Ketan D. Vora, DO, P.C.
400 Route 34, Suite A
Matawan, NJ 07747
Tel #: 1-877-SPINE-DR
Fax: (347) 708-8499
Billing Tel: (732) 441-7177, Fax: (732) 441-7165

Medical Re-Evaluation

Patient Name: Cindy Molina
Dt. of Exam: 02/20/2020
1st Exam Dt.: 01/22/2020
Dt. of Injury: 06/18/2019

Patient is here for follow-up of LESI with minimal results, LD/LPDA scheduled for 2/29/20, icing therapy and medications discussed, will be seen in 2 weeks.

Chief Complaint:
The patient complains of neck pain that is 8-9/10, with 10 being the worst, which is sharp in nature. The neck pain radiates to left shoulder and left arm. Neck pain is associated with numbness and tingling to the left arm and left hand. Neck pain is worsened with bending and lifting.

The patient complains of mid back pain that is 7-8/10, with 10 being the worst, which is dull and achy in nature. Mid-back pain is worsened with bending and lifting.

The patient complains of lower back pain that is 9/10, with 10 being the worst, which is sharp in nature. Lower back pain is associated with numbness and tingling to the left leg and left feet. Lower back pain is worsened with bending and lifting. The patient complains of worsening radiating low back pain, affecting quality of life and decreasing the activities of daily living. The pain is worse with bending, twisting and lifting as well as prolonged sitting. The pain prevents the patient from falling asleep as well as waking the patient up during sleep.

The patient complains of left shoulder pain that is 7/10, with 10 being the worst, which is dull and achy in nature. Left shoulder pain is worsened with lying.

REVIEW OF SYSTEMS: The patient denies seizures, chest pain, shortness of breath, jaw pain, abdominal pain, fevers, night sweats, diarrhea, blood in urine, bowel/bladder incontinence, double vision, hearing loss, recent weight loss, episodic lightheadedness and rashes.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL/HOSPITALIZATION HISTORY: Noncontributory.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

Physical Examination:

Neurological Examination: Patient is alert and cooperative and responding appropriately. Cranial nerves II-XII grossly intact.

Deep Tendon Reflexes: Are 2+ and equal.

Sensory Examination: It is intact with the following exceptions of hypoesthesia at left lateral arm (C5), hypoesthesia at left lateral forearm, thumb, index (C6), hypoesthesia at left middle finger (C7), hypoesthesia at left medial forearm, ring, little finger (C8), hypoesthesia at left arm (T1) and hypoesthesia at right lateral foot (S1).

Manual Muscle Strength Testing: Testing is 5/5 normal.

Cervical Spine Examination: Reveals tenderness upon palpation at C2-C7 levels bilaterally. The Spurling's test is positive. The Cervical Distraction test is positive. There are palpable taut bands/trigger points at bilateral levator scapulae, bilateral trapezius and bilateral posterior scalenes. ROM is as follows: Extension was 40 and is 40 degrees; forward flexion was 45 and is 45 degrees; right rotation was 75 and is 75 degrees; left rotation was 40 and is 40 degrees; right lateral flexion was 25 and is 25 degrees and left lateral flexion was 40 and is 40 degrees.

Thoracic Spine Examination: Reveals tenderness upon palpation at T1-T12 levels bilaterally with muscle spasm present. Trigger points with palpable taut bands were noted at bilateral rhomboids, bilateral trapezius and bilateral serratus posterior superior. ROM is mildly decreased.

Lumbar Spine Examination: Reveals tenderness upon palpation at L1-S1 levels bilaterally with muscle spasm present. Trigger points with palpable taut bands were noted at bilateral paraspinal levels L3-S1 with referral patterns laterally to the region in a fan-like pattern. ROM is as follows: Extension was 20 and is 20 degrees; forward flexion was 80 and is 80 degrees; right rotation was 20 and is 20 degrees; left rotation was 20 and is 20 degrees; right lateral flexion was 20 and is 20 degrees and left lateral flexion was 20 and is 20 degrees. Leg raised exam is positive bilaterally. The patient’s pain is exacerbated by axial loading and improves with recumbence. Patient has physical findings consistent with clinical radiculopathy.

Left Shoulder Examination: Reveals tenderness upon palpation of the left AC joint and scapular region. Neer's test is positive and Hawkins test is positive. ROM is as follows: Abduction was 180 and is 180 degrees; flexion was 180 and is 180 degrees; external rotation was 90 and is 90 degrees and internal rotation was 90 and is 90 degrees.

Diagnostic Studies:
9/28/2019 - MRI of the cervical spine reveals bulge at C2-3, C4-5 and HNP at C5-6, C6-7.
9/21/2019 - MRI of the thoracic spine reveals bulge at T5-6 through T7-8, T10 through L1 and HNP at T3-4, T4-5.
9/28/2019 - MRI of the lumbar spine reveals bulge at L1-2, L2-3, HNP at L3-4, L4-5, L5-S1 and annular tear at L5-S1.

The above diagnostic studies were reviewed.

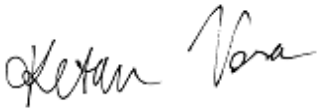
Diagnoses:
Lumbar disc bulge at L1-2, L2-3.
Lumbar disc herniation at L3-4, L4-5, L5-S1.
Lumbar annular tear at L5-S1.
Low back pain (Lumbago) - M54.5.
Spasm of back muscles - M62.830.
Sprain (lumbar) - S33.5xxD.
Strain (lumbar) - S39.012.
Cervical disc bulge at C2-3, C4-5.
Cervical disc herniation at C5-6, C6-7.
Cervicalgia (Neck pain) - M54.2.
Sprain of ligaments of cervical spine (whiplash) - S13.4xxD.
Strain of muscle, fascia, tendons (cervical) - S16.1xxD.
Thoracic disc bulge at T5-6 through T7-8, T10 through L1.
Thoracic disc herniation at T3-4, T4-5.
Back pain (thoracic): M54.6.
Sprain of ligaments (thoracic spine): S23.3xxD.
Left shoulder sprain/strain.
Left shoulder internal derangement.

Plan:

1. **Schedule lumbar discogram at L3-S1:** Based on additional levels found to have discogenic radiculopathy besides the suspected, we will request all affected levels have a lumbar percutaneous discectomy with annuloplasty and nucleoplasty, with decompression with surgical assist requested; followed by a postprocedural lumbar transforaminal epidural steroid injection and trigger point injection to reduce scar tissue and inflammation. Given today's finding and the fact that the patient has had multiple conservative therapy, including physical therapy, medication, injection therapy with not enough functional gain and persistent pain for several months, and given the diagnostic results, as well as the fact that the patient continues to have radiating low back pain, of a seemingly discogenic nature, I scheduled a lumbar discogram. This should help assess the suspected source of the patient’s low back pain, and help determine the levels involved as well as the quality and characteristics of the damaged discs in more detail to allow for a thorough evaluation of the patient’s discogenic pain. If the patient’s pain is reproduced in concordance when performing a discogram, the patient will then proceed that same day with spine surgery as discussed at all effected levels. The discogram then would have served in helping choose the type of spine surgery and approach. The multiple levels will then have decompression as well as postsurgical transforaminal epidural at the levels and side of the surgery to reduce postsurgical scarring. The trigger point injection will also help decrease the postop swelling and inflammation. The Goals of the diskectomy is to improve the range of motion as well increase the duration of sleep, decrease the pain level and improve the endurance level of sitting by at least 30%.

Follow-up: 2 weeks.

Rehan Khan, FNP-BC



Ketan D. Vora, D.O.
Diplomat of the American Board of Physical Medicine and Rehabilitation
Diplomat of the American Board of Pain Management
Interventional Spine
NYS WCB License # 243182-3w, coded OPCPMR

Dictated but not proofread

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Initial Comprehensive Medical Evaluation

Date: 01/22/2020

RE: Cindy Molina
DOB: 08/01/1991
1st Evaluation

HISTORY:
On 01/22/2020, Ms. Cindy Molina, a right-handed 28-year-old female presents for the evaluation of the injuries sustained in a motor vehicle accident which occurred on the date of 06/18/2019. The patient was seen at the Lindenhurst, NY office. The patient states she was the front seat passenger of a vehicle which was involved in a T-boned collision. The patient states that an EMS team arrived. She went to Good Samaritan Hospital via ambulance same day the accident occurred. She was evaluated and released. Patient was passenger seat in the vehicle. Upon making a left turn, another vehicle ran the stop sign, colliding into the patient's vehicle in a T-Bone Collision. The patient reports no injury to the head and no loss of consciousness. During the accident the patient reports injuries to neck, mid-back, low-back and left shoulder.

CHIEF COMPLAINTS:
The patient complains of neck pain that is 8-9/10, with 10 being the worst, which is sharp in nature. The neck pain radiates to left shoulder and left arm. Neck pain is associated with numbness and tingling to the left arm and left hand. Neck pain is worsened with bending and lifting.

The patient complains of mid back pain that is 7-8/10, with 10 being the worst, which is dull and achy in nature. Mid-back pain is worsened with bending and lifting.

The patient complains of lower back pain that is 9/10, with 10 being the worst, which is sharp in nature. Lower back pain is associated with numbness and tingling to the left leg and left feet. Lower back pain is worsened with bending and lifting.The patient complains of worsening radiating low back pain, affecting quality of life and decreasing the activities of daily living.

The patient complains of left shoulder pain that is 7/10, with 10 being the worst, which is dull and achy in nature. Left shoulder pain is worsened with lying.

REVIEW OF SYSTEMS: The patient denies seizures, chest pain, shortness of breath, jaw pain, abdominal pain, fevers, night sweats, diarrhea, blood in urine, bowel/bladder incontinence, double vision, hearing loss, recent weight loss, episodic lightheadedness and rashes.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL/HOSPITALIZATION HISTORY: Noncontributory.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Unknown.

PHYSICAL EXAM:
General: The patient presents in an uncomfortable state.

Neurological Examination: Patient is alert and cooperative and responding appropriately. Cranial nerves II-XII grossly intact.

Deep Tendon Reflexes: Are 2+ and equal.

Sensory Examination: It is intact with the following exceptions: Hypoesthesia at left lateral arm (C5); hypoesthesia at left lateral forearm, thumb, index (C6); hypoesthesia at left middle finger (C7); hypoesthesia at left medial forearm, ring, little finger (C8) and hypoesthesia at left arm (T1); hypoesthesia at right lateral foot (S1).

Manual Muscle Strength Testing: Testing is 5/5 normal.

Cervical Spine Examination: Reveals tenderness upon palpation at C2-C7 levels bilaterally. The Spurling's test is positive. The Cervical Distraction test is positive. There are palpable taut bands/trigger points at bilateral levator scapulae, bilateral trapezius and bilateral posterior scalenes with referral to the scapula. ROM is as follows: Extension is 40 degrees, normal is 50 degrees; forward flexion is 45 degrees, normal is 60 degrees; right rotation is 75 degrees, normal is 80 degrees; left rotation is 40 degrees, normal is 80 degrees; right lateral flexion is 25 degrees, normal is 50 degrees and left lateral flexion is 40 degrees, normal is 50 degrees.

Thoracic Spine Examination: Reveals tenderness upon palpation at T1-T12 levels bilaterally with muscle spasm present. Trigger points with palpable taut bands were noted at bilateral rhomboids, bilateral trapezius and bilateral serratus posterior superior with referral to the scapula. ROM is mildly decreased.

Lumbar Spine Examination: Reveals tenderness upon palpation at L1-S1 levels bilaterally with muscle spasm present. Trigger points with palpable taut bands were noted at bilateral paraspinal levels L3-S1 with referral patterns laterally to the region in a fan-like pattern. ROM is as follows: Extension is 20 degrees, normal is 30 degrees; forward flexion is 80 degrees, normal is 90 degrees; right rotation is 20 degrees, normal is 30 degrees; left rotation is 20 degrees, normal is 30 degrees; right lateral flexion is 20 degrees, normal is 30 degrees and left lateral flexion is 20 degrees, normal is 30 degrees. Straight leg-raise exam is positive bilaterally.

Left Shoulder Examination: Reveals tenderness upon palpation of the left AC joint and scapular region. ROM is as follows: Abduction is 180 degrees, normal is 180 degrees; flexion is

180 degrees, normal is 180 degrees; external rotation is 90 degrees, normal is 90 degrees and internal rotation is 90 degrees, normal is 90 degrees.

Diagnostic Studies: None reviewed.

Diagnoses:
Low back pain (Lumbago) - M54.5.
Spasm of back muscles - M62.830.
Sprain (lumbar) - S33.5xxA.
Strain (lumbar) - S39.012.
Lumbar radiculopathy M54.16.
Left shoulder pain (M25.512).
Left shoulder sprain/strain (S43.402A).
Cervicalgia (Neck pain) - M54.2.
Sprain of ligaments of cervical spine (whiplash) - S13.4xxA.
Strain of muscle, fascia, tendons (cervical) - S16.1xxA.
Back pain (thoracic): M54.6.
Sprain of ligaments (thoracic spine): S23.3xxA.

Plan:

1. **Schedule lumbar epidural steroid injection L4-L5:** Given today's finding and the fact that the patient has had conservative therapy with not enough functional gain and persistent pain for several months, and given the diagnostic results, as well as the fact that the patient continues to have radiating low back pain, I scheduled a lumbar epidural steroid injection. This should help alleviate the radiating low back pain, and help achieve a better range of motion and functional gains.
2. **Request MRI of the left shoulder:** I have advised the patient that this study should be performed immediately because if any ligamentous tears are present, then we need to address the injury immediately with an orthopedic surgery consult.
3. **Physical therapy**: The patient is to start physical therapy 3 times a week for 4-6 weeks.

Procedures: If the patient continues to have tender palpable taut bands/trigger points with referral patterns as noted in the future on examination, I will consider doing trigger point injections.

Care: Acupuncture, chiropractic and physical therapy. Avoid heavy lifting, carrying, excessive bending and prolonged sitting and standing.

Goals: To increase range of motion, strength, flexibility, to decrease pain and to improve body biomechanics and activities of daily living and improve the functional status.

Precautions: Universal.

Follow-up: 2 weeks.

It is my opinion that the injuries and symptoms Ms. Cindy Molina sustained to neck, mid-back, low back and left shoulder are causally related to the incident that occurred on 06/18/2019 as described by the patient.

Rehan Khan, FNP-BC

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Diplomat of the American Board of Physical Medicine and Rehabilitation
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Interventional Spine
NYS WCB License # 243182-3w, coded OPCPMR

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CINDY MOLINA **DI1901679** **Report Date:** 09/29/2019
DOB: 08/01/1991
Exam Date: 09/28/2019

GARY CULLIN, DC
193 N WELLWOOD AVE
LINDENHURST, NY 11757

MAGNETIC RESONANCE IMAGING SCAN OF THE LUMBAR SPINE

TECHNIQUE: Neutral Sitting: Sagittal T1, Sagittal T2, Axial T1, Axial T2, Sagittal STIR
Flexion: Sagittal T2.
Extension: Sagittal T2.

HISTORY: The patient complains of lower back pain radiating to left buttock.

INTERPRETATION:
In the **neutral sitting position**, there is near diffuse straightening of the lumbar lordosis with a slight residual curvature. Slight left convexity to the lumbar curvature is also present.

At L1-2 and L2-3, there are posterior and left peripheral subligamentous disc bulges.

At L3-4, there is a midline posterior disc herniation impressing on the ventral thecal sac, extending slightly left paramedian to midline with broad extension of the disc peripherally into the left more than right neural foramen.

At L4-5, there is a broad posterior subligamentous disc herniation extending slightly eccentric to the left and impresses on the left greater than right ventral thecal sac and nearly abuts the L5 nerve roots exiting from the thecal sac with broad extension of the disc peripherally into the foramina which nearly abut both L4 nerve roots.

At L5-S1, there is a posterior subligamentous disc herniation causing impression on the ventral and left ventral thecal sac, abutting the right and nearly abutting the left S1 nerve roots after they exit from the thecal sac with broad extension of the disc peripherally into the foramina. There is a midline radial annular tear.

Hydration loss involves L4-5 and L5-S1 with superior endplate of L5 Schmorl's node invagination where there are surrounding reactive changes.

- Lumbar curvature becomes moderately increasingly and uniformly lordotic in the **extension position**.

Thank you for referring your patient to us for evaluation.

Sincerely,

Steven Winter, M.D.
Diplomate of the American Board of Radiology
SW/rs