Highland
Musculo-Skeleta
Associates, Inc.

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

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Lauri E. Letts
Attorney at Law
Lakeside Place - Suite 410
323 Lakeside Avenue West
Cleveland, OH 441 13

RE: Carol Jackson
Case No. 313189 (Cuyahoga County)
File No. 53191

Dear Ms. Letts:

I evaluated the above plaintiff in my office on December 17, 1996 in reference to alleged residuals of injury sustained in a motor vehicular accident which occurred on May 14, 1996. Throughout the history and physical she was accompanied by an attorney, Susan Stephanoff.

The history was that she was the driver and solo occupant of a 1996 Baretta automobile on Solon Road in Solon, Ohio. She could not recall the precise intersection. She was stationary at a red light behind a small truck. As the light changed and the truck pulled away, a vehicle came out of a Harley Davidson parking lot and rear ended her car. In the interim, the truck had pulled through the intersection and no front end impact occurred.

She claimed at the moment of impact she was thrown forward and backwards, and she complained of **pain** immediately in her neck region. She was not wearing a seat belt, She may have hit her chest on the steering wheel but there was no bruising. Her motor vehicle was drivable and she subsequently went home.

The following day she drove herself to the Cleveland Clinic where she had received essentially all of her care and treatment related to this motor vehicular accident. She was seen on May 16, 1996, according to the medical records, with the history of feeling "fine after the accident with no numbness, tingling, headaches, loss of bladder or bowel control" or problems with gait or loss of consciousness. She essentially felt fine. However, over the next 24 hours she began feeling a dull headache and soreness in the neck. It was not relieved by aspirin so she came into the emergency room for an evaluation. No neurological complaints were noted. There was essentially a normal neck examination and it was felt that she had a neck strain. Toradol, an analgesic anti-inflammatory medication, was prescribed. She was essentially treated and released.

She was subsequently followed by the *Primary* Care Department at the Cleveland Clinic. This was on an intermittent basis. She had a number of appointments with the physical therapists, the exact dates were difficult to ascertain by history. The Cleveland Clinic records clearly do show some additional care and treatment. She stated she reduced her hours and her occupation. She owns and operates a barber shop which she has done for the past 20 years.

In addition to the analgesic medication, she was given anti-inflammatory medications. She noted gradually she developed some abdominal **pain** and ultimately an acute gastrointestinal bleed. This did ultimately necessitate a hospital admission from October 2, 1996 to October 5, 1996. This was precipitated by a passing out episode preceded by two days of black tarry stool. There was a previous history of peptic ulcer disease 10 years ago.

She underwent an upper gastrointestinal endoscopy which did show a definite ulcer, 10 mm x 20 mm on the anterior wall of the stomach. Biopsies were taken and it turned out that she was positive for H. pylon bacteria (recent medical evidence indicates that this chronic bacterial Section may be the cause of chronic peptic ulcer disease). Her blood pressure was stabilized with saline solution. Her condition did necessitate a number of blood transfusions.

In the course of the fall that precipitated the admission, she struck her right little finger. She was seen by the plastic surgery hand surgeons and they eventually, under local anesthetic, reduced the joint subluxation. She claims there was a surgical procedure done but it was difficult to note any incision. This sounded like a **closed** procedure.

She had a subsequent endoscopy done on November 19, 1996 for follow-up of her ulcer. The stomach appeared to be normal with a healed gastric ulcer. She remains on a number of medications for her stomach condition. She only takes Ultram for her intermittent pain and Prilosec for her stomach condition.

It was very difficult to ascertain in the Cleveland Clinic notes whether the GI Service felt that the bleed was directly related to treatment for the car accident. There was a history of one or two months of intermittent cramping **pain with** poor eating habits and a progressive increase in symptoms.

EMPLOYMENT HISTORY: As stated above she is self employed as a barber. She owns her own shop, She believes that some of her work load had to be reduced because of her continuing **pain in** the neck and upper back.

PAST MEDICAL HISTORY failed to reveal any previous trauma to her neck or low back. She claimed not to have any significant problems in the past in reference to her spine. This was not entirely accurate.

Extensive medical records were reviewed, as will be discussed below, including records from the Hough-Norwood Cleveland Neighborhood Health Services, Inc. She was complaining of radicular type of arm **pain** at that time. This did necessitate x-rays of the cervical spine which showed spondylosis (arthritis) of the cervical spine with facet joint degenerative disease at the C3-C4 level on the right. This arthritic condition of the neck was felt to be the cause of her right upper extremity symptoms.

Records from the Cleveland Clinic of January 24, 1996 (Page 111) indicates being seen for back and left leg **pain.** There was indication that this back and leg **pain** was worse at night, not with walking. She did receive medications. X-rays revealed some arthritic conditions in her low back as well.

CURRENT SYMPTOMS: The **pain** that she experiences comes from essentially two areas, the base of her neck and her low back. The complaints in her neck are essentially intermittent in nature. They are sometimes related to cold and damp weather, but basically "come and go as they please", This is felt primarily in the trapezius muscles, the left or the right side. She claims to have minimal soreness in this area. There is no significant complaint of stiffness. These symptoms are intermittent and not related to any particular activity or above shoulder level work.

In reference to her low back, she complains of aching stiffness which is there "all the time". She complains of **pain** in her right lateral hip area when lying on the right side at night. The Ultram seems to help. The pain is described as a nonradiating pain essentially at the waist level in a horizontal direction. There were no true radicular symptoms in either upper or lower extremities.

PHYSICAL EXAMINATION revealed a pleasant 63 year old female who appeared in no acute distress. She was able to sit comfortably through the history portion of the examination. Her gait pattern was normal being observed walking in and out of the examining suites. She was able to heel and toe walk without difficulty.

Examination of her cervical spine revealed no spasm, dysmetria or muscular guarding. There was no tenderness or increased muscle tone noted at the time of the examination. A very minimal restriction of motion of less than 10% of predicted normal was noted in forward flexion, extension, side bending and rotation. There was no objective abnormality noted that would cause this restriction. She does have known cervical spondylosis (arthritis). This would certainly account for this minimal diminished range of motion. There was no tenderness or abnormality noted in the sternocleidomastoid, scalene or trapezius muscles. Protraction, retraction, and

elevation of the scapulae were performed normally. There was normal muscle development with no atrophy noted in the neck, upper back and periscapular muscles.

Examination of both shoulders, elbows, wrists, and small joints of the hand essentially examined normally. She did complain of pain and stiffness in the right little finger. No significant incision was noted. There may have been a 10 degree diminution in flexion of the distal interphalangeal joint. This was difficult to ascertain as she has extremely long fingernails.

A detailed neurological examination including sensory, motor, and reflex testing of both upper extremities was normal. Circumferential measurements of both upper extremities at the axillary, midarm, forearm and wrist level were equal and symmetrical bilaterally. She is right handed.

Examination of her lumbar spine revealed no objective abnormalities in the form of spasm, dysmetria, or muscular guarding. She claimed to have some discomfort at the extremes of hyperextension and forward flexion. There was approximately 10% limitation of motion in both directions. There was, however, good reversal of her lumbar lordosis. Her straight leg raising in both the sitting and supine positions was performed to 90 degrees bilaterally, There was a full range of motion of both hips and knees. Neurologic examination of both lower extremities was normal.

IMPRESSION: By history, probable cervical strain or sprain. X-ray evidence of degenerative arthritis and disc disease of the cervical and lumbosacral spine. Lumbar complaints are solely arthritic in nature.

DISCUSSION: I have had the opportunity to review a volume of medica1 records concerning her care and treatment. These include extensive records from the Cleveland Clinic and University Hospitals of Cleveland, as well as the Hough-Norwood Center.

Mer careful questioning f the patient's history and physi al 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.

On the basis of this evaluation, in my opinion, at worst she sustained a soft tissue strain or sprain of the cervical spine. There is no indication of any significant soft tissue injury as there was essentially no pain for a minimum of 24 hours, probably more according to the records. When seen initially in the emergency room there was essentially a normal neck examination. It was felt that she had a cervical strain or sprain. This was probably the only injury sustained.

The physical therapy she received for her spinal complaints was appropriate and the treatments to the neck were directly related to the motor vehicular accident in question.

Careful review of the records, including the hospital admission for her gastrointestinal bleed, seemed to be related to an ongoing gastrointestinal disorder. There was a strong positive history of bleeding ulcer in the past, 10 years ago. Her cultures were positive for H. pylon which, according to recent medical literature, is implicated at the cause of chronic gastrointestinal complaints. It is difficult within a reasonable degree of medical certainty to state that her gastrointestinal bleed was directly and causally related to treatment for the motor vehicular accident in question. Certainly these same conditions can occur with the use of anti-inflammatories alone and also with H. pylori infection alone, The injury to her right hand was due to orthostatic hypotension due to her gastrointestinal bleed. There was no clear opinion as to the effects of her motor vehicular accident treatment and the hospital admission, upper GI endoscopies, and her ongoing gastrointestinal care.

At the time of this evaluation she has objectively recovered from any soft tissue injuries of the spine. Her ongoing complaints in reference to her cervical spine, in that they are intermittent and unrelated to particular activity, are more likely than not due to her degenerative condition. Her low back condition is clearly solely due to her degenerative condition. There was no back injury sustained and certainly no

complaints 48 hours after the injury. It is more likely than not that the low back complaints are solely arthritic in nature and not related to the motor vehicular .accident in question.

In *summary,* a minor soft tissue strain or sprain of the cervical spine was incurred. It is my opinion that the gastrointestinal complications, including the hospitalization and right hand injury, were related to chronic gastrointestinal disease and H. Pylori Section. which caused an upper gastrointestinal bleed. Her ongoing complaints are arthritic in nature. She has objectively recovered from any soft tissue injury sustained. The long-term prognosis is favorable. It is unclear how the residuals of a soft tissue injury restricted her work duties on the basis of the history presented.

Sincerely,

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

RCC/bn

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