REASON FOR NEUROLOGICAL CONSULTATION:, Muscle twitching, clumsiness, progressive pain syndrome, and gait disturbance.,HISTORY OF PRESENT ILLNESS: , The patient is a 62-year-old African-American male with a significant past medical history of diabetes, hypertension, previous stroke in 2002 with minimal residual right-sided weakness as well as two MIs, status post pacemaker insertion who first presented with numbness in his lower extremities in 2001. He states that since that time these symptoms have been progressive and now involving his legs above his knees as well as his hands. More recently, he describes a burning sensation along with numbness. This has become a particular problem and of all the problems he has he feels that pain is his primary concern. Over the last six months, he has noticed that he cannot feel hot objects in his hands and that objects slip out of his hands. He denies any weakness per se, just clumsiness and decreased sensation. He has also been complaining of brief muscle jerks, which occur in both hands and his shoulders. This has been a fairly longstanding problem, and again has become more prevalent recently. He does not have any tremor. He denies any neck pain. He walks with the aid of a walker because of unsteadiness with gait.,Recently, he has tried gabapentin, but this was not effective for pain control. Oxycodone helps somewhat and gives him at least three hours pain relief. Because of the pain, he has significant problems with fractured sleep. He states he has not had a good night's sleep in many years. About six months ago, after an MI and pacemaker insertion, he was transferred to a

nursing facility. At that facility, his insulin was stopped. Since then he has only been on oral medication for his diabetes. He denies any back pain, neck pain, change in bowel or bladder function, or specific injury pre-dating these symptoms., ,PAST MEDICAL HISTORY: , Diabetes, hypertension, coronary artery disease, stroke, arthritis, GERD, and headaches.,MEDICATIONS: , Trazodone, simvastatin, hydrochlorothiazide, Prevacid, lisinopril, glipizide, and gabapentin.,FAMILY HISTORY: , Discussed above and documented on the chart.,SOCIAL HISTORY: , Discussed above and documented on the chart. He does not smoke. He lives in a senior citizens building with daily nursing aids. He previously was a security guard, but is currently on disability.,REVIEW OF SYSTEMS: , Discussed above and documented on the chart.,PHYSICAL EXAMINATION: , On examination, blood pressure 150/80, pulse of 80, respiratory rate 22, and weight 360 pounds. Pain scale 7/10. A full general and neurological examination was performed on the patient and is documented on the chart.,The patient is obese with significant ankle edema.,Neurological examination reveals normal cognitive exam and normal cranial nerve examination. Motor examination reveals mild atrophy in bilateral FDIs, but still has a strong grip. Individual muscle strength is close to normal with only subtle weakness found in ankle plantar and dorsiflexion. Tone and bulk are normal. Sensory examination reveals a severe decrease to all modalities in his lower extremities from just above the knees distally. He has no vibration sense at his knees. Similarly,

there is decrease to all sensory modalities in his both upper extremities from just above the wrist distally. The only reflexes I could obtain with trace reflexes in his biceps. Remaining reflexes were unelicitable. No Babinski. The patient walks normally with the aid of a cane. He has severe sensory ataxia with inability to walk unaided. Positive Romberg with eyes open and closed.,IMPRESSION AND PLAN:,1. Probable painful diabetic neuropathy. Symptoms are predominantly sensory and severely dysfunctioning, with the patient having inability to ambulate independently as well as difficulty with grip and temperature differentiation in his upper extremities. He has relative preservation of motor function. Because these symptoms are progressive and, by report, he came off his insulin, suggesting somewhat mild diabetes, I would like to rule out other causes of progressive neuropathy.,2. He has history of myoclonic jerks. I did not see any on my examination today and I feel that these are benign and probably secondary to his severe insomnia, which he states is secondary to the painful neuropathy. I would like to rule out other causes such as hepatic encephalopathy., ,I have recommended the following:,1. EMG/nerve conduction study to assess severity of neuropathy and to characterize neuropathy.,2. Blood work, looking for other causes of neuropathy and myoclonus, to include CBC, CMP, TSH, LFT, B12, RPR, ESR, Lyme titer, and HbA1c, and ammonia level.,3. Neurontin and oxycodone have not been effective, and I have recommended Cymbalta starting at 30 mg q.d. for five days and then increasing to 60 mg q.d. Side effect profile

of this medication was discussed with the patient.,4. I have explained to him that progression of diabetic neuropathy is closely related to diabetic control and I have recommended tight diabetic control.,5. I will see him at followup at the EMG.