Highland
Musculo-Skeletal
Associates, Inc.

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RE: Kimberly Mizerak
Case No. 97 CV 000372 (Lake Co)
DOI: 7/20/96

Dear Mr. Hanson:

I evaluated the above plaintiff in my office on December 15, 1997 in reference to alleged residuals of injury sustained to her neck in a motor vehicular accident which occurred on July 20, 1996. Throughout the history and physical she was accompanied by her husband, Jack, who was also the driver of the motor vehicle.

She presented with the history of being a front seat passenger in a 1993 Escort wagon wearing a seatbelt at the vicinity of Route 2 and Burns Road in Madison, Ohio.., A rear-end collision occurred. At the moment of impact she was thrown forwards and backward. She had immediate pain in the neck, mid and upper back region. Police ultimately came on the scene and the appropriate reports were made. Her parents came to pick her up. She was apparently, at that time, one her way to her sister's wedding and had to go on to the wedding that evening. She did not seek any medical attention. She came home at approximately ten o'clock that evening. The neck pain persisted,

A few days later she consulted with her family physician. Dr. Rezai, who evaluated her on or about July 22, 1996. X-rays were ordered of both the neck and low back region, and after examination it was felt that she had a sprained neck and low back. Percocet, a narcotic analgesic, was recommended and represcribed on three occasions through October of 1996. There was no significant care or treatment rendered by that physician.

She subsequently referred herself to the Thomas Pain Center in Mentor, Ohio. She was evaluated in late July of 1996. Some physical therapy was initiated and there was no substantial relief of her discomfort. Subsequently an MRI scan was ordered or her cervical spine in August of 1996. This revealed a C5-6 paracentral disc herniation, both anterior and posterior. Mild foraminal stenosis was noted due to degenerative disc disease. There was a small anterior bulge at the C6-7 level as well.

She was subsequently referred to Dr. John Collis, a neurosurgeon affiliated with the Cleveland Spine and Arthritis Center at Lutheran Medical Center. She underwent an evaluation and it was felt that these were, by history, related to the motor vehicle accident in question. He advised her to wear a cervical collar, prescribed some muscle relaxants, and cervical paraspinal and epidural blocks were ordered. These were carried out at the Carnegie Surgery Center. Two blocks were given which gave her absolutely no relief. The bulk of her symptoms remained in the midline cervical spinal region. There was some radiation in to the mid trapezius area, but never below her shoulder level. There were never any true neurological complaints in the form of numbness, tingling or burning. She had about 10 physical therapy treatments with Dr. Thomas. She has had no further care or treatment since that time.

She became pregnant with her first child in late 1995. She found out in early 1996. She had a normal labor and delivery of her child on October 26, 1997 by cesarean section.

As stated above, since she completed her failed blocks, she has had no further care or treatment. Her symptoms have remained fairly constant in her neck region. They are essentially unchanged since shortly after the accident. The other symptom she did have was a left side parietal head pain. She did see a Dr. Timothy Herron, a

neurologist for this. This evaluation was done when she was approximately seven months pregnant. An MRI of the brain was done which was normal. She has not had any further care or treatment from this physician.

PAST MEDICAL HISTORY failed to reveal any previous problems or trauma with her neck.

EMPLOYMENT HISTORY: She was employed as an engineering assistant doing heavy office work including document work at the Cyberex Company. She worked until approximately her eighth month of pregnancy. She has not returned to work since then.

CURRENT SYMPTOMS: At the time of this evaluation she still had persistent pain, which essentially has been unchanged for about a year and one-half, in the mid cervical region. The left side is slightly worse than the right. Right rotation was performed without difficulty, but with left rotation she is somewhat weary and does it slowly. There are no adverse changes when there is changes in the weather. She describes a baseline constant pressure or burning sensation. Occasionally it radiates into the trapezius muscles but never into her arms. There is no true radiating or radicular pain below the level of the trapezius. There is no interscapular pain and no residual low back pain. Current medications include Tylenol. She was taking Percocet, She is on no medications since her pregnancy and, in that she is currently still breast-feeding, does not take any medications currently.

PHYSICAL EXAMINATION revealed a pleasant 34 year old female who appeared in no acute distress. Her gait pattern was normal. 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 a claim of tenderness in the mid cervical region. There was some mild tenderness in the trapezius muscle on the left side. A full unrestricted range of motion of her cervical spine was noted in forward flexion, extension, side bending, and rotation. No radiating or radicular pain was noted in any of these maneuvers. Protraction, retraction, and elevation of the scapulae were

performed normally. There was no spasm, dysmetria, muscular guarding or increased muscle tone 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. A detailed neurological examination including sensory, motor and reflex testing of both upper extremities was entirely within normal limits. There were no neurological objective deficits or subjective complaints involving the C5, C6 or C7 nerve roots.

IMPRESSION: Cervical strain or sprain. Probably aggravation of preexisting degenerative disc disease. MRI evidence of multiple level disc bulges. The most significant bulge at C5-6, both anterior and posterior indicating degenerative disc disease.

DISCUSSION: I have had the opportunity to review a number of medical records associated with her care and treatment. These records included those from Dr. Rezai, Dr. Thomas' Pain Center, and Dr. Collis' evaluation and treatment. Records were also reviewed from the MRI scan, as well as actual review of the MRI films. As part of these studies were flexion and extension laterals which showed some increased bulging at **anteriorly** at the C5-6 level. This confirms the suspicion of degenerative disc disease and not a traumatic disc herniation.

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 my medical opinion that the injury sustained was that of a cervical sprain. There was, in my opinion, multiple level degenerative disc disease which was asymptomatic prior to this accident. She has remained symptomatic ever since the accident. Her symptoms are that of a strain or sprain with diffuse muscular pain. There are absolutely no neurological complaints nor are there any neurological deficits detected. Although the MRI is fairly dramatic in appearance there are no objective correlations with this. In my opinion, this was not caused by a singular episode of trauma.

I do believe that she did sustained a soft tissue strain or sprain. This may have aggravated the preexisting degenerative disc disease which may be the source of her ongoing symptoms. I do not believe that surgical intervention is necessary or appropriate in light of the absence of neurological symptomatology. I do believe that a comprehensive therapy program, including flexibility, strengthening, and weight lifting and conditioning would be appropriate. She has not had any care or treatment for about a year. In my opinion, muscular rehabilitation would be the most viable treatment alternative at this point in time.

It is my medical opinion, within a reasonable degree of medical certainty, that the motor vehicular accident in question probably aggravated some preexisting cervical disc disease. Her major component of her symptoms, at this point in time, in my opinion, is due to the lack of any medical care for over a year. I do believe that the therapy program, as discussed, could be performed in the Mentor area with a supervised program for flexibility and strengthening. In my opinion, the bulk of her residual symptoms can be greatly diminished with appropriate muscular training. There has been no substantial worsening of her symptoms. In my opinion, there is no objective permanent aggravation of the degenerative disc disease. There may be a subjective aggravation in the form of a strain or sprain superimposed upon preexisting degenerative disc disease. No surgical intervention is necessary. The therapy should help her long-term prognosis. My prognosis for the long-term is favorable. Undoubtedly her degenerative condition will worsen with age. There is no objective evidence that the actual disc disease was permanently aggravated or accelerated.

Sincerely,

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

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