Highland
Musculo·Skeletal
Associates, Inc.

December 26, 1997

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

Mary Ann O. Rini
Assistant Attorney General
State Office Building
615 W. Superior Avenue, 12th Floor
Cleveland, OH 44113-1899

RE: Diane Ferro
DOI: 4/30/96
Case No. CV 97 05 3349

Dear Ms. Rini:

I evaluated Diane Ferro in my office on December 19, 1997 in the presence of her husband. The purpose of this evaluation was for an independent medical evaluation to ascertain what exactly transpired to her right knee on April 30,1996.

At that time, as you are aware, she was employed as a tour guide for the London Candies, a candy manufacturing company in Canton, Ohio. Her job involved giving walking tours. She did anywhere from two to six per day. These lasted from 45 minutes to an hour. The tours involved climbing up and down a series of 20 steps and escorting tours through the manufacturing facility.

On the day of injury she was standing on an elevated area and stepped down. She apparently hit the marble floor with her left knee initially. She lost her footing and tried to catch herself, severely twisting her right knee. There was, however: pain in both knees, the right knee was somewhat worse. She was helped up by a fellow employee and then later went to see her family doctor. Subsequently she was evaluated by her previously treating orthopaedic surgeon, Dr. Robert Erickson, III, of Massillon, Ohio. He had previously treated her for a "terrible triad" type of injury

which involved an open repair of the MCL and anterior cruciate ligament. According to his previous records, the last visit prior to this injury was on January 24, 1994 and she was doing quite well. There was no instability with "excellent progress".

He saw her and began treating her for what appeared to be a sprain of both knees, right greater than left, She continued with her home physical therapy but was not making any progress. Ultimately an MRI scan was performed. This did reveal that she re-tore her anterior cruciate ligament graft, as well as probably tore her medial meniscus. She continued to work from April until December of 1996 with progressive difficulties. She stopped working on December 9, 1997.

Ultimately she did go through a second ligament reconstruction on April 15, 1997. The preoperative diagnosis was failed ACL reconstruction right knee with a torn meniscus. An appropriate arthroscopic assisted anterior cruciate ligament repair with bone cadaver graft was performed.

Postoperatively he placed her in a hinged brace with crutches for about 13 weeks. She continued on a home physical therapy program. She returned to work the end of September of 1997. She continues to slowly improve.

At the time of this evaluation her main complaints were that she still has some discomfort in the knee and the right lower extremity feels generally weaker. The pain is generalized and the knee continues to swell on an intermittent basis. She continues With her home exercises including her over-the-counter medications occasionally. She is on stretching exercises but has not yet resumed progressive resistance exercises. I discussed this with her and she will probably start this in the very near future if okayed by Dr. Erickson.

PHYSICAL EXAMINATION revealed a pleasant, cooperative 48 year old female who appeared in no acute distress. There was some diffuse tenderness noted in the suprapatellar area of the right knee. There was, however, a full range of motion. A number of obvious scars were noted which included scars from her previous surgery, She did have a previous arthroscopy of that knee back in 1986. Small arthroscopic incisions were noted from that, as well as the most recent surgery. There was a long

anterior medial incision from the first medial collateral ligament and ACL repair, as well as two new incisions from the arthroscopically guided surgery.

Her knee was quite stable in all directions. There was no medially lateral or anteroposterior laxity. There was no rotatory instability. There was a negative Lachman and pivot shift sip. Patellofemoral examination was normal. She did have a slight degree of atrophy of approximately three-quarter inch in the right thigh as compared to the left. There was no calf atrophy.

IMPRESSION: Sprain of the knee with stretching and/or tearing of her previous ACL reconstruction.

DISCUSSION: I have had the opportunity to review a significant amount of medica1 records associated with her care and treatment. These included records from the Massillon Community Hospital, the Doctors Hospital and from a number of physicians, Dr. Alok Bhagat, Dr. John Given, Dr. Richard Klaphcar, and complex records from Dr. Robert Erickson.

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.

Clearly this knee did have problems in the past. There is clear indication of a rather significant knee sprain which included a complex ligament repair done in 1993. She did recover from this and had a very stable knee as noted in the last pre-injury note in 1994.

This fall off of the podium, in my opinion, within a reasonable degree of medical certainty, caused a sprain of her previous ACL graft. This gradually stretched out over the next three or four months and her symptoms seemed to worsen during this time period. The knee became quite unstable by the fall of 1996 and ultimately the MRI diagnosed that the previously placed graft had failed. This failure, in my opinion, within a reasonable degree of medical certainty, stemmed from this singular incident. The necessity for the operation described on her right knee was due to the

anterior cruciate ligament insufficiency. It is my medical opinion, within a reasonable degree of medical certainty, that the surgical procedure was solely due to this re-injury. This is primarily based on the history presented and the suspicion of her own treating physician.

The long-term prognosis is favorable. Despite the third operation on her knee, it is quite stable at this point in time. She 'needs to continue With the progressive resistance exercises in order to strengthen both her quadriceps and hamstring musculature. This would certainly, in a dynamic sense, help to protect the anterior cruciate ligament graft. It seems to be functioning quite well. She is back to work doing her same job duties. The long-tern prognosis is favorable. It does not appear that any permanent injury was sustained.

The long-term prognosis is good. Exercises should be continued indefinitely due to the complexity of her knee injury history. The incident in April of 1996 was competent to produce the injuries later identified.

Sincerely,

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

RCC/bn

cc: File