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RE: Celeste S. Carroccio
Case No. 298130 (Cuyahoga County)
File No. 2231 A/S

Dear Mr. Williams:

I evaluated the above plaintiff in my office on September 25, 1996, for the purpose of an Independent Medical Evaluation. This evaluation was carried out in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on December 30, 1994. During the history portion of the examination she was accompanied by her attorney. **A** female friend assisted her during the physical portion of the examination. Her attorney was not present for the examination.

She presented with a history of a motor vehicular accident which occurred on December 30, 1994. She was the driver and solo occupant of a motor vehicle described as a Chevrolet Cavalier. She was heading south-bound on Stearns Road near the I-480 exit. **A** car allegedly came off of the exit ramp, pulled suddenly in front of her and she could not stop. She tried to avoid the collision by turning to her right. An impact occurred on the front driver's side of her vehicle. She was wearing a seat belt. Despite this, her body was thrown forward striking her forehead on the windshield. There was no loss **of** consciousness. She complained of immediate pain in the neck, right shoulder and left knee, according to her history. Her vehicle **was** drivable.

In that she was somewhat concerned about her mother reacting to her going to the emergency room she elected not to be transported by police or EMS, and drove her vehicle home. She picked up her mother and stopped by her mechanic to have him take a look at her vehicle to make sure that it was safe to drive.

Her first medical contact was at the Elyria Memorial Hospital. She apparently had two emergency room visits within a short period of time. The initial visit on the day of the injury was solely and specifically related to her left knee. She claimed to have struck her left knee. There was a mild effusion and some tenderness, but no signs of ecchymosis or abnormality. It certainly did not appear to be "unstable" as characterized by the plaintiff. A series of x-rays were performed of her left knee. These are entirely within normal limits. She was given a knee immobilizer and discharged.

She then again appeared in the emergency room four days later on January 3, 1995. At that time her primary complaints were neck and right shoulder. She had no pain in her forehead from striking the visor and complained only of pain in the right side of the neck and upper back. Physical examination showed a supple neck with essentially only tenderness in the right cervical and right upper back and trapezius area. There was some mild tenderness noted in the right forehead area. A series of x-rays were performed of her skull and cervical spine. This showed some mild narrowing showing some pre-existing degenerative disc disease of the C5-6 level with a small osteophyte and spur formation as well. It was felt these were mild degenerative changes at the C5-6 level. The x-rays of her head were essentially normal.

Subsequently she returned to her family physician, Dr. Bradley Barker, who has been the primary treating physician for this injury. He had an MRI scan performed of her left knee which only showed some evidence of a strain of the patellar tendon but no significant interarticular pathology. She then underwent physical therapy at the Elyria Memorial Hospital. She stated she went through therapy for "six months" for hot packs, ultrasound, MEMS, and a TENS unit which she still wears. She went through three different sessions, sometimes three times a week, at the Elyria Memorial

Hospital. The therapy did improve her symptoms to some degree. She was placed on home exercises, as well as a number of medications including anti-inflammatory and pain medications.

She consulted with an orthopaedic surgeon, Dr. Paul Treuhaft, initially on March 21, 1995. Review of x-rays, including the MRI, indicated an initial impression of chronic knee pain secondary to what was felt to be a contusion of the anterior cartilage and chronic muscle imbalance, He recommended a physical therapy program, as well as adjusting her medications. Dr. Treuhaft saw her on two additional occasions, April 4, 1995, and for a final visit on May 9, 1995. It was noted the physical therapy helped but she still had some weakness in some of her muscle groups, primarily the hamstring muscles. It was recommended that she consider continuing physical therapy at Elyria Memorial Hospital. There was some subjective improvement with the therapy. He also placed her on Amitriptyline, a very low dosage, as a sleep aide.

Other than the follow-up with Dr. Bradley, she was evaluated by Dr. Edward Gabelman on only one occasion, October 19, 1995. This was approximately '10 months after the motor vehicular accident. She still had ongoing complaints of neck, as well as knee pain. There was some evidence of stiffness and Dr. Gabelman felt she may have had some wasting of the muscles in the upper back, neck and shoulder region. Examination of the left knee was benign. X-rays were taken of her right shoulder and left knee. She told me an MRI scan was performed of both of these areas but there does not seem to be any indication that this is what was performed by Dr. Gabelman. Only standard x-rays were performed of the left knee and right shoulder and these were essentially unremarkable. Dr. Gabelman's conclusion was that she had subjective pain that was related to the motor vehicular accident although no particular objective injuries were noted.

As you are aware, she is claiming to have a significant level of injury from this motor vehicular accident. She also claims that the severity of her trauma necessitated the use of a walker for a prolonged period of time. She had difficulty ambulating and developed "carpal tunnel syndrome" from this. She wears carpal tunnel braces on both

of her hands. Careful questioning did reveal that she, in fact, never had any diagnostic studies to confirm this. The braces do help her subjective symptoms. As will be discussed below, she had very minimal objective abnormalities to correspond with the seventy of her complaints.

EMPLOYMENT HISTORY: She has been employed as a PRN psychiatric nurse usually working three to four shifts per month. She also had a full time job as a mental health worker at the Nord Center Mental Health in Elyria, Ohio. She claims she has not been able to return to regular work because of inability to write due to neck, right arm and shoulder pain. She also claims she cannot walk because her left knee is "unstable."

PAST MEDICAL HISTORY revealed a problem of "arthritis in the right knee.". She also sustained a "hairline left tibial plateau fracture" about the left knee. She was immobilized for eight weeks and allegedly had no further complaints.

CURRENT SYMPTOMS: As will be discussed below, the patient had a litany of complaints. She claimed to be in a moderately severe level of pain between a "5 and an 8 and 9" at the time of the evaluation through different parts of the exam. There was a tremendous variety of complaints which will be discussed by region. There is Little correlation, as will be discussed below, in the physical examination.

In reference to her cervical spine, she still wears a 4-lead TENS unit. One is located on either side of the midline of her cervical spine, one on her right posterior shoulder blade area, and one along the right shoulder area. She claims that this reduces the pain from a "7 to 8 to a level 5." She wears this most of the time except for sleeping. She complains of diffuse neck pain, the right side worse than the left, but primarily this follows the trapezius muscle group. She claims to be right handed and any repetitive use of her right upper extremity in her activities of daily living causes her a tremendous amount of pain. She uses the TENS unit and Darvocet to control her pain. She usually has right upper back, shoulder and neck pain on a fairly consistent basis and they usual occur together, that is the neck with the arm and shoulder.

In reference to her **hands,** she complains of intermittent symptoms described as "electrical shocks." In the **right** hand, this involves the **index,** middle finger which feel "tight," and the left hand involves the index, middle, and ring finger. As noted above, the braces help her significantly. She does complain of diffuse weakness in both hands. Soaking her hands in warm water seems to decrease her symptoms to some extent.

In reference to the **left** knee, this feels "unstable." What she means by this is that she has difficulty standing on it without the knee feeling like it is going to collapse backwards. She states the brace that **was** provided by Dr. Gabelman helps her out dramatically. Essentially this is just a Neoprene sleeve with a patellar cutout. It is unlikely that this brace gives her any more than psychological support. There are no metal staves and clearly this brace is not designed for "instability." She had difficulty walking on carpeted floors. Her pain is mostly along the anterior patellar area, distal to the patellar tendon and along the medial joint line. She ambulated with the use of a quad cane at the time of her evaluation. She claims to have great difficulty with weight bearing.

PHYSICAL EXAMINATION revealed a somewhat heavyset 49 year old female who appeared somewhat apprehensive. Despite her level of pain she smiled and giggled through the bulk of the examination. She claimed most of the movements that I performed were severely painful in the range of a "7 to an 8." There were little objective confirmation of these complaints.

Her gait pattern was abnormal. She tends to use her cane in the right and left lower extremity protecting her knee. She moved about in a somewhat robotic fashion. She had great difficulty arising from a sitting position, although there was some chuckles and a smile on her face. Ascending and descending the examining table **was** performed in a bizarre fashion.

Examination of her cervical spine revealed tenderness just about every area that **was** touched on the right side and some on the left side. The tenderness seemed to follow

the trapezius muscle group. There was; however, no spasm, dysmetria, muscular guarding or increased muscle tone during this portion of the examination. With some coaxing there was very minimal restriction of range of motion of her cervical spine, although she claimed that this was severely painful. The TENS unit was detached during the exam and her pain immediately jumped two to three levels. Protraction, retraction, and elevation of the scapulae were performed normally. Despite her long-standing complaints of disuse there was no distinct muscular atrophy in the neck, upper back, shoulders or periscapular area.

Passive and active range of motion of both shoulders revealed a full range of motion although she complained bitterly of pain with movement of her right shoulder. There was no signs of adhesive capsulitis (frozen shoulder) or any documentable abnormality. The elbows, wrists, and small joints of the hand examined normally. There was symmetrical, proportional muscular development on circumferential measurements of both upper extremities at the axillary, midarm, forearm, and wrist level.

Specific examination of her hands and wrist, to rule out carpal tunnel syndrome, revealed a minimal positive Tinel's sign bilaterally. The nerve compression seemed to be most irritating in the mid forearm area and generally followed the median and ulnar nerve. A Phalen's sign was positive in both dorsi- and volar flexion which was not physiologic, creating diffuse numbness in both of her hands. There was no atrophy noted in the thenar or hypothenar musculature. Symmetrical reflexes were noted bilaterally. On objective neurological evaluation, no deficits were detected.

Examination of her left knee revealed no effusion. There was no atrophy of her left lower extremity as compared to her right on direct measurements or on circumferential measurement with a tape measurement. The upper and lower thigh, and upper and lower calf levels were equal and symmetrical bilaterally. No effusion was noted and circumferential measurements at the knee joint and mid patellar level were equal and symmetrical bilaterally.

There was absolutely no instability detected in her left knee. Her medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no rotational instability. There was a tendency toward recurvatum bilaterally but no instability was noted. Patellofemoral examination revealed some discomfort but no objective findings. No retropatellar crepitance was noted in either lower extremity. The balance of the neurological examination of both lower extremities was normal.

IMPRESSION: Severe subjective residuals of a soft tissue strain or sprain of the neck and right shoulder. Probable contusion to left knee. Absolutely no physical findings that corresponded with her complaints.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These include some records from the Elyria Memorial Hospital, including both the ER visits and physical therapy; some records from her medical physician and the report from Dr. Edward Gabelman. I have also reviewed the records of Dr. Paul Treuhaft.

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 has only been on a very rare occasion, probably less than 10 people in 17 years of private practice, that I have ever witnessed such severe subjective symptoms without objective findings. There is no anatomical or physiological explanation for the severity of her claims of pain without any documented objective clinical abnormality. This plaintiff is claiming a severe disabling injury to her neck, right shoulder, as well as bilateral carpal tunnel syndrome. However, on objective testing, there was only some mild degenerative arthritis and disc disease of her neck. There was no objective neurological abnormality and no electrical evidence of a carpal tunnel syndrome. The only sophisticated diagnostic test she had, according to the medical records, was an MRI scan of her left knee which was essentially normal. No other objective abnormalities were documented in the medical records.

Her ongoing subjective symptoms are solely related to the accident by the history presented to all the physicians involved in her care and treatment, and at the time of this evaluation. In my opinion, at worst, the original injury was a strain or sprain of the neck and right shoulder. As a result of the physical examination as described above, there were no clinical objective residuals of injury that would correspond with her level of **pain.** From an objective standpoint she has completely recovered. The long-term prognosis is favorable. On the basis of this evaluation, no further orthopaedic care or treatment is necessary or appropriate. Certainly no surgical intervention is indicated. There are no objective orthopaedic or neurological abnormalities present at the time of this evaluation. The prognosis is favorable.

Sincerely,

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

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