**Medical Re-Evaluation**

Patient Name: Ronald Iovino

Dt. of Exam: 08/16/2019

1st Exam Dt.: 07/23/2018

Dt. of Injury:

Others^ Medications were reviewed.

**Procedures performed:**

11/27/2018 - EMG LE

2/1/19 - LTPI #1

2/23/19 - LESI#1(L5-S1)

**Chief Complaint:**

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

The patient complains of lower back pain that is 8/10, with 10 being the worst, which is sharp, dull and achy in nature. The lower back pain radiates to bilateral side, bilateral hips and bilateral legs. Lower back pain is associated with numbness and tingling to the bilateral legs. 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 and right knee. He is is status post MVA. He has been having low back pain with radiculopathy to his right leg. He has muscle weakness in his quadriceps. He states he is unable to get up in the morning due to his persistent back and right extremity pain

He reports improvement in the right knee pain. He is on a stable dose of medications to include oxycontin and Percocet but would like to discontinue oxycontin. He is not able to stand for prolonged period of time due to the back pain. He states when he goes shopping, he has to sit down after some time as his quad muscles hurt. He is waiting for his supplemental insurance where he undergoes lumbar surgery.

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. The patient states the right knee has improved but he is having excruciating pain in his right leg. He reports difficulty with movement and is unable to to get up in the morning due to right lower extremity pain. He has been receiving physical therapy since the accident.

**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:**  Visual disturbances, arthritis, hearing loss, stomach ulcers, arm or leg weakness, sexual difficulties.

**PAST SURGICAL / HOSPITALIZATION HISTORY:**  Left ear drum removed.

**MEDICATIONS:**  Aleve and Advil tid, acetaminophen 500 mg 1 tab q6h, oxycodone 10 mg prn severe pain, oxycodone 5 mg prn moderate pain, docusate sodium 100 mg capsule bid, senna 8.6 mg one at bedtime, melatonin 3 mg at bedtime, ibuprofen 600 mg every 6 hours, as needed for pain.

**ALLERGIES:**  Penicillin.

**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. 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 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. Trigger points with palpable taut bands were noted at bilateral para spinal level L3-S1 with referral patterns laterally to the region in a fan-like pattern. 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. Leg raised exam is positive bilaterally and Braggard's test is positive bilaterally.

**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:**

11/9/2018 - MRI of the Cervical spine reveals bulge at C2-3 through C7-T1 and Spondylitic foraminal stenosis from C2-3 through C7-T1.

6/4/2019 - MRI of the Lumbar spine reveals bulge at L1-2 through L5-S1 , HNP at L1-2 extruded posterior left paracentral and foraminal. L3-4 and L4-5 superimposed broad-based posterior and L2-3 moderate central stenosis and bilateral foraminal stenosis. L4-5 moderately severe central canal stenosis in conjunction with facet hypertrophy. L5-S1 retrolisthesis, bilateral foraminal stenosis, minimal moderate central stenosis.

8/17/2018 - CT Scan of the right knee reveals Posttraumatic appearance of the left tibial plateau, possibly of mixed chronicity although the patient denies recent trauma. Lucent fracture lines are identified laterally and to a lesser extent medially. MRI is recommended to evaluate the acute component. Tricompartmental degeneration. Joint effusion. Chondrocalcinosis. Limited evaluation of soft tissues.

11/27/2018 - LE NCV/EMG acute bilateral L4-5 radiculopathy and peripheral neuropathy of bilateral lower extremities involving the superficial peroneal nerves..

8/17/2018 - CT Scan of the right femur: Degenerative change of the hip and knee. Vascular calcification.

12/23/2017 - MRI of the brain: Multiple nonspecific subcortical white matter FLAIR and T2 hyperintensities as noted.

8/17/2018 - CT Scan of the right tibia and fibula: Posttraumatic appearance of the tibial plateau and metaphysis of questionable chronicity..

6/4/2019 - MRI of the bilateral knees: Moderate degenerative changes in the right knee with a suprapatellar effusion and very mild in the left knee..

The above diagnostic studies were reviewed.

**Diagnosis:**

Cervical disc bulge at C2-3 through C7-T1.

Cervical Spondylitic foraminal stenosis from C2-3 through C7-T1..

Lumbar disc bulge at L1-2 through L5-S1.

Lumbar disc herniation at L1-2 extruded posterior left paracentral and foraminal. L3-4 and L4-5 superimposed broad-based posterior.

Lumbar L2-3 moderate central stenosis and bilateral foraminal stenosis. L4-5 moderately severe central canal stenosis in conjunction with facet hypertrophy. L5-S1 retrolisthesis, bilateral foraminal stenosis, minimal moderate central stenosis..

Cervical Muscle Sprain/Strain.

Possible Cervical Disc Herniation.

Possible Cervical Radiculopathy Vs. Plexopathy Vs. Entrapment Syndrome.

Cervicalgia (Neck pain): M54.2

Low back pain (Lumbago): M54.5

Sacroiliitis: M46.1

Bilateral knee sprain/strain.

Bilateral knee internal derangement.

**Plan:**

Administered right knee intraaricular injection today.

Discontinued oxycontin.

Continue with Percocet

Start Soma 250 mg b.i.d. for pain.

Administered right knee intraaricular injection today.

Discontinue oxycontin.

Continue with Percocet

Start Soma 250 mg bid

Administered right knee intraaricular injection today.

Discontinue oxycontin.

Continue with Percocet.

Start Soma 250 mg bid.

**Medications:**

Refills provided for:

Percocet 10/325 mg one tablet q6h prn pain dispense #120.

Discontinued oxycontin.

Added Soma 250 mg b.i.d. p.r.n. pain.

**Follow-up:** 4 weeks.



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