Progress Notes

Progress Notes signed by Mary-Katherine Slattery at 11/26/2022 12:00 AM

Patient: Little, Jamar ()
DOB: 6/13/1986
Date: 11/18/2022
Attending: Mary Katherine Slattery PA-C

HISTORY OF PRESENT ILLNESS: Mr. Little is a pleasant 36-year old gentleman, otherwise healthy, right-hand-dominant, who presents for evaluation of low back and bilateral leg pain. He endorses symptoms began in 2019. Denies inciting trauma or injury. He reports pain began exacerbating ongoing over past month or so. Pain radiates along bilateral posterior legs predominantly to the knee and occasionally into the posterior calf and into the plantar aspect of both feet, right significantly greater than left. He endorses pain is 5/10, sharp, shooting, constant, worsened with walking, standing and improved with sitting. He endorses numbness and tingling in the same distribution as pain. He denies weakness to bilateral lower extremities. Denies bowel or bladder dysfunction.

He additionally endorses evidence of right neck and arm pain initially occurring in 2019. He endorses in 2019 when onset of pain began he was experiencing intermittent syncopal episodes with pain radiating to his right temporal region where he would lose consciousness. He endorses these syncopal episodes have resolved and he has followed up with Neurology, however, was unable to confirm a specialized medical diagnosis for this or cause. He endorses occasionally will experience arm pain in the ulnar aspect of his right arm into the small and ring finger of his right hand. He endorses tingling sensation in same distribution as pain as well as numbness. Denies left upper extremity symptoms. Denies weakness to bilateral upper extremities. He does endorse gait instability intermittently as well as hand clumsiness ongoing over the past few years, however, the symptoms of balance and hand clumsiness have improved over the past few years moderately.

Attempted interventions include physical therapy ongoing over the past 3 weeks with uncertain relief of pain. He utilizes edible marijuana at night which mildly improves symptoms. He has undergone weight loss as well as utilized ibuprofen 800 mg p.r.n. which provides moderate relief. He denies prior history of epidural steroid injections or neck or back surgery. He presents today for further recommendations.

PAST MEDICAL HISTORY: Negative.

PAST SURGICAL HISTORY: Negative.

ALLERGIES: Denies known allergies to medications.

MEDICATIONS: Advil.

SOCIAL HISTORY: He does not smoke tobacco. He utilizes marijuana as well as mushrooms. He drinks about 2-3 times per week.

OCCUPATION: Desk role.

FAMILY HISTORY: Negative for neck or back problems.

REVIEW OF SYSTEMS: Negative.

CERVICAL SPINE PHYSICAL EXAMINATION: He is 5 feet 8.75 inches tall and weighs 243 pounds. Pulse and respirations are normal. The patient is alert, awake, and oriented to person place and time with a pleasant affect and was examined in the office, appearing their stated age. Head exam is normal. Anterior throat is nontender.

No rashes or skin changes are seen. There is no lymphedema or lymphadenopathy. There is tenderness to palpation over the cervical spine in multiple areas. There is limited range of motion of the cervical spine associated with pain.

Upper Extremity

Motor Strength	Deltoid	Biceps	Triceps	WE	WF	HI	Grip
Right	5	5	5	5	5	5	5
Left	5	5	5	5	5	5	5

Lower Extremity

Motor Strength	IP	Quads	AT	EHL	GS
Right	5	5	5	5	5
Left	5	5	5	5	5

Sensation is intact to light touch in the C3-T1 distributions.
Biceps, triceps, brachioradialis reflexes are equal and symmetric bilaterally.
Negative Spurling's sign bilaterally. Negative Lhermitte's sign. Negative Hoffmann's sign bilaterally.
Normal tandem gait. No difficulty with rapid alternating movements.
Radial, ulnar and distal blood flow is intact.

LUMBAR SPINE PHYSICAL EXAMINATION: Pulse and respirations are normal. The patient is alert, awake, and oriented to person place and time with a pleasant affect and was examined in the office, appearing their stated age. Head exam is normal. Abdomen is soft, nontender.

No rashes or skin changes are seen. There is no lymphedema or lymphadenopathy. There is diffuse tenderness to palpation over the lumbar spine. There is limited range of motion of the lumbar spine associated with pain.

Lower Extremity

Motor Strength	IP	Quads	AT	EHL	Gastroc
Right	5	5	5	5	5
Left	5	5	5	5	5

Sensation is intact to light touch in the L2-S1 distributions.
Patellar and Achilles reflexes are equal and symmetric bilaterally.
Negative straight leg raise bilaterally. Negative Babinski sign and no clonus bilaterally.
No pain with range of motion of the hips.
Pedal and distal blood flow is intact.

IMAGING: X-rays of lumbar spine performed today, four views, which demonstrated degenerative changes at L5-S1 level. No evidence of instability or fracture.

X-rays of cervical spine performed today, four views, which demonstrate straightening of cervical lordosis with trace anterolisthesis at C4-C5 level. No evidence of fracture.

MRI of cervical spine reviewed today, dated June 6, 2019, which demonstrates a congenitally narrow canal without evidence of spinal cord compression or myelomalacia.

ASSESSMENT:
1. Low back pain with bilateral lumbar radiculopathy.
2. Balance problems.
3. Right sided cervical radiculopathy.

PLAN: Mr. Little is a pleasant 36-year old gentleman, otherwise healthy who presents for evaluation of low back and bilateral leg pain intermittent over past 2 years and worsening over the past month. Denies inciting trauma or injury. He additionally endorses evidence of balance problems ongoing over past 2 years, however, mildly improving over the past few years as well as hand clumsiness.

X-rays of lumbar spine performed today which demonstrate degenerative disk disease at L5-S1 level. There is no evidence of instability or fracture. X-rays of the cervical spine performed today which demonstrate mild degenerative anterolisthesis grade I at C4-C5 level.

Discussed with patient today advise proceeding with physical therapy focusing on cervical and lumbar spine without evidence of traction or manipulation indicated. Due to prior MRI of cervical spine without evidence of central cord compression, lower suspicion for underlying cervical stenosis at this time especially with symptoms improving, however, we will proceed with physical therapy focused on the cervical and lumbar spine with a referral provided today. He will follow up in about 6 week to provide symptomatic update. If symptoms unresolved or worsening, he would be a candidate for an updated MRI of cervical spine without contrast as well as MRI of lumbar spine for further evaluation. All of the patient's questions were addressed and answered.

Electronically Signed by:
Mary Katherine Slattery PA-C