SUMMIT SPINE & ORTHOPEDIC CENTER

2451 Medical Plaza Drive, Suite 300 | Portland, OR 97210

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PATIENT INFORMATION

Patient Name: Johnson, Margaret E.

Date of Birth: 03/15/1957

Age: 68 years

Gender: Female

MRN: 847392-MJ

Insurance: Medicare Part B (ID: 4892A73619A)

Date of Service: October 8, 2025

CHIEF COMPLAINT

Progressive lower back pain with bilateral leg pain and neurogenic claudication limiting ambulation to less than one block. Patient reports worsening symptoms over past 18 months despite conservative management.

HISTORY OF PRESENT ILLNESS

Ms. Johnson is a 68-year-old female presenting with chronic lumbar spinal stenosis. She describes constant dull aching in the lower lumbar region with radiation to both lower extremities, worse on the right side. Pain increases with standing and walking, partially relieved with forward flexion and sitting. She experiences numbness and tingling in bilateral L4-L5 distribution. Neurogenic claudication limits her walking distance to approximately 50-75 feet before requiring rest.

Conservative treatments over the past 14 months include:

- Physical therapy (3x/week for 12 weeks, completed 6/2024)
- NSAIDs (Naproxen 500mg BID - discontinued due to GI upset)
- Gabapentin 300mg TID (minimal relief)
- Epidural steroid injections (2 series: 3/2024 and 7/2024, temporary relief 4-6 weeks each)
- Home exercise program and activity modification

Despite adherence to conservative management, symptoms have progressively worsened affecting quality of life and functional status.

PAST MEDICAL HISTORY

- Hypertension (controlled on Lisinopril 10mg daily)
- Type 2 Diabetes Mellitus (HbA1c 6.8%, on Metformin 1000mg BID)
- Hypothyroidism (on Levothyroxine 75mcg daily)
- Osteoarthritis, bilateral knees

PHYSICAL EXAMINATION

Vital Signs: BP 132/78, HR 74, Temp 98.4°F, Wt 168 lbs, Ht 5'4"

General: Alert and oriented x3, appears uncomfortable when standing

Spine: Mild kyphotic posture, tenderness to palpation L3-S1, no step-off deformity, limited lumbar extension, forward flexion to 60 degrees

Neurological:

- Motor: 4+/5 strength bilateral ankle dorsiflexion, 5/5 elsewhere in lower extremities
- Sensory: Decreased light touch sensation in L5 distribution bilaterally
- Reflexes: Patellar 2+ bilaterally, Achilles 1+ bilaterally, negative Babinski
- Straight leg raise: Negative bilaterally
- Gait: Antalgic, narrow-based, requires walker for distances >50 feet

DIAGNOSTIC IMAGING

MRI Lumbar Spine without contrast (9/18/2025):

FINDINGS: Moderate to severe central canal stenosis at L4-L5 measuring 8mm AP diameter (normal >12mm). Marked ligamentum flavum hypertrophy bilaterally measuring 5-6mm thickness. Moderate bilateral foraminal narrowing. Disc desiccation and mild posterior disc bulging at L3-L4 and L4-L5. Facet joint hypertrophy and degenerative changes L3-L5. No evidence of spondylolisthesis. Conus medullaris terminates normally at L1-L2.

IMPRESSION: Severe lumbar spinal stenosis, worst at L4-L5 level with ligamentum flavum hypertrophy and facet arthropathy contributing to canal narrowing.

X-Ray Lumbar Spine, AP/Lateral (9/18/2025):

Degenerative disc disease L3-L5 with disc space narrowing. Facet joint arthropathy. No acute fracture or subluxation. Maintained vertebral body height.

FUNCTIONAL ASSESSMENT

Assessment Tool	Score	Interpretation
Oswestry Disability Index (ODI)	58%	Severe disability
Visual Analog Scale (VAS) - Back Pain	7/10	Severe pain
VAS - Leg Pain	8/10	Severe pain
Walking Distance	50-75 feet	Severely limited

CLINICAL TRIAL ENROLLMENT STATUS

Study Name: MOTION Study - Minimally Invasive Treatment for Spinal Stenosis

ClinicalTrials.gov ID: NCT04789234

Study Site: Summit Spine & Orthopedic Center (Site #17)

Principal Investigator: Dr. Robert Chen, MD

Enrollment Date: September 25, 2025

Study Arm: Intervention (PILD procedure)

IRB Approval: Western IRB #20240318, approved 3/15/2024

Informed Consent: Obtained and documented 9/25/2025

Device: mild® Percutaneous Image-Guided Lumbar Decompression System (FDA-cleared K182474)

PHYSICIAN ASSESSMENT AND RECOMMENDATION

Ms. Johnson presents with symptomatic lumbar spinal stenosis confirmed by clinical examination and MRI findings. Her symptoms significantly impair functional capacity and quality of life. She has undergone appropriate conservative management for over 14 months without sustained improvement.

The patient meets inclusion criteria and has been enrolled in the MOTION prospective longitudinal study investigating outcomes following PILD. All study requirements including informed consent, baseline assessments, and protocol adherence have been completed.

PLAN: Proceed with percutaneous image-guided lumbar decompression at L4-L5 level under fluoroscopic guidance as part of approved clinical research protocol. Procedure scheduled for 10/22/2025 at Summit Surgical Center. Follow-up assessments per study protocol at 6 weeks, 3 months, 6 months, and 12 months post-procedure.

PROVIDER INFORMATION

Attending Physician:	Robert Chen, MD
Specialty:	Interventional Spine & Pain Management
NPI:	1234567890
License:	OR-MD-47892
Date:	October 8, 2025

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Electronically signed by:

Dr. Robert Chen, MD

10/08/2025 14:32 PST