Redwood Hills Medical Center

987 Meadowbrook Way
Glendale, XY 12345
(333) 555-7890
contact@redwoodmed.org

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Ms. Ronny Reader
123 Address St
Anytown, ST 12345

This document presents a consolidated overview of recent clinical findings, radiological examinations, surgical interventions, and neurological assessments pertaining to several patients under the care of Redwood Hills Medical Center. Detailed summaries are provided below for reference and further review.

Imaging Report: Cervical Spine Evaluation

EXAM: CT of the cervical spine for trauma.

FINDINGS: CT imaging was performed without contrast, with coronal and sagittal reformats for optimal anatomical detail. Cervical vertebral body height, alignment, and interspacing are preserved. No fractures or destructive osseous lesions are identified. There are no significant degenerative endplate or facet changes, and no notable osseous central canal or foraminal narrowing.

IMPRESSION: Negative cervical spine.

Based on the imaging results, no immediate surgical or medical intervention was necessary specifically for cervical injury. Further evaluation was directed toward other existing orthopedic or neurological conditions. The following section addresses one such intervention regarding the right foot.

Surgical Summary: Right Foot Intervention

PREOPERATIVE DIAGNOSES:

- Painful enlargement of the navicula, right foot.
- Osteochondroma of the right fifth metatarsal.

POSTOPERATIVE DIAGNOSES:

- Painful enlargement of the navicula, right foot.
- Osteochondroma of the right fifth metatarsal.

PROCEDURE PERFORMED:

- Partial tarsectomy (navicula), right foot.
- Partial metatarsectomy, right foot.

A 41-year-old patient presented with significant pain over the navicular bone aggravated by shoe wear, along with a known history of hereditary osteochondromas. Previous dissections for similar bony growths had been performed in the past. The patient opted for surgical correction at this time.

After appropriate anesthesia and preparation, a curvilinear incision was made over the navicular region. Bony prominences were resected using an osteotome, mallet, and sagittal saw, with care taken to protect tendon attachments. The site was irrigated and closed in layers. A second incision addressed an osteochondroma on the dorsal and lateral aspects of the right fifth metatarsal; excision and closure were performed similarly. The patient tolerated the procedure well, was placed in a partial weight-bearing protocol, and instructed to follow up with the attending physician.

While orthopedic conditions such as osteochondromas and navicular pathology can require surgical management, certain pain syndromes involve more complex neurologic interventions. The next segment details a stellate ganglion procedure performed for Complex Regional Pain Syndrome.

Stellate Ganglion RFTC and Radiograph Findings

PREOPERATIVE DIAGNOSIS: Complex Regional Pain Syndrome Type I.

POSTOPERATIVE DIAGNOSIS: Same.

PROCEDURE:

- Stellate ganglion radiofrequency thermocoagulation (left side).
- Interpretation of radiograph.

ANESTHESIA: IV sedation with Versed and Fentanyl.

ESTIMATED BLOOD LOSS: None.

COMPLICATIONS: None.

The patient exhibited hallmark signs of reflex sympathetic dystrophy in the left upper extremity, including allodynia, skin discoloration, and swelling. Under fluoroscopic guidance, a 22-gauge SMK 5-mm bare-tipped needle was carefully advanced to the stellate ganglion region at approximately the C7 vertebral body. After confirming negative aspiration, a mixture of local anesthetic and corticosteroid was administered, followed by radiofrequency thermocoagulation at 80°C for 60 seconds. Repeat lesions ensured thorough neurolysis. The patient was placed upright post-procedure to limit cephalad spread of the anesthetic solution, and no adverse sequelae were noted.

Radiographs confirmed the needle tip's correct positioning near the stellate ganglion, with four lesions completed. A marked increase in cutaneous temperature of the affected side verified a successful blockade.

The management of pain and neurological issues often extends beyond targeted interventions; patients with complex neurosurgical histories also require ongoing monitoring. In the final section, we outline a case of spinal lesions with associated oncological findings and rehabilitation challenges.

Neurological and Oncological Case Overview

A 30-year-old right-handed patient presented with progressive cervical spine lesions and intramedullary/extramedullary nodules. Initial imaging revealed abnormalities at C2–3 and C6–7, leading to decompressive surgery and partial improvement. Over time, worsening symptoms included bilateral upper extremity weakness, ataxia, and hyperreflexia. Subsequent MRI revealed multiple enhancing nodules consistent with hemangioblastoma in the posterior fossa and along the spinal cord. Treatment included suboccipital craniotomy for tumor excision and decompression, followed by radiation therapy to the brain and cervical/thoracic cord.

As of late 1995, the patient reported significant proximal muscle weakness, dysphagia, and difficulty with fine motor tasks. By late 1996, additional findings included lower extremity numbness, urinary retention, and decubitus ulcers, attributed to a syrinx extending to T10 and multiple intradural extramedullary lesions along the spine. No new intervention was initiated at that time; instead, a palliative approach with visiting nursing was arranged. Ongoing care remains under the supervision of local physicians.

Sincerely,

Dr. Samantha E. Rivers
Chief Medical Officer, Redwood Hills Medical Center