some residual symptoms which are not specifically manifested by any precise clinical findings. There was a slight degree of stiffness of the ankle which is a common subjective complaint following similar type injuries. There is; however, no substantial objective abnormality. She

has recovered to a great extent. On the basis of this evaluation no further care or treatment is necessary or appropriate. She should attempt to continue doing her stretching exercise on a routine basis which would eliminate the residual. minor degrees of stiffness. On the basis of this evaluation she has objectively recovered. No permanent injury was sustained. The care and treatment for her injuries were appropriate for the level of trauma. She has recovered quite well from this injury.

Sincerely,



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

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