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RE: Claudia Kramer
Case No. 424077
File No. 1170-B-101

Dear Mr. Proe:

I evaluated Claudia Kramer in my office on June 12, 2003. She presented with a paralegal. She is a 53-year-old right hand dominant female, here with a paralegal. On December 5, 1998 she stepped into an open manhole filled with water. Her right leg went down to the hip. She had abrasions on her left leg and hip. Her left shoulder was sore immediately, neck sore the next day. Left hip was also sore.

The next day she saw her family doctor, Dr. Rychlik. X-rays of the left hip and left shoulder reportedly negative. She was referred to Dr. Daniels, an orthopaedic surgeon, who gave her an injection in her left shoulder. She had an MRI scan of the left shoulder. She was told he had a small tear. Had physical therapy, which helped some. She subsequently had more physical therapy, which helped some.

She had an MRI scan of the neck and reports she was told she had slight disc damage but they don't know what it's from. She reports a few days after the accident she went to push a heavy chair and her left arm felt different. She started have numbness on the ulnar aspect of the left forearm and the 4th and 5th fingers. This is improved.

She reports she underwent physical therapy for her neck. She reports her left hip pain improved. The abrasions healed. She reports her back and knees hurt, but doesn't think these are necessarily related to the accident. She reports eight to nine months

Ex A

after the accident her right shoulder started to hurt intermittently. No MRI. This improved.

CURRENT SYMPTOMS: Presently she reports her neck is sore constantly. Tiny bit of tingling occasionally of the ulnar aspect of the forearm and 5th finger. Left shoulder sore constantly, not really any problem with movements of the shoulder. Right shoulder a little soreness on the top occasionally. No other complaints.

PAST MEDICAL HISTORY: Inguinal hernia surgery in 1984, GYN surgery. She reports she had left shoulder bursitis, pain left shoulder in 1990 after gardening. Had a Cortisone injection, which helped, and then the pain recurred. Had physical therapy and this resolved. She denies any prior neck problems. No other motor vehicle accidents or injuries. She is 5' 6-1/2" and weighs 110 pounds.

MEDICATIONS: Wellbutrin, Effexor, Lorazepam.

PHYSICAL EXAMINATION reveals a thin female with an intact gait. Heel and toe raise intact.

Examination of the neck revealed diffuse tenderness posteriorly in bilateral trapezial muscle body regions with even light pinching of the skin. Skin normal. Muscles supple. She demonstrated good range of motion of the neck without complaint.

Examination of the shoulders revealed symmetric appearance, good active elevation. Good resistive abduction and external rotation strength. She reported diffuse tenderness circumferential around the left shoulder, non-focal, also with slight pinching of the skin, skin normal. Right shoulder nontender.

Examination of the upper extremities revealed reflexes symmetric. She reported mild hyperesthesia along the ulnar border of the left hand and 5th finger. Intrinsic function intact. No atrophy. Good grip strength. Mildly positive Tinel's at the cubital tunnel bilaterally. Right arm good strength, sensation, grip.

Examination of the lower extremities revealed good range of motion of the hips without complaint. Knees good range of motion without complaint. Good resistive strength in the lower extremities. Reflexes and sensation intact. Negative sitting straight leg raise bilaterally.

REVIEW OF THE MEDICAL RECORDS: I reviewed voluminous medical records regarding Claudia Kramer. There was no records available from prior to the December 5, 1998 accident.

Records of Dr. Rychlik and a January 30, 2003 report were reviewed. These indicate that Ms. Kramer was first evaluated after the accident on December 7, 1998. History of fall into a hole, complaining of pain in her left hip, lower back and left shoulder.

A follow-up note December 11, 1998 indicated the back pain was resolving.

There was no indication in the initial evaluation or Dr. Rychlik's report that she sustained a neck injury as a result of the accident of December 5, 1998.

A December 29, 1998 note of Dr. Rychlik noted left shoulder complaints, also for the first time left elbow with paresthesia into the left hand. There was a notation regarding neck. X-rays were ordered of the cervical spine and left elbow.

January 9, 1999 records of Dr. Hovi indicate evaluated for complaints of left shoulder, elbow, and left hand. Swollen and sensitive. History of fall early December. History notes six years of bursitis shoulder, left. Physical therapy and exercises. There is no report of low back or lower extremity complaints in this evaluation nor are these marked on the pain drawing diagram.

January 14, 1999 Ms. Kramer was evaluated by Dr. Daniels, orthopaedic surgeon. History of the December 5, 1998 accident. Noted that when she fell she supported herself with her left arm and legs. Noting over the succeeding weeks the pain has increased in her left arm and shoulder with difficulty lifting her arm, internally or externally rotating it. She has pain with driving, pain with her activity as an artist.

Left hip pain and contusions in and around her lower extremities have healed uneventfully. Dr. Daniels yielded an impression of "I feel she has suffered a contusion to her left shoulder which may now be persisting as rotator cuff tendonitis and bursitis. Certainly she may have a partial thickness tear of the rotator cuff or even a small full thickness tear from her fall. Secondarily, she may also be experiencing a contusion to the ulnar nerve from supporting herself during the direct fall or an injury to the C7, 8 nerve roots from the fall as well."

An MRI of the cervical spine was obtained January 20, 1999. Radiologist's interpretation notes mild degenerative disc disease at several levels. Further notes there are minimal ventral impressions on the thecal sac at the C3-4 through C6-7 levels on the basis of mild posterior bulging of disc margin. At C3-4 there appears to be focal central posterior disc herniation extruding slight inferiorly but this does not cause significant central canal stenosis. The neural foramen are widely patent.

Follow-up January 26, 1999 with Dr. Daniels notes she is having quite a lot of pain in her neck though radiating into her left arm down into the ulnar aspect of the hand. She had no significant weakness however. She also has some pain down the left shoulder but this is gradually improving today. While discussing her condition, she is gesturing with her left arm without any hesitation whatsoever. She does have a mildly positive impingement test but has good strength, internal and external rotation, but her range of motion of the neck was painful. Dr. Daniels noted an impression of she has an injury superimposed on disc pathology in her cervical spine. Referred to Dr. Yuk.

A February 8, 1999 evaluation by Dr. Yuk, neurosurgeon, notes history of the accident of December 5, 1998. Notes she had treatment with Dr. Hovi and Dr. Daniels. For her complaints of shoulder pain she had one steroid injection. Dr. Yuk notes "about three weeks after her fall, she noticed some aching in her neck." There was one episode when she felt some 'cold and then warm' involving her left hand. She also thought there was some brief swelling of the ulnar aspect of her left hand. This has not been a recurrent problem. At present she complains of stiffness in the neck. This is particularly bothersome in the morning. An MRI scan of the cervical

spine had been done. The study did not show any serious structural problem other than some mild degenerative changes. Otherwise, she does not complain of right arm symptoms. She also does no complaint of any lower extremity symptoms."

Past medical history noted slight low back problems some years ago.

Exam noted no neurologic findings. Dr. Yuk noted she complained of some diffuse shoulder pain on range of motion of the left shoulder. Her low back flexibility was excellent. Straight leg raising test was negative bilaterally. Further noted specifically I do not see any discoloration or swelling involving the hands. There was no Tinel signs over the wrist or elbow. Phalen's test was negative bilaterally.

Dr. Yuk notes an impression of cervical sprain. He further notes I am not certain how she sprained her neck. I certainly do not expect symptoms from a cervical sprain, which she might have sustained on December 5, 1998 to start giving her trouble three weeks later. It was reassuring that her MRI scan did not show any significant structural abnormality and that her neurologic examination did not show any focal abnormality today. Dr. Yuk recommended conservative treatment, no surgery.

MRI of the left shoulder was ordered February 10, 1999. Radiologist's impression notes the supraspinatus muscle and tendon can be traced continuously to the attachment of the rotator cuff. However, on oblique sagittal views there appears to be a focus of abnormally increased signal within the tendon. This suggests a small amount of fluid in the tendon, which would be compatible with tears of individual fibers. Impression: Although supraspinatus muscle and tendon appear to be continuous to the rotator cuff, the presence of small focus of abnormally increased signal within the tendon suggests the presence of micro tears.

Records of Dr. Sunderlage indicate initially evaluated February 6, 1999. Noted complaints of shoulder and neck pain, sometimes arm and hand, left side. Treated into April of 1999. April 26, 1999 note indicates neck feeling better but shoulder still very sore. April 29, 1999 received phone call from Claudia. Shoulder still very sore,

seemed aggravated by treatment, but did a lot of work last two days. Further notes shoulder possibly overworked.

HealthSouth physical therapy records, January 28, 1999 through July 13, 1999, indicate improvement. March 5, 1999 notes neck is 75 to 80% better. Left shoulder 30 to 40% better. March 26, 1999 note indicates had episode of increased pain. Appears to indicate doing yard work. Notes assessment of slow progress. June 3, 1999 notes continued intermittent shoulder soreness. Notes reinforced the patient the need to increase exercises at home.

December 18, 1999 Dr. Jablonsky, orthopaedic surgeon, evaluated her for complaints of bilateral knee, patellofemoral, and bilateral lateral hip pain. History of December 5, 1998 accident. Impression was evidence of bilateral hip greater trochanteric bursitis with evidence of moderate IT band syndrome. There is evidence of bilateral patellofemoral chondromalacia and quadriceps atrophy.

Lake Forest Hospital records indicate evaluation October 25, 1999. History of accident December 5, 1998. Initial evaluation notes previous history includes since childhood has problems with knees and feet. Chondromalacia, plantar fasciitis. History of left shoulder bursitis. The evaluation that day by Dr. Ingberman notes history of prior treatments. Notes in spite of all these treatments, the patient continues to suffer from pain which has now become more generalized. The patient is currently suffering from pain that is present more on the left side than the right side, but is located in the neck, shoulders, arms, knees, hips, and ankles.

Dr. Ingberman notes on exam she has multiple non-organic pain symptoms revealed on physical examination such as axial loading. She complained of pain in her legs, in her neck, and in her back. She had pain in her neck with simple passive knee stretching. She also has very sensitive areas on her lower back with simple skin movements such as making skin folds.

Further history October 25, 1999 indicates she had previous had knee and leg problems since she was a child and she attributed that to running and walking a lot, as

well as her background in waitressing. She had been treated orthopaedically for that 16 or 17 years in the past.

October 27, 1999 pain treatment evaluation notes medical diagnosis of chronic pain syndrome. Psychological diagnosis of pain disorder associated with psychological factors, MMPI results valid profile, mild level of depression. Tendency to somatize.

Ms. Kramer was discharged from treatment February 9, 2000. "In relation to current pain rating, only 1 to 2 out of 10, neck and left shoulder but feels the car is a challenge. Once in a while 3/10. Feels pain is decreased 50%." Further noted improved postural alignment and body mechanics. Noted to have resumed artwork.

Records of Dr. Haywood, staff psychiatrist, included a progress note of April 12, 2000 which includes diagnoses of Axis 1, major depression, single episode, in remission, on medication, adult ADD, under medication management. Axis 3, medical, full recovered from trauma to left shoulder.

Crystal Lake Chiropractic records indicate start of treatment November 6, 2000. Complaints of left shoulder pain for three weeks, had pain on left side, shoulder, hip, knee, ankle after a bad fall into a grease pit in Ohio in 1998. Got relief from original pain after going to pain clinic and chiro. Was almost pain free until three weeks ago, was doing art work and lifting some things, and went grocery shopping, also did some gardening. Shoulder started to hurt after all that.

I also reviewed records from various mental health providers.

I also reviewed records of orthopaedic surgeon, Dr. Karpen, who initially evaluated Ms. Kramer on March 31, 1999 at the referral of Dr. Daniels. Notes he examined the patient and reviewed the MRI films. His impression was left rotator cuff tendonitis/bursitis. Subsequent follow-up May 4, 1999 noted she has continued to have complaints of discomfort in her left shoulder. States this has been continuing since her massage, which aggravated her symptoms. Exam noted full range of motion

of the left shoulder in all directions, including internal rotation. Impression of left rotator cuff tendonitis. July 1, 1999, also noted full range of motion.

I reviewed the October 11, 1999 report of Dr. Karpen. He indicated no plan for surgery. Note he thought the more active she is the better off she will be.

MRI scan dated January 25, 2000 was interpreted as showing very small effusion into the shoulder joint space, otherwise normal MRI of the left shoulder. Noted the rotator cuff tendon and biceps tendon did not reveal any abnormalities.

I also reviewed reports of Dr. Daniels, Dr. Kohn, and also two reports of Dr. Robert Porter, October 12, 2000 and February 26, 2003.

Dr. Porter had noted in his report a reference to records dated September 26, 2000. She had been pulling weeds the day prior and "may have heard a pop in chest, left side."

Ms. Kramer had been referred to Dr. Nager, April 5, 2001, for electrodiagnostic studies of the left arm. This was interpreted as a normal study. There is no electro-physiologic evidence of cervical radiculopathy or of peripheral nerve neuropathy to account for the patient's symptoms (pain and paresthesias radiating down the left arm).

CONCLUSION: Ms. Kramer has reported significant prior history of complaints and treatment regarding the left shoulder, history of left shoulder bursitis. Prior history of low back pain, problems with the knees and feet, chondromalacia, and a long period of orthopaedic treatment previously.

She reported in her history to me that a few days after the accident she went to push a heavy chair and the left arm felt different and then started having numbness in the ulnar aspect of the left forearm and 4th and 5th fingers, which was noted to have improved. The records indicate that these complaints did not start until several weeks

after the accident of December 5, 1998. This together supports that these complaints were not causally related to the December 5, 1998 accident.

The records do not support that she sustained an injury to the cervical spine as a result of the December 5, 1998. As noted, neck complaints did not start until three weeks later. The initial evaluations do not support that she sustained an injury to the neck as a result of the December 5, 1998 accident. The findings on the MRI scan of the cervical spine are degenerative in nature. These were not caused by the December 5, 1998 accident nor were they aggravated by that event.

Ms. Kramer had a significant prior history of left shoulder problems.

By history, she sustained a contusion to the left shoulder and some component of rotator cuff tendonitis as a result of the accident of December 5, 1998. This was subsequently aggravated by activities such as gardening, this not related to the accident (she had reported her prior left shoulder problems started after gardening).

The injury to her left shoulder as a result of the December 5, 1998 accident had resolved by the time of the MRI scan of January 25, 2000, which noted a normal rotator cuff.

Ms. Kramer could have sustained a low back strain as a result of the December 5, 1998 accident. This resolved within a matter of weeks.

She also sustained lower extremity contusions as a result of the accident. These rapidly resolved. The subsequent complaints regarding the knees and feet much later are not related to the accident of December 5, 1998.

The records do not support that she sustained any neurologic injury as a result of the accident in question. The diagnostic studies do not support that she has cervical radiculopathy or carpal tunnel syndrome.

It is my opinion that it cannot be stated to within a reasonable degree of medical certainty that Ms. Kramer's present complaints would be related to the accident of December 5, 1998. They probably are not related.

Treatment for the diagnosis of chronic pain syndrome and subsequent treatment would not be related to the accident of December 5, 1998.

These opinions stated to within a reasonable degree of medical certainty.

Sincerely,

T. Gordon

Timothy L. Gordon, MD

TLG/bn

cc: File