



ReVive Orthopedics---Lithia Springs Office

939 Bob Arnold Blvd, Lithia Springs, GA 30122
P: 770-769-1724 F: 678-504-7799

Spine Initial Visit Consult



Patient Name: **Jane Doe**
D.O.B.: **6/3/1967** Age: **55**
Visit Date **9/28/2022**

Medical Record #:
Attending Physician: **Shevin D. Pollydore, M.D.**
Physician Requesting Consultation: **Dr. John C. Doe D.C**

Type of Visit: CONSULTATION

CHIEF COMPLAINT: **Cervical Spine, Left Knee, Left Shoulder and Low Back** Low Back Pain, Neck Pain, Left shoulder Pain, Left Knee Pain Left Upper Extremity Numbness/Tingling, Right Lower Extremity Numbness and Tingling.

HISTORY OF PRESENT ILLNESS

Jane Doe is a 55 year old female with Low Back Pain, Neck Pain, Left shoulder Pain, Left Knee Pain Left Upper Extremity Numbness/Tingling, Right Lower Extremity Numbness and Tingling, who is a Account Rep: for ' ABC company '. Onset of Pain/Symptoms: was 09/02/2022. The mechanism of injury was described in the following manner: **Motor Vehicle Accident**. *The patient states that she was a restrained driver who was in a Volvo XC90 SUV (Sport Utility Vehicle). She was rear ended while at a complete stop by a Chrysler minivan ; causing her to hit the vehicle in front of her She says that her body was 'jerked' forwards and then backwards., The patient says that she sustained a Coup-Contrecoup type injury where her body 'jerked' forwards and then backwards and that her head hit the headrest. She says that her left hand was on the steering wheel at the time of impact. There was no airbag deployment. She developed pain in her low back, neck, and left shoulder. She also developed some left wrist pain. She says that her left knee hit the dashboard and she developed some swelling in the left knee.*

The patient says the she was treated in the Gwinnett medical Emergency Room. X-rays of the affected areas which were negative, she was then given some anti-inflammatory medication along with a muscle relaxer and some tramadol for pain, and she then was released.

She has been treating with a chiropractor Dr. John Doe. She has had diagnostic imaging of the affected body parts.

The patient denies any significant back pain and/or spine history requiring prolonged treatment and/or significant hospitalization/surgery and other major spine procedures



(this excludes minor sprains/strains that resolved quickly).

She had a prior motor vehicle accident in 2015 with some neck and back pain treated by the same chiropractor with no residual symptoms. Her MRI scans were negative at that time. She denies any pre-existing problems with the left knee or left shoulder.

The patient denies any prior Worker's Compensation injuries. She did have a sports injury while playing soccer in high school where she injured her left ankle and was in a cast boot for several weeks. This resolved with physical therapy. She also had a right ACL tear at age 15 which was repaired surgically with no residual symptoms.. Workers compensation case: No. Work status: She is not working. Last day of work was 8/3/2022. Jane is experiencing Right lower extremity, Left Upper Extremity Numbness/Tingling numbness and tingling. Aggravating factors are: bending, lifting, overhead activities with the left arm, turning the neck to look over the shoulder. Alleviating factors are: rest, lying down. The patient filled out a pain diagram and rates her pain as 8. The patient has had no prior spine injections, Previous to physical therapy and chiropractic treatments which both helped somewhat.. She has had prior cervical X-Rays and prior lumbar X-Rays, a prior cervical MRI scan, a prior lumbar MRI scan, no prior EMG tests. The patient has had no previous surgery to the back or neck. She has no bowel or bladder problems. She has a history of sleep disturbance but no depression and denies any history of diabetes or peripheral neuropathy.

PAST MEDICAL/SURGICAL HISTORY:

Previous Medical History: Asthma, High Blood Pressure, Diabetes

Previous Surgical History: Appendectomy (2015), breast reduction (2013); right knee ACL reconstruction at age 15

ALLERGIES: Sulfa

CURRENT MEDICATIONS: Naprosyn 500 mg twice daily; Flexeril 10 mg 3 times daily, tramadol 50 mg twice daily; metformin 1000 mg twice daily; lisinopril 20 mg daily; amlodipine 10 mg daily

FAMILY HISTORY:

Father: Alcoholism, Heart attack / Angina. **Mother:** Diabetes.

Brother(s) Living: 1. **Brother(s) Deceased:** 0.

Sister(s) Living: 1. **Sister(s) Deceased:** 0.

Children: 2 Alive and Well.

SOCIAL HISTORY:

Marital Status: Married



Occupation: Account Rep

Tobacco Use: Yes 1 - 2 cigarettes a day

Alcohol Use: Yes, 1 drink a day

Weight Change: gained more than 10 lbs

Cancer History: denies any cancer history

Constitutional Symptoms: **Recent weight gain (10 pounds since the MVA on 8/3/2022)**

Allergic/Immunologic: No problems

Cardiovascular: **High Blood Pressure**

Respiratory: **Asthma**

GI Disorders: **nausea, vomiting**

Kidney Problems: No problems

Metabolic / Endocrine: **Diabetes -Non-insulin**

Integumentary / Skin: No problems

Ears, Nose, Mouth and Throat: **Tinnitus, noise sensitivity**

Eyes: No problems

Neuro

Problems: **Headaches, Numbness/Tingling, Light Headedness, Off Balance, Vertigo**

Psychiatric: **Insomnia, Memory loss or confusion and Nervousness**

Hem / Lymph Disorders: No problems

Musculoskeletal: **Back pain, Neck Pain, Shoulder Pain**

PHYSICAL EXAMINATION

GENERAL: The patient appears the stated age, is slightly overweight. She stands 5 ft 7 in tall and weighs 189 lbs. Blood Pressure is 110/70 mmHg. She is afebrile and respirations are unlabored.

ORIENTATION: The patient is awake, alert, oriented times 3, answers and responds to all questions appropriately..

GAIT, STATION and COORDINATION: The patient exhibits a wide based gait and mildly impaired coordination.

NECK EXAMINATION:

Inspection: No evidence of atrophy or asymmetry.

Range of motion: **moderately decreased in all planes.**

Stability: No evidence of crepitation, laxity, or instability.

Palpation: **Left sided Cervical Facet tenderness, Midline lower cervical tenderness, midline upper cervical spine tenderness and Right lower cervical facet tenderness.**

Strength: Manual muscle testing is normal without cervical spine weakness.

Cervical facet maneuvers are positive bilaterally.



THORACIC EXAMINATION:

Thoracic Palpation: **diffuse thoracic paraspinal tenderness with some trigger points .**

Thoracic Inspection: No evidence of atrophy or asymmetry.

OTHER UPPER EXTREMITY EXAMINATION:

Inspection:

Left Side:

No evidence of atrophy or asymmetry.

Right Side:

No evidence of atrophy or asymmetry.

Palpation:

Left Side:

posterior shoulder myofascial pain and tenderness, trigger points in the shoulder, AC joint tenderness, greater tuberosity tenderness.

Right Side:

posterior shoulder myofascial pain and tenderness, trigger points in the shoulder.

Range of Motion:

Left Side:

decreased shoulder passive forward elevation, positive shoulder impingement (Neer & Hawkins) signs.

Right Side:

full for all joints tested.

Stability:

Left Side:

No evidence of crepitation, laxity, or instability.

Right Side:

No evidence of crepitation, laxity, or instability.

LUMBOSACRAL SPINE EXAMINATION:

Inspection: No evidence of atrophy, asymmetry, or pelvic obliquity.

Range of motion: **Markedly decreased in all planes.**

Stability: No evidence of crepitation, laxity or instability.

Palpation: **Midline lower lumbar spine tenderness and right buttock tenderness.**

Facet Joint Palpation: **tender left lower lumbar facet joints with positive facet loading maneuvers and tender right lower lumbar facet joints with positive facet loading maneuvers.**

SI Joint Palpation: **Right SI Joint tenderness with 3/3 maneuvers positive.**

SHOULDER EXAMINATION:

Range of Motion:

Left Side:

mildly decreased in passive forward elevation

Right Side:

is normal and symmetrical



Motor Strength:

Supraspinatus: **4/5**

External Rotators: **5/5**

Supraspinatus: **5/5**

External Rotators: **4/5**

HIP EXAMINATION:

Range of Motion:

Left Side:
symmetrical.

Right Side:
symmetrical.

Provocative Maneuvers:

Left Side:
negative

Right Side:
negative

OTHER LOWER EXTREMITY EXAMINATION:

Inspection:

Left Side:
a knee effusion.

Right Side:
No evidence of atrophy
or asymmetry.

Palpation:

Left Side:
**medial joint line tenderness in the
knee, positive McMurray's maneuver over the
medial joint line of the knee.**

Right Side:
No tenderness to
palpation.

Range of Motion:

Left Side:
mild hamstring tightness.

Right Side:
**mild hamstring
tightness.**

Stability:

Left Side:
No evidence of crepitation laxity or instability.

Right Side:
No evidence of
crepitation laxity or
instability.

ABDOMINAL EXAMINATION:

The abdomen is soft, nontender, with no guarding or rebound.

There is no pain referred to spine from either the anterior or posterior abdomen.

NEUROLOGICAL EXAMINATION:

Sensation:

Left Side:
**Hand Numbness/tingling in
dig 1 and 2.**

Right Side:
**right lower extremity
numbness/tingling in a L5 distribution.**

Motor

Upper extremity strength:

Left Side:
Elbow flexors: **5/5.**

Right Side:
Elbow flexors: **5/5.**



Elbow extensors: **5/5**.
Wrist extensors: **5/5**.
Hand FDI: **5/5**.
Hand APB/Opponens: **4/5**.

Elbow extensors: **5/5**.
Wrist extensors: **5/5**.
Finger EIP: **5/5**.
Hand FDI: **5/5**.
Hand APB/Opponens: **5/5**.

Motor

Lower extremity strength:

Left Side:

Knee extensors: **5/5**.
Ankle dorsiflexors: **5/5**.
Ankle plantarflexors: **5/5**.
Extensor hallucis longus: **5/5**.

Right Side:

Knee extensors: **5/5**.
Ankle dorsiflexors: **4/5**.
Ankle plantarflexors: **5/5**.
Extensor hallucis longus: **4/5**.

Reflexes:

Left Side:

Deep tendon reflexes: **2+ and symmetrical**.

Right Side:

Deep tendon reflexes: **2+ and symmetrical**.

PROVOCATIVE NEUROLOGIC MANEUVERS:

Upper extremity/neck: The Spurling's maneuver is negative.

Low back/buttock:

Left straight leg raises: negative in the supine, seated, and slumped positions.

Right straight leg raises: **positive in supine position**.

Left Babinski and Hoffman: absent.

Right Babinski and Hoffman: absent.

VASCULAR EXAMINATION: 2+ in all extremities.

LYMPH NODE EXAMINATION: no lymphadenopathy.

SKIN EXAMINATION: a left knee effusion.

IMAGING STUDIES:

Cervical Spine MRI shows:

- *I reviewed the films myself and it showed:*

A central disc herniation at C3/4 w annular tear and a large broad based disc herniation at C5/6..

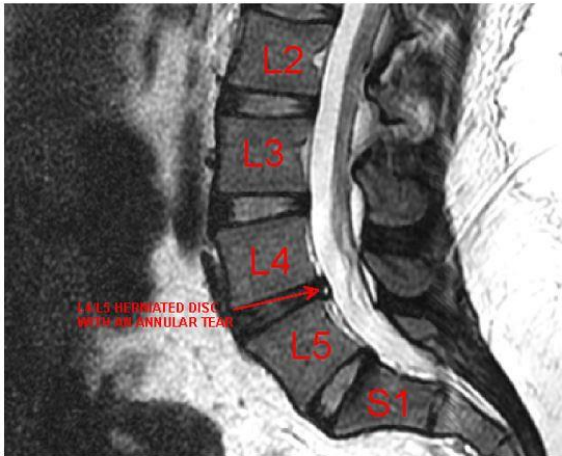
Lumbar Spine MRI shows:

- *I reviewed the patient's lumbar MRI dated 9/1/2022: There is a disc herniation at L4/5 with an annular tear.*

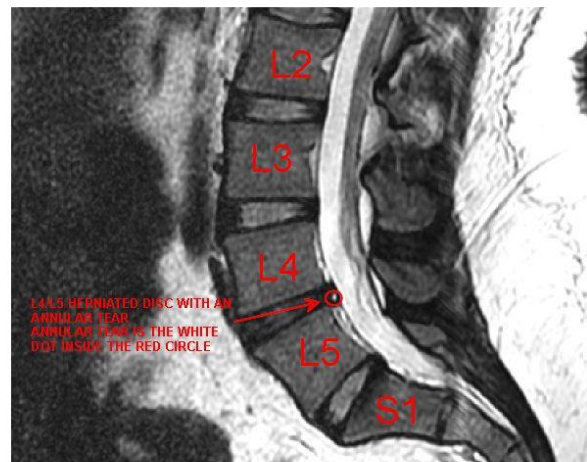
Left Shoulder MRI shows:

- *a partial tear of the supraspinatus muscle/tendon involving less than 50% width or thickness of the cuff
a superior labral tear.*

Left knee MRI scan shows: a medial meniscus tear



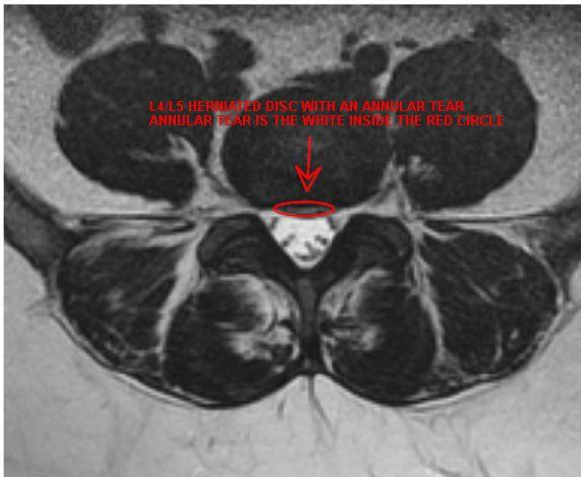
MRI Lumbar Spine Sag T2 view #1



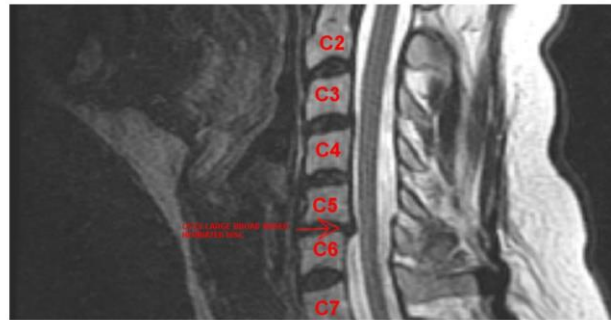
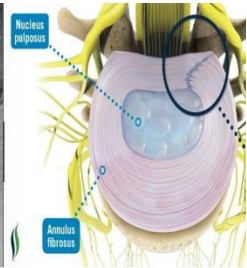
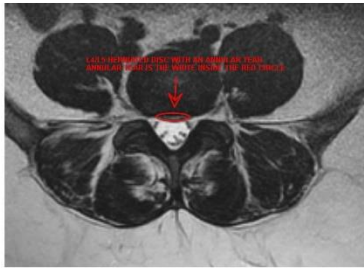
MRI Lumbar Spine Sag T2 view #2



MRI Lumbar Spine Axial T2 view #1

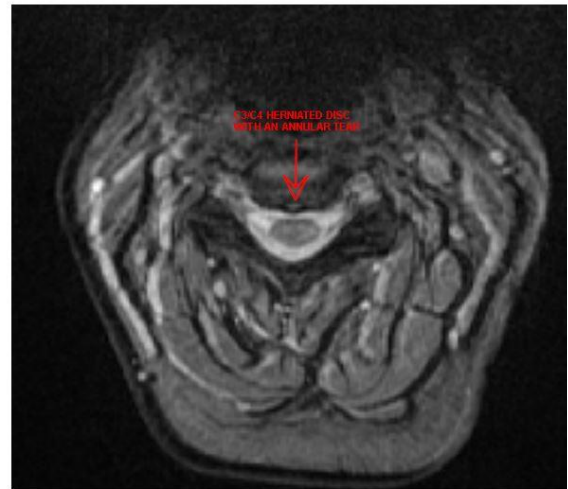
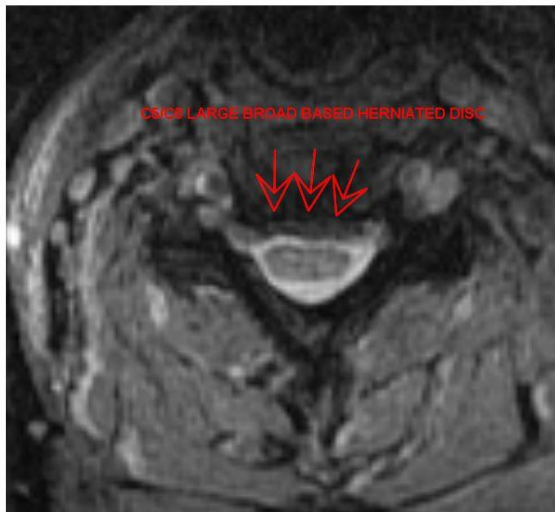


MRI Lumbar Spine Axial T2 view #2



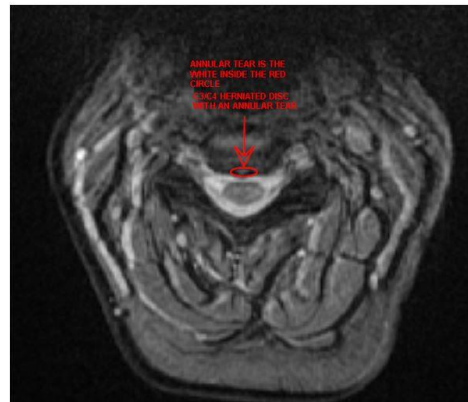
MRI Lumbar Spine Axial T2 view #3

MRI Cervical Spine T2 Sag View #1

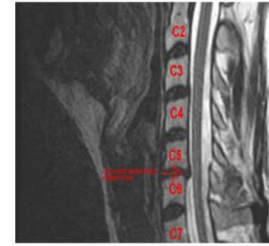
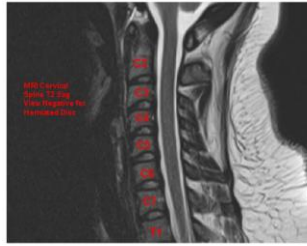
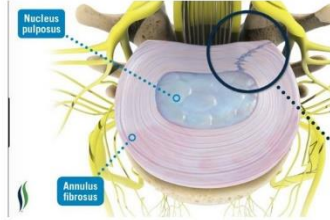
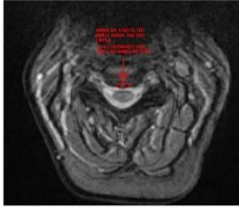


MRI Cervical Spine T2 Axial View #1

MRI Cervical Spine T2 Axial View #2



MRI Cervical Spine T2 Axial View #3



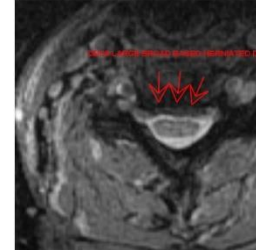
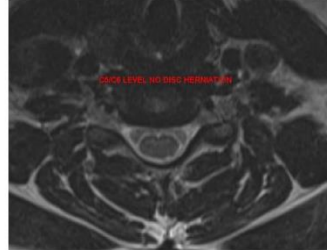
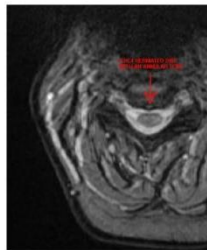
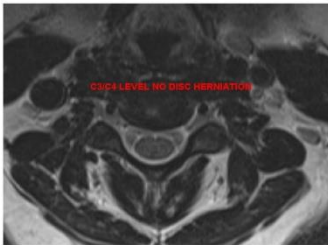
MRI Cervical Spine T2 Sag View 2015

MRI Cervical Spine T2 Sag Vi 2022

MRI Cervical Spine Comparison

MRI Cervical Spine T2 Axial View #4

Cervical Spine MRI comparison 2015 & 2022 #1



MRI Cervical Spine T2 Axial View 2015

MRI Cervical Spine T2 Axial View 2022

MRI Cervical Spine T2 Axial View 2015

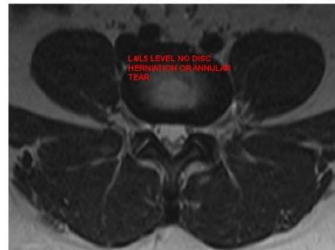
MRI Cervical Spine T2 Axial View 2022

MRI Cervical Spine Comparison

MRI Cervical Spine Comparison

Cervical Spine MRI comparison 2015 & 2022 #2

Cervical Spine MRI comparison 2015 & 2022 #3



MRI Lumbar Spine T2 Sag View 2015

MRI Lumbar Spine T2 Sag View 2022

MRI Lumbar Spine T2 Axial View 2015

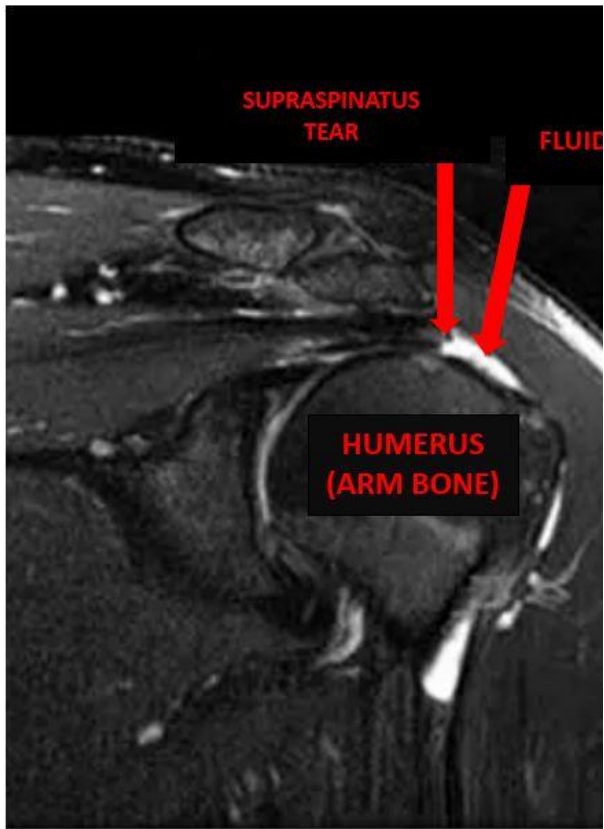
MRI Lumbar Spine T2 Axial View 2022

MRI Lumbar Spine Comparison

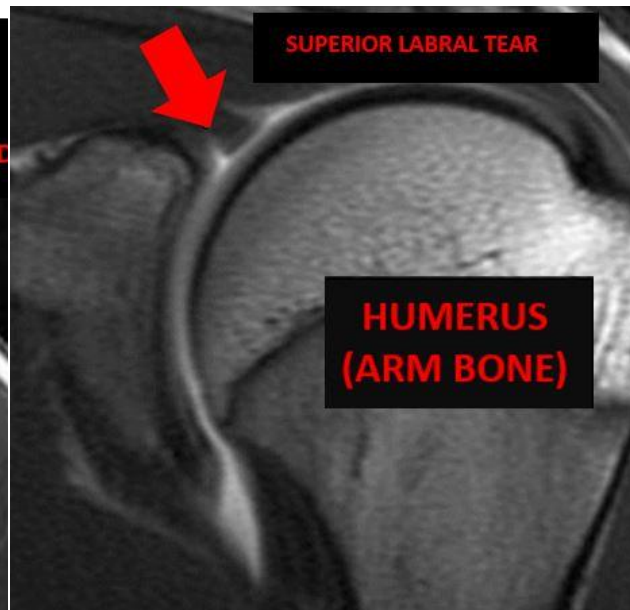
MRI Lumbar Spine Comparison

Lumbar Spine MRI comparison 2015 & 2022 #1

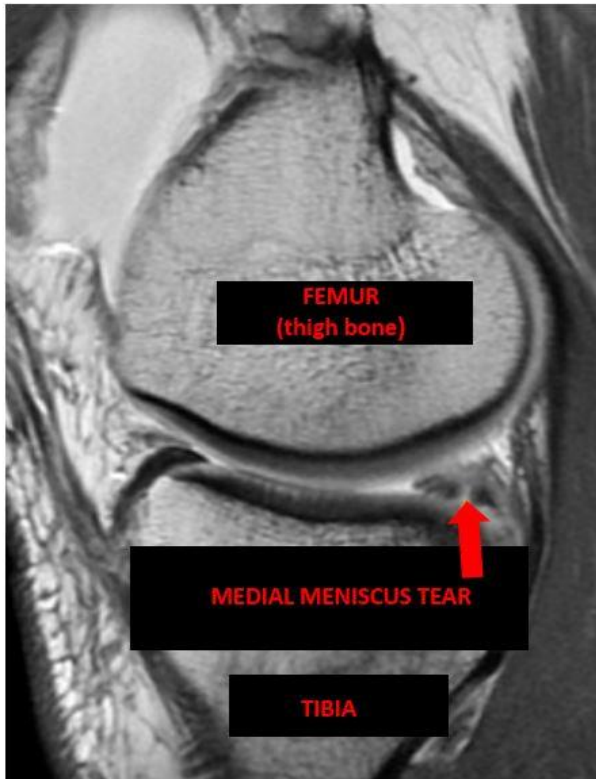
Lumbar Spine MRI comparison 2015 & 2022 #2



Left Shoulder MRI #1



Left Shoulder MRI #2



Left Knee MRI

Concussion Questionnaire

Date of Injury: 09/02/2022

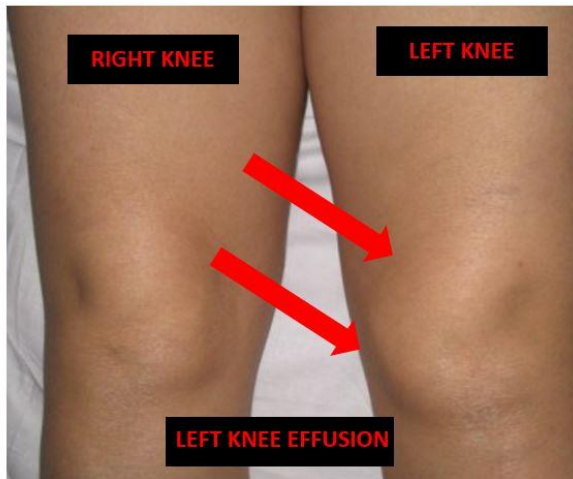
Please use the following scale to rate your symptoms as listed below:

0 = Never Experienced
 1 = Mild
 2 = Moderate
 3 = Severe
 R = Resolved

Dizziness	0	1	2	3	R
Headaches	0	1	2	3	R
Hearing changes	0	1	2	3	R
Vision Changes	0	1	2	3	R
Balance Changes	0	1	2	3	R
Nausea and/or Vomiting	0	1	2	3	R
Light Sensitivity, bothered by bright light	0	1	2	3	R
Noise Sensitivity, bothered by loud noise	0	1	2	3	R
Sleep Disturbance	0	1	2	3	R
Fatigue, Tiring More Easily	0	1	2	3	R
Being Irritable, Easily Angered	0	1	2	3	R
Feeling Depressed or Tearful	0	1	2	3	R
Feeling Anxious or Tense	0	1	2	3	R
Poor Memory	0	1	2	3	R
Poor Concentration	0	1	2	3	R
Feeling Mentally Foggy	0	1	2	3	R

TOT

Stanford Concussion Questionnaire

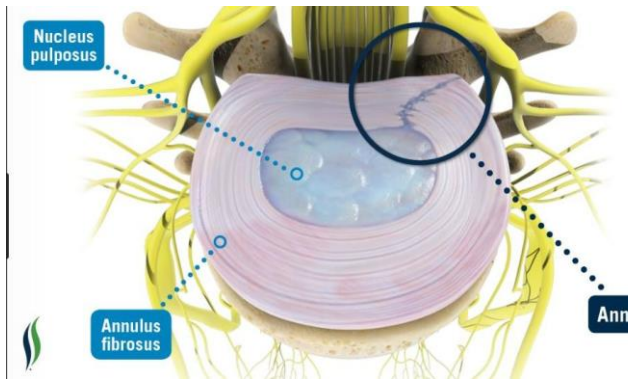


Left Knee Clinical Image (showing effusion)



Above is an illustration of a herniated disc (next to a healthy disc for comparison)

herniated disc illustration



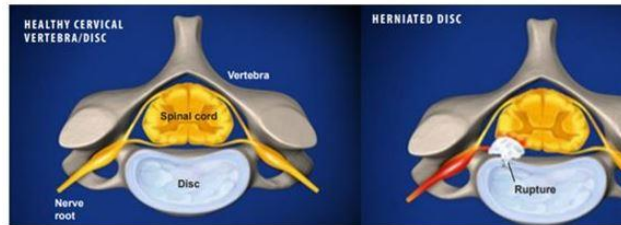
annular tear illustration

Cervical Radiculopathy

NUMBNESS AND TINGLING: (Numbness or total lack of sensation in a part of the symptom of nerve damage or dysfunction essentially means that the patient has an arm or leg that is getting irritated or damaged causing pain or an unpleasant sensation)

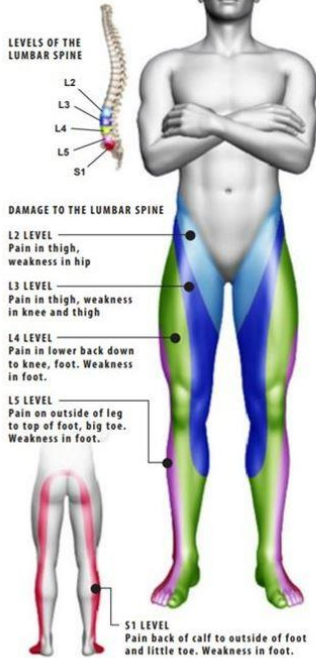
Radiculitis is inflammation, irritation of a nerve in the spine. It is commonly caused in the spine such as a herniated disc (see stenosis (narrowing) of the spinal canal. Radiculitis (also called Radiculopathy) is nerves in the neck.

The illustration to the left shows symptoms. The patient typically has pain/numbness in a particular part down the arm depending on which nerve is damaged in the neck. Damage to the C6 nerve sends pain/numbness to the thumb and upper arm. Damage to the C7 nerve sends pain/numbness into the middle finger. Damage to the C8 nerve sends pain/numbness to the small finger. Below is a normal cervical spine next to a Herniated Disc which is causing "Radiculitis".



cervical radiculopathy illustration

Lumbar Radiculopathy (Sciatica)



Numbness and Tingling: (Numbness or total lack of sensation in a part of the symptom of nerve damage or dysfunction essentially means that the patient has a (or arm) that is getting irritated or damaged causing pain or an unpleasant sensation

Radiculitis is inflammation, irritation of a nerve in the spine. It is commonly caused by the spine such as a herniated disc (see below) (narrowing) of the spinal canal. Lumbar (also called Radiculopathy or "**Sciatica**") nerves in the Low Back.

The illustration to the left shows Radiculitis/Sciatica symptoms. It typically has pain/numbness in a pattern down the leg depending on which nerve is damaged in the Low Back. Damage to L2 and L3 nerve causes pain/numbness in the thigh. Damage to L4 and L5 nerves sends pain and numbness down the leg and foot. Below is a normal (Low Back) Disc next to a Herniated Disc.

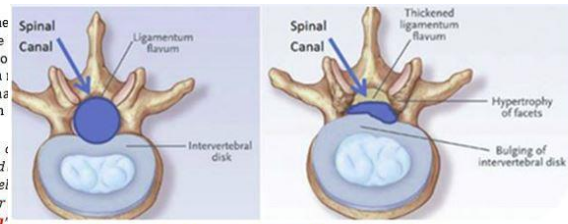


Illustration of spinal stenosis above

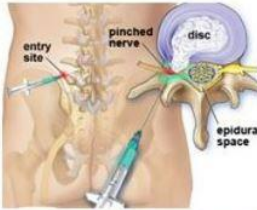
spinal stenosis illustration

lumbar radiculopathy illustration

Epidural Steroid Injection (ESI)

An Epidural Steroid Injection (ESI) is a minimally invasive procedure performed to help relief pain in the cervical, thoracic or lumbar spine. It treats conditions such as Herniated Discs, Spinal Stenosis and Radiculopathy (pinched nerves), and Degenerative Pain/Annular Tears.

Preparation: In preparation for the procedure, the patient is then taken to the operating room and placed face down. The physician injects local anesthetic which numbs the skin and tissue around the level(s) that will be injected.



Inserting the Needle: Next the physician pushes a 3" to 5" Spinal Needle through the numbed tissue and uses a rotating X-Ray device called a Fluoroscope to see the needle in your body. The needle is



carefully pushed into the epidural space (the area surrounding the spinal cord) and dye is injected the needle is positioned correctly.

EPIDURAL STEPS



1. Area Identified 2. Skin Numbered 3. Needle placed 4. Medicine Injected

Injection: When the needle is in place, the physician injects a steroid-anesthetic mix into the epidural bathing the painful area with soothing medication to reduce inflammation and pain.

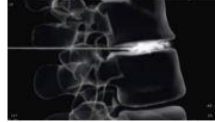


Dr. Polydore performing a Cervical Epidural



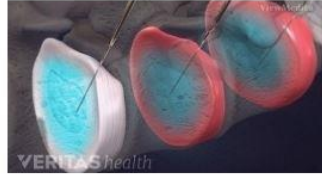
End of Procedure: The needle is removed and a bandage is placed over the site. Extended pain relief may start within 30 minutes to 3 hours after the procedure. The patient will get the full benefit of the medication.

ESI RISKS:
Allergy
Bleeding
Nerve Injury
Spinal Cord



Discography

Discography or **Discogram** is a minimally invasive diagnostic procedure that is performed at a Surgery Center to determine if back pain is coming from one or more discs. This procedure consists of applying contrast dye to suspected disc(s) with an injection with a needle to induce pain. This procedure is performed to help the physician determine a treatment plan.

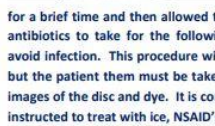


Preparation: In preparation for the procedure, an IV is placed and sedation is administered to calm the patient. The patient is then taken to the operating room and positioned face down or on the side. The physician then injects local anesthetic which numbs the skin and tissue around the level or levels that will be injected.

Needle Insertion: The physician inserts a needle through the anesthetized track to the outer edge of the disc. A smaller needle is then used and inserted into the disc. This same procedure could be done on more than one level.

Once the needle(s) are in place, the disc is applied pressure and contrast dye one at a time. If the patient feels pain, the physician compares the pain the patient experiences on one side to the other. If the pain is the same this could be an indication that the disc is the source of the pain. If the pain is different, the physician may decide to check another level. Images will be taken with the fluoroscope.

Needles Removed: After the diagnostic test has been completed, the needles are removed and a small bandage is placed on the skin.

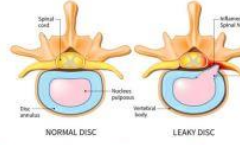
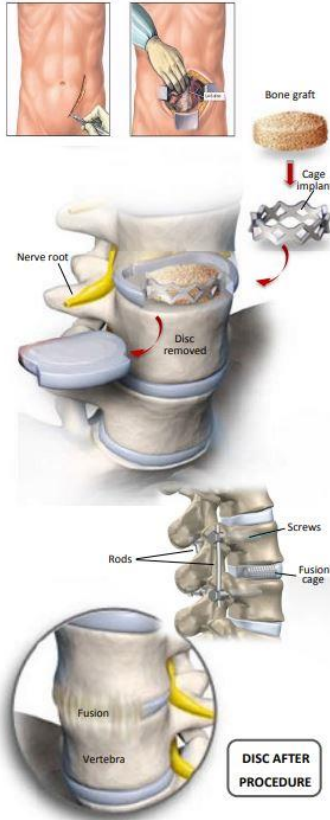


The patient will be monitored for a brief time and then allowed to go home. The patient is given antibiotics to take for the following days after the procedure to avoid infection. This procedure will take less than 1hr to complete but the patient must be taken for a CT scan to get additional images of the disc and dye. It is common to have soreness for a few days after the procedure and the patient is instructed to treat with ice, NSAID's or other medication for pain.

epidural injection illustration

discogram illustration

Anterior Lumbar Interbody Fusion (ALIF)



Anterior Lumbar Interbody Fusion is generally used to treat discogenic low back pain. The surgeon will stabilize the fusing vertebrae together with bone material.

The procedure is performed through a five-inch incision on the stomach. Two common approaches are over the center of the stomach or slightly to the side.

The damaged disc is partially removed. The remaining disc wall is left behind to help hold the bone graft material.

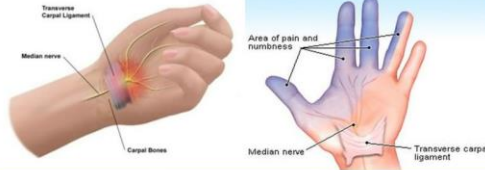
A metal cage implant filled with bone is placed in the empty disc space. This lifts the vertebral bodies, lifting pressure off the pinched nerve roots.

In some patients, this will be enough to stabilize the vertebrae. For others, the surgeon may need to implant a series of screws and rods along the back of the spine for additional support.

Over time, the bone graft will grow and fuse with the vertebral bodies, forming a solid bridge that connects the vertebrae. This solid bone bridge is called a fusion.

lumbar fusion illustration

MEDIAN NERVE INJURY



- Signs and Symptoms**
- Pain in the front of the wrist.
 - Numbness or tingling in the thumb, index, middle, and ring fingers.
 - Weakness in the hand, leading to a tendency to drop objects.
 - Increased pain at night while sleeping.

The Median Nerve provides sensation to the first three and 1/2 of the fourth finger in the hand. It can be compressed in the Carpal Tunnel by repetitive compression of the Median Nerve over time by the Transverse Carpal Ligament as Carpal Tunnel Syndrome. It can also be suddenly injured by direct trauma, such as a blow to the wrist or by directly hitting the dashboard. Damage to the nerve is treated with Bracing, Cortisone Injection, and Endoscopic carpal tunnel release.



median nerve injury illustration

Rotator Cuff Tear and Arthroscopic Repair



The Rotator Cuff is a group of muscles and tendons in the shoulder which holds your upper arm bone in your shoulder socket. It keeps your arm stable while allowing it to lift and rotate. Too much stress on the rotator cuff can cause a painful injury called a **Rotator Cuff (RTC) Tear**.

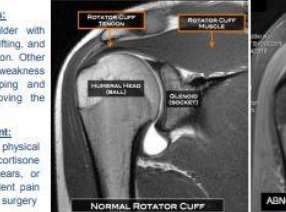
Rotator Cuff Tears



Cause: A rotator cuff tear can occur as a result of a fall on the shoulder, a repetitive overhead activity, or a sudden increase in activity. It is also common in athletes who do overhead activities, such as baseball pitchers.

Symptoms: Pain in the shoulder with overhead activity, lifting, and at night are common. Other symptoms include weakness with motion, popping and grinding when moving the shoulder.

RTC Treatment: Rest, medications, physical therapy injections (cortisone or PRP). Large tears, or patients with persistent pain or weakness require surgery.



Above is an illustration of an Arthroscopic Rotator Cuff Repair

rotator cuff tear/repair illustration

Meniscus Tear



Your knee joint is cushioned by two C-shaped wedges of cartilage called the "menisci." Each individual cushion is called a "meniscus." These serve as shock absorbers and are known as the medial meniscus and the lateral meniscus. A Meniscus Tear is a common injury of the knee where a slit or rip is created in these cushions. This can occur in different parts.



Image above is a knee hitting dashboard causing a meniscus tear. Typical football "hit" causing Meniscus tear.

Meniscus tears are commonly caused by trauma, such as the knee hitting the dashboard, door or center console in a MVA, or a "hit" on the knee or leg in Football involving the knee. The tears are diagnosed on

Symptoms: pain, a popping sensation, trouble straightening or twisting you.

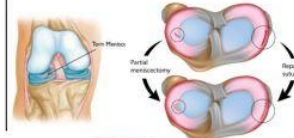
by trauma, such as the knee console in a MVA, or a "hit" on sudden twisting and rotation of physical exam and a MRI scan

Surgical Treatment options include

Arthroscopic Meniscus Repair

Treatment: rest,

Meniscus tear and treatment



Preparation: The patient is first anesthetized. After the procedure: the openings in the skin are closed and the knee is bandaged. The patient is kept in observation for a brief time before allowed to go home. A series of small openings are created on the skin. An arthroscope is placed through one of the openings to allow the surgeon see inside.



Meniscectomy: Surgeon trims away damaged tissue and the rough areas are "smoothed" out.



or a Partial Meniscectomy.

After the procedure: the openings in the skin are closed and the knee is bandaged and patient observed and later

meniscus tear/repair illustration

PLATELET RICH PLASMA (PRP) THERAPY

Platelet rich plasma treatment areas

- Shoulder injuries**
 - Rotator cuff tendinitis and partial tears
 - Anterior & Posterior band ofIGHL
 - ACJ, SCJ and C-C ligament
 - SLAP lesion
- Wrist & Hand**
 - Ligament sprains
 - Triangular Fibrocartilage Complex
- Elbow**
 - Lateral epicondylitis
 - Medial epicondylitis
- Back & Hip injuries**
 - Facet joint arthritis
 - Sacroiliac joint pain
 - Hip gluteal muscle pain
 - Hamstring tendinitis
- Knee**
 - Patellar tendinitis
 - Meniscus
 - Ligament (MCL, LCL, ACL, PCL)
 - Cartilage defects
 - Osteoarthritis
- Ankle & Foot**
 - Plantar Fasciitis
 - Achilles tendinitis
 - Ankle sprains

PROCESS OF PRP THERAPY

- COLLECT BLOOD**
Extract blood from patient using a syringe and needle.
- SEPARATE THE PLATELETS**
Place blood on a specially prepared centrifuge and spin the blood. The platelets separate from the rest of the blood.
- EXTRACT PLATELET-RICH PLASMA**
Now in its separate components, platelet rich plasma is removed from the preparation.
- INJECT AREA WITH PRP**
Inject into the tissue, preferably using ultrasound guidance for better accuracy.

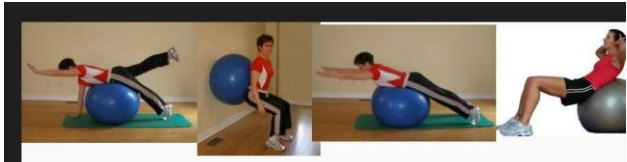
PRP illustration

Releases the pressure

Irritate Joint
Hernia Disc
Pin Nerve

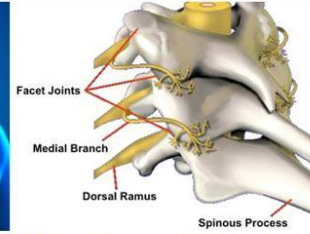
Cervical Traction is a medical device that helps create space between the spinal bones (vertebrae) in the neck to keep the spinal discs healthy. It is one of the most effective ways of stretching out the neck to relieve pressure on delicate structures such as nerve roots, intervertebral disc and irritated spinal joints within the neck. The Traction device also comes with an Ice Pack with "Velcro" that is attached on the inside. This helps to relieve muscle spasms.

cervical traction illustration



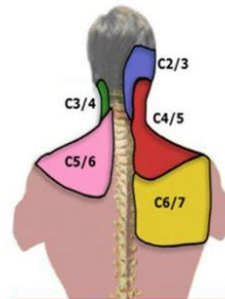
Back Exercise Handout Given: I counseled the patient for 15 minutes on core strengthening exercises. It is clear that although much weight loss nevertheless strengthening the muscles around the spine would be helpful. These would include spine extensor and abdominal muscles. I recom modified Pilates program and demonstrated some of the exercises for the patient. I also demonstrated some of the Pilates exercises on the intern gave a printout to do at home. I also encouraged the patient to take a class but informing the instructor of the back problems so that some of the e adjusted. I also demonstrated how to adjust some of the exercises. The patient understood this and will make the appropriate exercise changes.

Exercise Ball (patient will use this along with home exercise program)



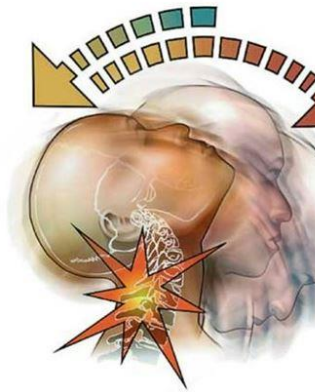
Above is an illustration of a Facet Joint in the Cervical Spine (neck region). Patients with a dull ache in the neck which can become very painful. It is usually worse with such as turning the neck to the left or right or looking over the shoulder into their " while driving. Facet Joint Pain in the neck is comonly felt in the shoulder or upper a referral patterns below). Facet Joint pain high up in the neck can cause pain shooti head leading to severe headaches (see C2/3, C3/4 and C4/5 referral patterns below)

lumbar exercises illustration



Cervical Facet Joint - Pain Referral Patterns -

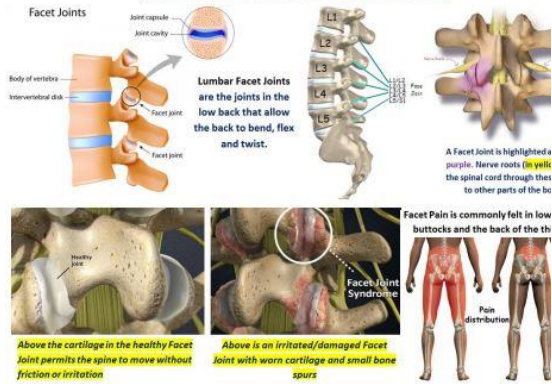
The patient may feel pain distant from the facet joint that is affected



Facet Joint pain is commonly caused by trauma such as car accidents (MVA's,

cervical facet pain illustration

LUMBAR FACET JOINT SYNDROME



Lumbar Facet Joint Syndrome is a condition where the Facet Joints become irritated, stressed (inflamed) or damaged causing pain in the low back/buttock region and can radiate into the legs. Facet Joint Pain is commonly caused acutely from trauma, such as MVA's or falls and can also develop slowly over time from arthritis (begins in your 20's). Non-Painful Bone Spurs can become painful after trauma when the spur (jagged edge) is "Jammed" into the joint/capsule/cartilage causing pain. Image on right, arrow points to a pre-existing bone spur (jagged edge) which may not be causing pain but Trauma (MVA or Fall) can "Jam" it into the Facet Joint like a piece of broken glass causing damage and severe pain



In order to diagnose Facet Joint Pain, a diagnostic **Facet Joint Injection** (above left) or "**Medial Branch Blocks (MBB)**"—above right—is performed to determine if the patient's pain is coming from a Facet Joint. If the Joint Injection or MBB proves helpful, **Radiofrequency Ablation (RFA)**—a procedure where the facet nerve is *ablated* ("burned") is performed to provide longer term relief. The nerve typically grows back in 6 months and has to be "burned" again.

lumbar facet pain illustration

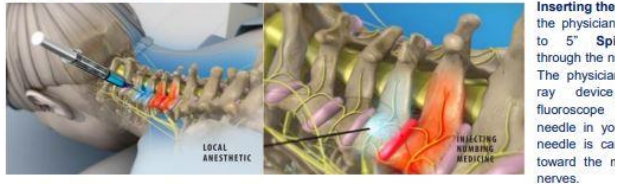
MEDIAL BRANCH BLOCK



A **Medial Branch Block (MBB)** is an injection of a strong local anesthetic on the **Medial Branch Nerves** that supply the facet joints. The **Facet Joints** are the **Joints** in your spine that make your back or neck flexible and enable you to bend and twist. Nerves exit your spinal cord through these **Joints** on their way to other parts of your body. Healthy **Facet Joints** have cartilage, which allows your vertebrae to move smoothly against each other without grinding.

Overview: This is an injection of numbing medicine that bathes the **Medial Branch Nerves**. These nerves are attached to the facet joints of the spine. Disease or injury of these joints can cause pain in the **Medial Branch**. This pain may travel through the neck, shoulders, head, upper/mid/lower back. A medial branch block can help a physician find the source of your pain. It may also provide temporary pain relief.

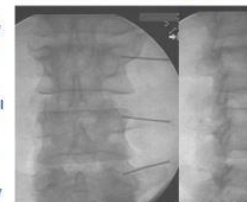
Preparation: In preparation for the procedure, an IV is placed and sedation is administered to calm the patient. The patient is then taken to the operating room. The Patient is positioned face down. The physician then injects local anesthetic which numbs the skin and tissue around the level or levels that will be injected.



Inserting the the physician to 5" Spine through the n The physician ray device fluoroscope needle in yo needle is ca toward the r nerves.

Injection: When the needle is in place, the physician injects numbing medicine onto the nerves. This medicine temporarily numbs sensation. If this area is the source of your pain, you will experience immediate pain relief. More than one level of the spine may need to be injected.

End of Procedure: When the procedure is complete, you will be monitored for a brief time and then allowed to go home. A medial branch block may relieve your pain for the next few hours. You may be asked to keep track of your pain level as the medicine wears off. If the block was successful, your physician may recommend a procedure called radiofrequency ablation. This can provide longer term pain relief.



Lumbar AP and Oblique Fluoroscopy

medial branch block illustration

RADIOFREQUENCY ABLATION



Radiofrequency Ablation is a medical procedure in which the Medial Branch Nerves to the Facet Joints are Ablated (burned) to relieve pain coming from the Facet Joints. The Medial Branch Nerves are burned using the heat generated from high frequency sound (Radio) waves.



Overview: During this minimally-invasive procedure, the physician uses heat from Radio Waves to treat painful facet joints in the Cervical Spine (neck), Thoracic Spine (Mid-Back), and Lumbar Spine (Lower Back). This procedure is also called **Radiofrequency Rhizotomy**. It can treat pain that doesn't respond to or to physical therapy or Chiropractic treatment.



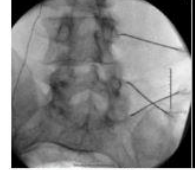
Preparation: In preparation for the procedure, an IV is placed and administered to calm the patient. The patient is then taken to the operating room. The Patient is positioned face down. The physician then injects local anesthetic which numbs the skin and tissue around the level or levels that will be treated.

Inserting the Needle: The physician inserts a tube called a "cannula" into the numb tissue. The physician uses an X-Ray device called a fluoroscopy to guide the cannula towards the medial branch nerves.

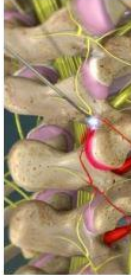


Treating the Nerves: The physician inserts an electrode through the cannula. A small electrical current is used to test its position. If the current causes the pain but does not cause any other effects, it is positioned correctly. The physician uses the electrode to heat the medial branch nerves. This disrupts their ability to transmit pain signals to the brain. Several nerves may be treated.

End of Procedure: When the procedure is complete, the electrode and cannula are removed. A small bandage is placed on the skin. The patient will be monitored for a brief time and then allowed to go home. The injection site may feel sore after the procedure and the patient may still have neck or back pain. If the correct nerves were treated, gradual pain relief will be felt as it heals over the next couple of weeks. The relief may last for several months.



monitored for a brief time and then allowed to go home. The injection site may feel sore after the procedure and the patient may still have neck or back pain. If the correct nerves were treated, gradual pain relief will be felt as it heals over the next couple of weeks. The relief may last for several months.



radiofrequency ablation illustration



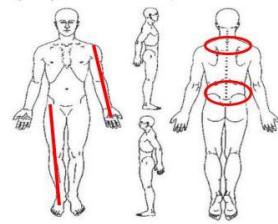
Jane Doe's Vehicle (property damage)



Vehicle that hit Jane Doe (property damage)

Pain Diagram

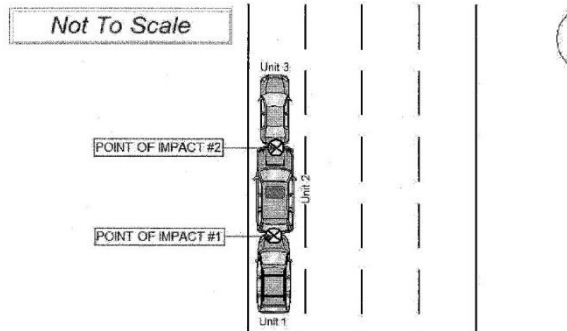
Please mark the area of injury or discomfort on the chart below using the applicable symbols:



Please **check** the worse & best your pain has been and **circle** your current pain level according to the key below.

Pain Level: 0 1 2 3 4 5 6 7 8 9 10

Pain Diagram



Police Report Diagram

IMPRESSION

- **Lumbar Disc Herniation (M51.26); right-sided herniation L4-5 with annular tear**

Abnormal Skin Sensation (R20.9) right lower extremity numbness and tingling, likely a L5 radiculitis

Left Shoulder Impingement/Tendinitis (M75.42)

Traumatic Left Shoulder Rotator Cuff Tear S46. 012A with some weakness in the supraspinatus and external rotators

Superior Labral Tear Left Shoulder S43.432A>>Initial Encounter

Medial meniscal tear of the left knee S83. 242A

A Left Knee Effusion M25. 462

Cervical Disc Herniation--Unspecified cervical region (M50.30); C5-6 and C6/7 herniated discs

Stenosis, Cervical (723.00); mild stenosis at C5/6 and moderate at C6/7

- **Left upper extremity numbness and tingling (R20.2);** primarily numbness in digits 1 and 2, a median nerve injury versus a C6 radiculopathy.



Possible Concussion

- The patient was seen today at the request of her chiropractor Dr. John Doe. She has multiple issues which will be addressed below.

With regards to her cervical spine, she has 2 herniated disks, one at C3-C4 with an annular tear and the other one at C5-C6. These are causing some spinal stenosis as well. She also has left upper extremity neurologic symptoms which could be related to the herniated disc, but could be secondary to a median nerve injury at the left wrist as she does have a contusion of the left wrist and forearm as well. We will order epidural injections for the neck and we will do EMG and nerve conduction studies of the left upper extremities to rule out a median nerve injury versus a cervical radiculitis.

With regards to the left shoulder, she has some shoulder impingement and tendinitis and has a rotator cuff tear as well as a labral (SLAP) tear seen on her MRI scan. She will continue with some physical therapy. We will also do some PRP injections in the shoulder. If this fails to alleviate her symptoms, then arthroscopic rotator cuff repair along with labral repair, subacromial decompression and distal clavicle excision will be performed.

With regards to the patient's lumbar spine, she has a herniated disc at L4-5 and is having some right lower extremity neurologic symptoms. She likely has a L5 radiculopathy. She will continue with some chiropractor treatment and we will order a right L4 and right L5 epidural. We will also do EMG nerve conduction studies to assess the extent of the nerve damage. If the damage is significant we may more aggressively recommend surgery. The surgery would likely be an anterior lumbar discectomy and fusion (ALIF).

With regards to the patient's left knee, she has a medial meniscus tear, she has had conservative management. We will have her continue with some physical therapy, we will perform PRP injections into her left knee, if this does not alleviate the symptoms then a medial meniscectomy will likely be performed in the future.

We had the patient fill out the Stanford concussion questionnaire, she possibly has a post concussion syndrome after hitting her head. We will refer her to a neurologist for further assessment of this.

TREATMENT PLAN



- Activity modification
Medications (LidoPro cream and Flexeril cream); gabapentin for the neurologic symptoms
Continue chiropractic treatment for the neck and low back
Continue physical therapy for the left shoulder and left knee
Epidural Steroid Injections for the cervical and lumbar spine
EMG/Nerve Conduction Studies of the Left Upper Extremity and the Right Lower Extremity **(To be performed by Dr. Pollydore himself and not by a 3rd party)**
PRP injections Left Shoulder and Left Knee
Neurology Referral for Post-Concussion Syndrome

DIAGNOSTIC STUDIES: EMG Left Upper Extremity (95909, 95886, 95887), EMG Right Lower Extremity (95910, 95886, 95887)

PROCEDURES: Left C5/C6 Cervical Epidural Steroid Injection (62321), Right L4/ Right L5 transforaminal ESI(64483/72275; 64484)

WORK STATUS:

No lifting >10 pounds frequently, 20 pounds occasionally.
No repetitive bending or twisting.
Alternate standing/sitting.
No overhead use of the left upper extremity

If light duty not available, or if the Employer cannot accommodate the restrictions, then the patient can be kept out of work

RETURN TO WORK DATE: 9/29/2022

RETURN TO CLINIC: For EMG/Nerve Conduction Studies

The patient was counseled with regard to her condition, prognosis, and made aware of all treatment options and plans.

Document Electronically Signed by Shevin D. Pollydore M.D.