CHIEF COMPLAINT:, Neck pain, thoracalgia, low back pain, bilateral lower extremity pain.,HISTORY OF PRESENT ILLNESS:, Ms. XYZ is a fairly healthy 69-year-old Richman, Roseburg resident who carries a history of chronic migraine, osteoarthritis, hypothyroidism, hyperlipidemia, and mitral valve prolapse. She has previously been under the care of Dr. Ninan Matthew in the 1990s and takes Maxalt on a weekly basis and nadolol, omeprazole and amitriptyline for treatment of her migraines, which occur about once a week. She is under the care of Dr. Bonaparte for hyperlipidemia and hypothyroidism. She has a long history of back and neck pain with multiple injuries in the 1960s, 1970s, 1980s and 1990s. In 2000, she developed ""sciatica"" mostly in her right lower extremity.,She is seen today with no outside imaging, except with MRI of her cervical spine and lumbar spine dated February of 2004. Her cervical MRI reveals an 8 mm central spinal canal at C6-7, multilevel foraminal stenosis, though her report is not complete as we do not have all the pages. Her lumbar MRI reveals lumbar spinal stenosis at L4-5 with multilevel facet arthropathy and spondylitic changes.,The patient has essentially three major pain complaints.,Her first pain complaint is one of a long history of axial neck pain without particular radicular symptoms. She complains of popping, clicking, grinding and occasional stiffness in her neck, as well as occasional periscapular pain and upper trapezius myofascial pain and spasms with occasional cervicalgic headaches. She has been told by Dr. Megahed in the past that she is not considered a surgical candidate. She

has done physical therapy twice as recently as three years ago for treatment of her symptoms. She complains of occasional pain and stiffness in both hands, but no particular numbness or tingling.,Her next painful complaint is one of midthoracic pain and thoracalgia features with some right-sided rib pain in a non-dermatomal distribution. Her rib pain was not preceded by any type of vesicular rash and is reproducible, though is not made worse with coughing. There is no associated shortness of breath. She denies inciting trauma and also complains of pain along the costochondral and sternochondral junctions anteriorly. She denies associated positive or negative sensory findings, chest pain or palpitations, dyspnea, hemoptysis, cough, or sputum production. Her weight has been stable without any type of constitutional symptoms.,Her next painful complaint is one of axial low back pain with early morning pain and stiffness, which improves somewhat later in the day. She complains of occasional subjective weakness to the right lower extremity. Her pain is worse with sitting, standing and is essentially worse in the supine position. Five years ago, she developed symptoms radiating in an L5-S1 distribution and within the last couple of years, began to develop numbness in the same distribution. She has noted some subjective atrophy as well of the right calf. She denies associated bowel or bladder dysfunction, saddle area hypoesthesia, or falls. She has treated her back symptoms with physical therapy as well.,She is intolerant to any type of antiinflammatory medications as well and has a number of allergies to multiple medications.

She participates in home physical therapy, stretching, hand weights, and stationary bicycling on a daily basis. Her pain is described as constant, shooting, aching and sharp in nature and is rated as a 4-5/10 for her average and current levels of pain, 6/10 for her worst pain, and 3/10 for her least pain. Exacerbating factors include recumbency, walking, sleeping, pushing, pulling, bending, stooping, and carrying. Alleviating factors including sitting, applying heat and ice.,PAST MEDICAL HISTORY:, As per above and includes hyperlipidemia, hypothyroidism, history of migraines, acid reflux symptoms, mitral valve prolapse for which she takes antibiotic prophylaxis.,PAST SURGICAL HISTORY:, Cholecystectomy, eye surgery, D&C.;,MEDICATIONS:, Vytorin, Synthroid, Maxalt, nadolol, omeprazole, amitriptyline and 81 mg aspirin.,ALLERGIES:, Multiple. All over-the-counter medications. Toradol, Robaxin, Midrin, Darvocet, Naprosyn, Benadryl, Soma, and erythromycin.,FAMILY HISTORY:, Family history is remarkable for a remote history of cancer. Family history of heart disease and osteoarthritis.,SOCIAL HISTORY:, The patient is retired. She is married with three grown children. Has a high school level education. Does not smoke, drink, or utilize any illicit substances.,OSWESTRY PAIN INVENTORY:, Significant impact on every aspect of her quality of life. She would like to become more functional.,REVIEW OF SYSTEMS:, A thirteen-point review of systems was surveyed including constitutional, HEENT, cardiac, pulmonary, GI, GU, endocrine, integument, hematological, immunological,

neurological, musculoskeletal, psychological and rheumatological. Cardiac, swelling in the extremities, hyperlipidemia, history of palpitation, varicose veins. Pulmonary review of systems negative. GI review of systems is positive for irritable bowel and acid reflux symptoms. Genitourinary, occasional stress urinary incontinence and history of remote hematuria. She is postmenopausal and on hormone replacement. Endocrine is positive for a low libido and thyroid disorder. Integument: Dry skin, itching and occasional rashes. Immunologic is essentially negative. Musculoskeletal: As per HPI. HEENT: Jaw pain, popping, clicking, occasional hoarseness, dysphagia, dry mouth, and prior history of toothache. Neurological: As per history of present illness. Constitutional: As history of present illness.,PHYSICAL EXAMINATION:, Weight 180 pounds, temp 97.6, pulse 56, BP 136/72. The patient walks with a normal gait pattern. There is no antalgia, spasticity, or ataxia. She can alternately leg stand without difficulty, as well as tandem walk, stand on the heels and toes without difficulty. She can flex her lumbar spine and touch the floor with her fingertips. Lumbar extension and ipsilateral bending provoke her axial back pain. There is tenderness over the PSIS on the right and no particular pelvic asymmetry.,Head is normocephalic and atraumatic. Cranial nerves II through XII are grossly intact. Cervical range of motion is slightly limited in extension, but is otherwise intact to flexion and lateral rotation. The neck is supple. The trachea is midline. The thyroid is not particularly enlarged. Lungs are clear to

auscultation. Heart has regular rate and rhythm with normal S1, S2. No murmurs, rubs, or gallops. The abdomen is nontender, nondistended, without palpable organomegaly, guarding, rebound, or pulsatile masses. Skin is warm and dry to the touch with no discernible cyanosis, clubbing or edema. I can radial, dorsalis pedis and posterior tibial pulses. The nailbeds on her feet have trophic changes. Brisk capillary refill is evident over both upper extremities.,Musculoskeletal examination reveals medial joint line tenderness of both knees with some varus laxity of the right lower extremity. She has chronic osteoarthritic changes evident over both hands. There is mild restriction of range of motion of the right shoulder, but no active impingement signs.,Inspection of the axial skeleton reveals a cervicothoracic head-forward posture with slight internal rotation of the upper shoulders. Palpation of the axial skeleton reveals mild midline tenderness at the lower lumbar levels one fingerbreadth lateral to the midline. There is no midline spinous process tenderness over the cervicothoracic regions. Palpation of the articular pillars is met with mild provocation of pain. Palpation of the right posterior, posterolateral and lateral borders of the lower ribs is met with mild provocable tenderness. There is also tenderness at the sternochondral and costochondral junctions of the right, as well as the left bilaterally. The xiphoid process is not particularly tender. There is no dermatomal sensory abnormality in the thoracic spine appreciated. Mild facetal features are evident over the sacral spine with extension and lateral bending at the level of the sacral ala.,Neurological

examination of the upper and lower extremities reveals 3/5 reflexes of the biceps, triceps, brachioradialis, and patellar bilaterally. I cannot elicit S1 reflexes. There are no long tract signs. Negative Hoffman's, negative Spurling's, no clonus, and negative Babinski. Motor examination of the upper, as well as lower extremities appears to be intact throughout. I may be able to detect a slight hand of atrophy of the right calf muscles, but this is truly unclear and no measurement was made.,SUMMARY OF DIAGNOSTIC IMAGING:, As per above.,IMPRESSION:,1. Osteoarthritis.,2. Cervical spinal stenosis.,3. Lumbar spinal stenosis.,4. Lumbar radiculopathy, mostly likely at the right L5-S1 levels.,5. History of mild spondylolisthesis of the lumbosacral spine at L4-L5 and right sacroiliac joint dysfunction.,6. Chronic pain syndrome with myofascial pain and spasms of the trapezius and greater complexes.,PLAN: ,The natural history and course of the disease was discussed in detail with Mr. XYZ. Greater than 80 minutes were spent facet-to-face at this visit. I have offered to re-image her cervical and lumbar spine and have included a thoracic MR imaging and rib series, as well as cervicolumbar flexion and extension views to evaluate for mobile segment and/or thoracic fractures. I do not suspect any sort of intrathoracic comorbidity such as a neoplasm or mass, though this was discussed. Pending the results of her preliminary studies, this should be ruled out. I will see her in followup in about two weeks with the results of her scans.