Patient Information

Patient Name: Porter, Stephen D
DOB: 08/06/1966
Age: 57
Gender: M
MRN: M000139

Admission ID: A000172
Date of Admission: 2023-02-06
Date of Discharge: 2023-02-11

Address: 7428 Jones Stream Apt. 316
City: Thomaston
State: IN
ZIP: 79218
Phone:

Emergency Contact

Name: Angela Hart
Relation: Parent
Phone: 925-620-7388

History Of Presenting Illness

Mr. Stephen Porter, a 57-year-old male with a history of ESRD on home HD, thyroid cancer, HTN, lumbar spondylosis with radiculopathy, and CAD s/p CABG, presents with severe low back pain and inability to ambulate. Chief Complaint: Low back pain and inability to walk. Onset: Patient reports onset of symptoms approximately one month ago following a motor vehicle accident where he was rear-ended. The pain acutely worsened recently, prompting him to contact his PCP's office on the day of presentation. Location: Low back with radiation down the back of both legs. Duration: One month, with acute exacerbation. Character: Patient describes the pain as sharp and shooting. Alleviating/Aggravating Factors: Pain is exacerbated by movement and attempts to ambulate. Alleviating factors are not clearly identified. Radiation: Pain radiates down the back of both legs. Timing: Constant pain with recent acute worsening. Severity: Severe enough to impair ambulation, suggesting 9-10/10 on pain scale. Associated Symptoms: Patient denies bowel or bladder incontinence, saddle anesthesia, fever, or chills. He reports significant spinal tenderness and weakness in the lower extremities, being unable to stand or walk without a cane. In the ED, the patient was noted to be hypertensive with BP up to 200s/90s, likely due to pain and missed HD session.

Chief Complaint

Low back pain and inability to ambulate

Review Of Systems

General

Denies fever or chills. Reports severe pain and inability to ambulate.

Respiratory

No SOB or cough reported.

Cardiovascular

Hypertensive in ED. No chest pain, palpitations, or syncope reported.

Musculoskeletal

Severe low back pain with radiation down legs. Unable to ambulate without assistance. Weakness in lower extremities noted.

Neurological

Alert and oriented. Denies bowel or bladder incontinence, saddle anesthesia. Reports weakness in lower extremities.

Endocrine

History of thyroid cancer, current status not specified. No acute endocrine complaints reported.

Psychiatric

No acute psychiatric symptoms reported. Patient interactive and appropriate.

Assessment

Summary Of Findings

57-year-old male with hx of ESRD on home HD, thyroid cancer, HTN, lumbar spondylosis with radiculopathy, and CAD s/p CABG presents with severe low back pain and inability to ambulate. Pain onset 1 month ago after MVA, acutely worsened recently. Pain radiates down both legs, exacerbated by movement. Patient hypertensive in ED (BP 200s/90s). Unable to stand or walk without cane. Denies bowel/bladder incontinence or saddle anesthesia.

Differential Diagnosis

1. Acute exacerbation of chronic lumbar radiculopathy 2. Spinal stenosis 3. Cauda equina syndrome 4. Epidural abscess 5. Vertebral osteomyelitis 6. Pathological vertebral fracture

Primary Diagnosis

Acute exacerbation of chronic lumbar radiculopathy

Secondary Diagnoses

1. ESRD on home HD 2. Hypertensive urgency 3. CAD s/p CABG 4. History of thyroid cancer 5. Lumbar spondylosis

Plan

Diagnostic Plan

1. MRI lumbar spine without contrast 2. X-ray lumbar spine AP/Lateral 3. CBC, CMP, CRP, ESR 4. Urinalysis 5. EKG 6. Neurology consult for EMG/NCS if needed

Therapeutic Plan

1. Pain management: IV hydromorphone 0.5-1mg q3h PRN 2. Muscle relaxant: Cyclobenzaprine 10mg PO TID 3. Anti-inflammatory: Methylprednisolone 125mg IV q24h 4. BP control: Amlodipine 10mg PO daily, titrate PRN 5. Resume home HD schedule 6. DVT prophylaxis: Enoxaparin 40mg SQ daily

Patient Education And Counseling

1. Discuss chronic nature of lumbar spondylosis and potential for acute exacerbations 2. Educate on importance of pain control and gradual mobilization 3. Review HD schedule and importance of adherence

Follow Up Plan

1. Neurosurgery consult for surgical evaluation 2. Physical therapy evaluation and treatment 3. Nephrology follow-up for HD management 4. Outpatient follow-up with PCP within 1 week of discharge

Disposition

Admit to medical floor for pain management, workup, and HD

Consultations

1. Nephrology for HD management 2. Neurosurgery for surgical evaluation 3. Physical therapy for mobilization assessment and treatment plan 4. Pain management service for optimizing pain control

Past Medical History

Chronic Conditions

End-stage renal disease (ESRD) on home hemodialysis
Hypertension
Coronary artery disease (CAD) status post coronary artery bypass graft (CABG)
Lumbar spondylosis with radiculopathy
Thyroid cancer (status post treatment)

Past Illnesses

Myocardial infarction (leading to CABG)
Chronic kidney disease progression to ESRD

Surgeries

Coronary artery bypass graft (CABG) - 5 years ago
Total thyroidectomy for thyroid cancer - 8 years ago
Arteriovenous fistula creation for hemodialysis access - 3 years ago

Hospitalizations

Admission for CABG - 5 years ago
Admission for thyroidectomy - 8 years ago
Multiple admissions for ESRD-related complications in the past 3 years

Allergies

No known drug allergies

Medications

Amlodipine 10mg daily

Metoprolol 50mg twice daily

Atorvastatin 40mg daily

Aspirin 81mg daily

Levothyroxine 125mcg daily

Calcium acetate 667mg with meals

Erythropoietin injection three times weekly

Gabapentin 300mg three times daily for radiculopathy

Family History

Father	Died of myocardial infarction at age 65
Mother	Hypertension, alive at 80
Siblings	Brother with type 2 diabetes

Social History

Occupation	Retired accountant
Marital Status	Married
Children	Two adult children

Smoking	Former smoker, quit 10 years ago
Alcohol	Occasional, less than 1 drink per week
Exercise	Limited due to back pain, previously active

Preventive Care

Last Colonoscopy	2 years ago, normal
Last Echocardiogram	1 year ago, showed preserved EF
Vaccinations	Up to date, including annual flu shots and COVID-19 vaccination
Cancer Screening	Regular thyroid ultrasounds and thyroglobulin levels post thyroidectomy

Physical Examination

General Appearance

57-year-old male in moderate distress due to pain. Alert, cooperative, and well-nourished.

Vital Signs

Blood Pressure	180/85 mmHg
Heart Rate	88 bpm
Respiratory Rate	18 breaths/min
Temperature	36.8°C
Oxygen Saturation	97% on room air

Heent

PERRL, EOMI. No scleral icterus. Oropharynx clear. No JVD.

Cardiovascular

RRR, no murmurs, rubs, or gallops. S1/S2 normal. Peripheral pulses 2+ bilaterally. No edema.

Respiratory

CTAB, no wheezes or crackles. Respirations non-labored.

Abdomen

Soft, non-tender, non-distended. BS+. No hepatosplenomegaly.

Musculoskeletal

Severe tenderness to palpation over lumbar spine. Positive SLR bilaterally. Decreased ROM in lumbar spine due to pain. Unable to stand or walk without assistance. Motor strength 4/5 in bilateral lower extremities.

Neurological

A&Ox3. CN II-XII intact. DTRs 2+ and symmetric. Sensation intact to light touch. No saddle anesthesia.

Skin

Warm and dry. No rashes or lesions. Surgical scars noted on chest (CABG) and neck (thyroidectomy).

Progress Notes

Progress Note

Date	2023-06-12
Time	08:00

Patient Identification

Name	Stephen D Porter
Dob	1966-08-06
Gender	M
Mrn	M000139
Admission Number	A000172

Subjective

57-year-old male with ESRD on home HD, thyroid cancer, HTN, lumbar spondylosis, and CAD s/p CABG presents with severe low back pain and inability to ambulate. Pain began 1 month ago after MVA, acutely worsened recently. Pain radiates down both legs, exacerbated by movement. Denies bowel/bladder incontinence or saddle anesthesia. Reports significant spinal tenderness and weakness in lower extremities.

Objective

Vital Signs

Blood Pressure	180/85 mmHg
Heart Rate	88 bpm
Respiratory Rate	18/min
Temperature	36.8°C
Oxygen Saturation	97% on room air

Physical Exam

In moderate distress due to pain. Severe tenderness over lumbar spine. Positive SLR bilaterally. Decreased ROM in lumbar spine. Unable to stand or walk without assistance. Motor strength 4/5 in bilateral lower extremities. No saddle anesthesia.

Assessment

Acute exacerbation of chronic lumbar radiculopathy, ESRD on home HD, Hypertensive urgency

Plan

Admit to medical floor

MRI lumbar spine without contrast

X-ray lumbar spine AP/Lateral

Labs: CBC, CMP, CRP, ESR, UA

EKG

Pain management: IV hydromorphone 0.5-1mg q3h PRN

Cyclobenzaprine 10mg PO TID
Methylprednisolone 125mg IV q24h
Amlodipine 10mg PO daily for BP control
Resume home HD schedule
Neurosurgery and Nephrology consults

Progress Note

Date 2023-06-13

Time 09:00

Patient Identification

Name Stephen D Porter

Dob 1966-08-06

Gender M

Mrn M000139

Admission Number A000172

Subjective

Patient reports mild improvement in pain control. Still having difficulty with movement. No new symptoms. Denies bowel/bladder issues.

Objective

Vital Signs

Blood Pressure 160/80 mmHg

Heart Rate 82 bpm

Respiratory Rate 16/min

Temperature 36.6°C

Oxygen Saturation 98% on room air

Physical Exam

Less distressed. Lumbar tenderness persists. SLR still positive. Slight improvement in ROM. Motor strength unchanged.

Assessment

Improving lumbar radiculopathy. BP better controlled. Awaiting MRI results.

Plan

Continue current pain management regimen
Adjust BP meds: increase Amlodipine to 15mg daily
Physical therapy evaluation
Review MRI results when available
Continue HD as scheduled

Progress Note

Date 2023-06-14

Time 10:00

Patient Identification

Name Stephen D Porter

Dob 1966-08-06

Gender M

Mrn M000139

Admission Number A000172

Subjective

Patient reports further improvement in pain. Able to sit up in bed with less discomfort. No new complaints.

Objective

Vital Signs

Blood Pressure 145/75 mmHg

Heart Rate 78 bpm

Respiratory Rate 16/min

Temperature 36.7°C

Oxygen Saturation 98% on room air

Physical Exam

Improved affect. Lumbar tenderness decreased. SLR improved. Increased ROM in lumbar spine. Motor strength 4+/5 in lower extremities.

Assessment

Continuing improvement in lumbar radiculopathy. BP well controlled. MRI shows severe spinal stenosis at L4-L5.

Plan

Gradually decrease IV pain meds, transition to oral

Continue PT and start gentle mobilization

Neurosurgery recommends conservative management

Maintain current BP management

Discuss potential for discharge tomorrow if improvement continues

Progress Note

Date 2023-06-15

Time 09:00

Patient Identification

Name Stephen D Porter

Dob 1966-08-06

Gender	M
Mrn	M000139
Admission Number	A000172

Subjective

Patient reports significant improvement. Pain well controlled with oral meds. Able to ambulate short distances with walker.

Objective

Vital Signs

Blood Pressure	138/72 mmHg
Heart Rate	76 bpm
Respiratory Rate	16/min
Temperature	36.5°C
Oxygen Saturation	99% on room air

Physical Exam

Alert and in good spirits. Minimal lumbar tenderness. Negative SLR. Further improved ROM. Motor strength 5/5 in lower extremities.

Assessment

Resolving lumbar radiculopathy. BP well controlled. Ready for discharge.

Plan

Discharge home with outpatient PT
Prescribe oral pain medications and muscle relaxants
Follow up with Neurosurgery in 2 weeks
Resume home HD schedule
Instruct on red flag symptoms
Follow up with PCP in 1 week

Progress Note

Date	2023-06-16
Time	10:00

Patient Identification

Name	Stephen D Porter
Dob	1966-08-06
Gender	M
Mrn	M000139
Admission Number	A000172

Subjective

Patient reports continued improvement. Pain well managed. No new concerns. Ready for discharge.

Objective

Vital Signs

Blood Pressure	135/70 mmHg
Heart Rate	74 bpm
Respiratory Rate	16/min
Temperature	36.6°C
Oxygen Saturation	99% on room air

Physical Exam

Alert and comfortable. Minimal lumbar tenderness. Full ROM. Ambulating well with walker.

Assessment

Resolved acute exacerbation of lumbar radiculopathy. BP well controlled. ESRD stable.

Plan

Discharge home today
Provide prescriptions and follow-up appointments
Review discharge instructions and red flag symptoms
Ensure understanding of medication regimen and HD schedule

Radiology Reports

Radiology Report #103592

Patient Info

Name	Stephen D Porter
Age	57
Gender	Male
Mrn	M000139
Dob	1966-08-06
Clinicalhistory	57-year-old male with ESRD on home HD, thyroid cancer, HTN, lumbar spondylosis with radiculopathy, and CAD s/p CABG. Presenting with severe low back pain and inability to ambulate.

Study Info

Type	MRI of the lumbar spine without contrast
Datetime	2023-06-12
Reason	Evaluate for cause of severe low back pain and radiculopathy

Technique

MRI of the lumbar spine was performed without contrast, including T1-weighted, T2-weighted, and STIR sequences in multiple planes.

Findings

Alignment	Normal lumbar lordosis maintained. No spondylolisthesis.
Vertebralbodies	Normal vertebral body heights. No compression fractures or bone marrow edema.
Discspaces	Severe disc height loss at L4-L5 and L5-S1 levels. Moderate disc desiccation at these levels.
Spinalcanal	Severe central canal stenosis at L4-L5 due to a combination of disc bulge, facet hypertrophy, and ligamentum flavum thickening. Moderate central canal stenosis at L5-S1.
Neuralforamina	Severe bilateral neural foraminal narrowing at L4-L5 and L5-S1 levels.
Nerveroots	Bilateral L4 and L5 nerve root compression noted.
Facetjoints	Severe facet joint arthropathy at L4-L5 and L5-S1 levels.
Paravertebralsofttissues	No abnormal paravertebral soft tissue masses or collections.

Impression

1. Severe spinal stenosis at L4-L5 level with bilateral L4 nerve root compression.
2. Moderate to severe spinal stenosis at L5-S1 level with bilateral L5 nerve root compression.
3. Severe facet joint arthropathy at L4-L5 and L5-S1 levels.

4. No evidence of acute fracture, infection, or malignancy.

Conclusion

Findings consistent with severe degenerative changes in the lower lumbar spine, most pronounced at L4-L5 and L5-S1 levels, resulting in severe spinal stenosis and nerve root compression. These findings correlate with the patient's symptoms of low back pain and radiculopathy.

Radiologist Info

Name	Dr. Jane Smith
Signature	Electronically signed by Dr. Jane Smith
Contact	555-123-4567

Lab Reports

Firstname	Stephen
Lastname	Porter
Middlename	D
Dob	1966-08-06
Gender	M
Medical Record Number	M000139
Admission Id	A000172
Charttime	2023-10-01 08:30:00
Category	Chemistry
Test Name	Comprehensive Metabolic Panel

Results

Component	Value	Unit	Reference Range	Flag
Sodium	138	mEq/L	135-145 mEq/L	WNL

Component	Value	Unit	Reference Range	Flag
Potassium	4.2	mEq/L	3.5-5.1 mEq/L	WNL

Component	Value	Unit	Reference Range	Flag
Chloride	102	mEq/L	98-107 mEq/L	WNL

Component	Value	Unit	Reference Range	Flag
CO2	24	mEq/L	22-30 mEq/L	WNL

Component	Value	Unit	Reference Range	Flag
BUN	18	mg/dL	7-20 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
Creatinine	1.1	mg/dL	0.6-1.2 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
Glucose	110	mg/dL	70-100 mg/dL	H

Component	Value	Unit	Reference Range	Flag
Calcium	9.2	mg/dL	8.5-10.2 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
Total Protein	7.0	g/dL	6.0-8.3 g/dL	WNL

Component	Value	Unit	Reference Range	Flag
Albumin	3.8	g/dL	3.5-5.0 g/dL	WNL

Component	Value	Unit	Reference Range	Flag
Total Bilirubin	0.8	mg/dL	0.3-1.2 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
Alkaline Phosphatase	75	U/L	30-120 U/L	WNL

Component	Value	Unit	Reference Range	Flag
AST	32	U/L	10-40 U/L	WNL

Component	Value	Unit	Reference Range	Flag
ALT	28	U/L	7-56 U/L	WNL

Firstname	Stephen
Lastname	Porter
Middlename	D
Dob	1966-08-06
Gender	M
Medical Record Number	M000139
Admission Id	A000172
Charttime	2023-10-01 09:15:00
Category	Hematology
Test Name	Complete Blood Count

Results

Component	Value	Unit	Reference Range	Flag
WBC	9.2	K/uL	4.5-11.0 K/uL	WNL

Component	Value	Unit	Reference Range	Flag
RBC	4.8	M/uL	4.5-5.9 M/uL	WNL

Component	Value	Unit	Reference Range	Flag
Hemoglobin	14.2	g/dL	13.5-17.5 g/dL	WNL

Component	Value	Unit	Reference Range	Flag
Hematocrit	42	%	41-53%	WNL

Component	Value	Unit	Reference Range	Flag
MCV	88	fL	80-100 fL	WNL

Component	Value	Unit	Reference Range	Flag
MCH	29.6	pg	27-31 pg	WNL

Component	Value	Unit	Reference Range	Flag
MCHC	33.8	g/dL	32-36 g/dL	WNL

Component	Value	Unit	Reference Range	Flag
RDW	13.2	%	11.5-14.5%	WNL

Component	Value	Unit	Reference Range	Flag
Platelet Count	245	K/uL	150-450 K/uL	WNL

Firstname	Stephen
Lastname	Porter
Middlename	D
Dob	1966-08-06
Gender	M
Medical Record Number	M000139
Admission Id	A000172
Charttime	2023-10-03 10:45:00
Category	Chemistry
Test Name	Lipid Panel

Results

Component	Value	Unit	Reference Range	Flag
Total Cholesterol	210	mg/dL	<200 mg/dL	H

Component	Value	Unit	Reference Range	Flag
Triglycerides	165	mg/dL	<150 mg/dL	H

Component	Value	Unit	Reference Range	Flag
HDL Cholesterol	42	mg/dL	>40 mg/dL	WNL

Component	Value	Unit	Reference Range	Flag
LDL Cholesterol (calculated)	135	mg/dL	<100 mg/dL	H

Firstname	Stephen
Lastname	Porter
Middlename	D
Dob	1966-08-06
Gender	M
Medical Record Number	M000139
Admission Id	A000172
Charttime	2023-10-05 14:20:00
Category	Chemistry
Test Name	Thyroid Function Tests

Results

Component	Value	Unit	Reference Range	Flag
TSH	2.8	mIU/L	0.4-4.0 mIU/L	WNL

Component	Value	Unit	Reference Range	Flag
Free T4	1.2	ng/dL	0.8-1.8 ng/dL	WNL

Medications

Order Id	Medication Name	Dosage	Route	Frequency	Start Date	End Date
1	Lisinopril	10mg	PO	Daily	2023-08-01	2023-08-05
2	Metoprolol Tartrate	25mg	PO	BID	2023-08-01	2023-08-05
3	Aspirin	81mg	PO	Daily	2023-08-01	2023-08-05
4	Heparin	5000 units	SC	q8h	2023-08-01	2023-08-05
5	Morphine Sulfate	2-4mg	IV	q4h PRN	2023-08-01	2023-08-03
6	Ondansetron	4mg	IV	q6h PRN	2023-08-01	2023-08-03
7	Pantoprazole	40mg	IV	Daily	2023-08-01	2023-08-05

Discharge Summary

Patient Information

Full Name
Stephen D Porter

Date Of Birth
1966-08-06

Gender
Male

Medical Record Number
M000139

Admission Date
2023-06-12

Discharge Date
2023-06-16

Reason For Admission

Mr. Porter, a 57-year-old male with a history of ESRD on home HD, thyroid cancer, HTN, lumbar spondylosis with radiculopathy, and CAD s/p CABG, was admitted due to severe low back pain and inability to ambulate. The pain began one month ago following a motor vehicle accident and acutely worsened prior to admission.

Hospital Course

During his 5-day stay, Mr. Porter underwent evaluation and treatment for acute exacerbation of chronic lumbar radiculopathy. Key events included: 1. MRI of the lumbar spine revealed severe spinal stenosis at L4-L5 and L5-S1 levels with bilateral nerve root compression. 2. Pain management: Initially treated with IV hydromorphone, gradually transitioned to oral pain medications. 3. Physical therapy: Initiated for gentle mobilization and gait training. 4. Hypertension management: Amlodipine dose was increased to 15mg daily for better BP control. 5. Neurosurgery consultation: Recommended conservative management. 6. Continued home hemodialysis schedule. 7. Gradual improvement in pain and mobility throughout the stay, progressing from being unable to ambulate to walking short distances with a walker.

Discharge Diagnosis

Primary
Acute exacerbation of chronic lumbar radiculopathy due to severe spinal stenosis

Secondary
End-stage renal disease on home hemodialysis

Hypertension

Coronary artery disease status post CABG

History of thyroid cancer

Medications At Discharge

Name	Dosage	Route	Frequency
Amlodipine	15mg	PO	Daily

Name	Dosage	Route	Frequency
Metoprolol Tartrate	25mg	PO	Twice daily

Name	Dosage	Route	Frequency
Aspirin	81mg	PO	Daily

Name	Dosage	Route	Frequency
Oxycodone	5-10mg	PO	Every 4-6 hours as needed for pain

Name	Dosage	Route	Frequency
Cyclobenzaprine	10mg	PO	Three times daily as needed for muscle spasms

Name	Dosage	Route	Frequency
Levothyroxine	125mcg	PO	Daily

Follow Up Plans

Follow up with primary care physician in 1 week

Neurosurgery appointment in 2 weeks for reassessment

Continue outpatient physical therapy 2-3 times per week

Resume home hemodialysis schedule as previously established

Pain management clinic appointment in 2 weeks for medication adjustment if needed

Discharge Instructions

Activity Restrictions

Gradually increase activity as tolerated. Use walker for ambulation. Avoid heavy lifting or strenuous activities.

Dietary Recommendations

Continue renal diet as prescribed by nephrologist. Limit sodium intake to help control blood pressure.

Medication Management

Take all medications as prescribed. Use pain medications only as needed and gradually decrease use as pain improves.

Signs Requiring Attention

Seek immediate medical attention if experiencing: - Severe, uncontrolled pain - New or worsening weakness in legs - Loss of bladder or bowel control - Fever above 38°C (100.4°F) - Shortness of breath or chest pain

Additional Notes

Social Support

Patient lives with spouse who will assist with care at home.

Equipment Needs

Walker provided for home use.

Educational Resources

Patient and spouse educated on proper body mechanics, pain management strategies, and importance of adherence to medication and dialysis schedules.