**Medical Re-Evaluation**

Patient Name: Hardev Dhillon

Dt. of Exam: 09/09/2019

1st Exam Dt.: 03/12/2018

**Chief Complaint:**

The patient complains of neck pain that is 7/10, with 10 being the worst, which is sharp and shooting in nature. Neck pain is associated with numbness and tingling. Neck pain is worsened with sitting, standing and lying down.

The patient complains of lower back pain that is 8/10, with 10 being the worst, which is sharp in nature. Lower back pain is associated with numbness and tingling Lower back pain is worsened with sitting, standing, lying down, movement activities and climbing stairs. The patient presents today for followup evaluation of low back pain. She complains of low back pain and right shoulder pain. She states the low back pain has been getting worse which is radiating down the lower extremities. She is having persistent pain in the right shoulder. She states the symptoms have gotten worse over the last 10 days. Her back pain has gotten worse and spasms have gotten worse. She is taking gabapentin at night with benefit.

The patient complains of right shoulder pain. The patient presents today for followup evaluation of right shoulder pain. She continues to experience persistent right shoulder pain and states the symptoms have gotten worse over the last 10 days. Her back pain has gotten worse and spasms have gotten worse. She is taking gabapentin at night with benefit.

The patient complains of left knee pain that is 7/10, with 10 being the worst, which is sharp, shooting, dull and achy in nature. Left knee pain is worsened with walking, climbing stairs and squatting.

The patient complains of right knee pain that is 7/10, with 10 being the worst, which is sharp, shooting, dull and achy in nature. Right knee pain is worsened with walking, climbing stairs and squatting.

**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:**  Hypertension, diabetes.

**PAST SURGICAL / HOSPITALIZATION HISTORY:**  Noncontributory.

**MEDICATIONS:**  None.

**ALLERGIES:**  No known drug allergies.

**Physical Examination:**

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

**Deep Tendon Reflexes:** Are 2+ and equal with the exception of right triceps 1/2 and left triceps 1/2.

**Sensory Examination:** Is checked by pinprick. It is intact.

**Manual Muscle Strength Testing:** Testing is 5/5 normal with the exception of right shoulder abduction 5-/5, left shoulder abduction 5-/5, right shoulder flexion 5-/5, left shoulder flexion 5-/5, right hip flexion 5-/5 and left hip flexion 5-/5.

**Cervical Spine exam:** Cervical spine examination reveals tenderness upon palpation at C2-8 levels on the left bilaterally with muscle spasm present. ROM is as follows: extension was 10 and is 10 degrees; forward flexion was 30 and is 30 degrees; right rotation was 10 and is 10 degrees; left rotation was 10 and is 10 degrees; right lateral flexion was 10 and is 10 degrees and left lateral flexion was 10 and is 10 degrees.

**Lumbar Spine Examination:** Lumbar spine examination reveals tenderness upon palpation atL1-S1 levels bilaterally with muscle spasm present. ROM is as follows: extension was 10 and is 10 degrees; forward flexion was 30 and is 30 degrees; right rotation was 10 and is 10 degrees; left rotation was 10 and is 10 degrees; right lateral flexion was 10 and is 10 degrees and left lateral flexion was 10 and is 10 degrees.

**Right Shoulder Examination:** Reveals tenderness upon palpation of the right

**Left Knee Examination:** Reveals tenderness upon palpation of the left peripatellar region. McMurray's test is positive and Valgus test is positive. ROM is as follows: extension was -5 and is -5 degrees and forward flexion was 110 and is 110 degrees.

**Right Knee Examination:** Reveals tenderness upon palpation of the right peripatellar region. McMurray's test is positive and Valgus test is positive. ROM is as follows: extension was -5 and is -5 degrees and forward flexion was 110 and is 110 degrees.

**GAIT:** Normal.

**Diagnostic Studies:**

11/14/2018 - MRI of the Cervical spine reveals Cervical spine fusion consistent with spasm. Multilevel spondylosis. Bilateral foraminal stenosis at C6-7 secondary to spondylolisthesis. Large bridging osteophytes from C3 through C7.

11/14/2018 - MRI of the Lumbar spine reveals HNP at L1-2, L2-3, L3-4 and Mild facet hypertrophy at L2-3. L3-4 grade 1 anterior spondylolisthesis and posterolateral recess stenosis. L5-S1 anterolisthesis, significant foraminal stenosis right greater than left.

The above diagnostic studies were reviewed.

**Diagnosis:**

Cervical Cervical spine fusion consistent with spasm. Multilevel spondylosis. Bilateral foraminal stenosis at C6-7 secondary to spondylolisthesis. Large bridging osteophytes from C3 through C7..

Lumbar disc herniation at L1-2, L2-3, L3-4.

Lumbar Mild facet hypertrophy at L2-3. L3-4 grade 1 anterior spondylolisthesis and posterolateral recess stenosis. L5-S1 anterolisthesis, significant foraminal stenosis right greater than left..

Cervical Muscle Sprain/Strain.

Possible Cervical Disc Herniation.

Possible Cervical Radiculopathy Vs. Plexopathy Vs. Entrapment Syndrome.

Lumbar Muscle sprain/strain.

Possible Lumbar disc herniation.

Possible Lumbar radiculopathy vs. entrapment syndrome vs. polyradiculopathy.

Sacroiliitis.

Lumbosacral radiculopathy M54.17

B/l Knee OA

B/l Shoulder OA

**Plan:**

of the Lumbar spine to rule out herniated nucleus pulposus/soft tissue injury.

She is to continue with gabapentin

The patient is scheduled for lumbar transforaminal epidural injection at L4-L5 bilaterally.

Also scheduled for right shoulder intra-articular injection.

**Request lumbar transformainal epidural steroid Injections at Bilateral L4-L15 levels:** The patient has been counseled on the risks and benefits of this procedure with anesthesia and with local anesthetic. In light of the patient’s apprehension in moving forward with the procedure, patient has specifically requested anesthesia. It is my opinion based on medical literature and my experience that the anesthesia will not influence the accuracy or validity of any diagnosis achieved following the injections. It is also my belief that relying exclusively on local anesthesia raises the risks of voluntary or involuntary movement during the injection which raises the risk of neural injury. As such, there is an additional safety component which necessitates the use of anesthesia in connection with the above procedure.

She is to continue with gabapentin

The patient is scheduled for lumbar transforaminal epidural injection at L4-L5 bilaterally.

Also scheduled for right shoulder intra-articular injection.

**Request right shoulder intra-articular injection under ultrasound guidance:** I am requesting an intra-articular steroid injection under ultrasound guidance of the right shoulder today. The patient has been receiving therapy since the accident and had an MRI of the right shoulder as noted above. The ultrasound will aid in assuring that the needle indeed enters the intra-articular space. In an effort to avoid surgery, this injection should decrease inflammation and pain which will aid the physical therapist in achieving and maintaining the conditioned increase in the range of motion and overall expedite recovery.

She is to continue with gabapentin

The patient is scheduled for lumbar transforaminal epidural injection at L4-L5 bilaterally.

Also scheduled for right shoulder intra-articular injection.

**Follow-up:** 8 weeks



Gurbir Johal, M.D.