A Note to Patients: Symptoms are concisely summarized to inform treatment recommendations. For reasons of privacy and brevity, this note does not attempt to capture all experiences that were discussed.

Progress Notes

Igor Immerman at 3/4/2024 3:00 PM

Orthopaedic Hand and Upper Extremity Surgery New Patient Note

I had the pleasure of evaluating Norman Armour in the Orthopaedic Surgery Hand and Upper Extremity Clinic today.

Chief Complaint: R wrist pain

History of Present Illness: Norman Armour is a 77 y.o. year old RHD male who presents today for the first time to my clinic.

He has a history of right total hip arthroplasty on 8/10/2015. He has a history of of right hip osteoarthritis. He has received physical therapy in the past. He sustained a fall off a roof 1969 that caused bilateral lower extremity weakness and a traumatic left below-elbow amputation for which he uses a cane in the R hand.

He broke his left femur in 2022 and had surgery to fix it, which began to cause him to rely on the R hand and cane more. His pain is burning and aching in the wrist front and back. It has gotten worse with time and also worse within a walk (more walking -- more pain). Rest improves the pain, as does offloading the wrist. He does not have pain with pinch.

He feels numbness in his hand at night that feels to be more the back of the thumb to him. He has no palmar numbness and never any numbness/tingling when he walks with a cane. No neck, elbow pain.

He does not take pain medications. He has not had any treatment.

Duration of symptoms / DOI: 2 years

Ortho Sports Medicine Patient Answers

2/28/2024
12:45 PM

Ortho Sports Medicine	
What side are we seeing you for?	Right
What part of your body is injured?	Shoulder
Was there a specific injury?	Yes
If so, what happened?	I am a partial paraplegic with an amputated left hand - resulting from a fall off a roof in 1969. In November, 2022 I fell and broke my left femur. Ever since my ability to walk has been increasingly hampered. I now use a walker for longer walks. Without a walker or cane, I can hobble with baby steps. , I am seeking ways of improving walking with a cane. The issue is that I put much pressure on my right arm while

	walking with a cane. This is causing pain in my right shoulder and right wrist as I walk. When I am not walking there is no pain. Also, my right hand tends to fall asleep in bed at night., I am making good efforts to improve my walking: 4,000+ steps a day, 6 flights of stairs and regular PT. Nonetheless further improvements will take a very long time. In the meantime, I seek ways of preserving and ameliorating the condition of my remaining upper extremity.
On a scale of 0-10, how severe is your pain?	3
What treatments have you tried so far?	Physical Therapy
What makes the pain better?	Stopping using the cane
What makes the pain worse?	Walking more than, say, 50 feet with the cane.
What sports/activities do you participate in?	Daily:, 25 minutes exercise upon waking, 5 minutes exercise after afternoon nap, Over an hour of walking and climbing stairs, 5 minutes exercise before bed
What questions can we answer for you at your appointment?	While walking with a cane - but not forgetting all the other uses of my right arm, what might be some good ways to strengthen and protect my right arm?

Review of Systems:
Constitutional - Negative for fevers, chills
Musculoskeletal - Positive for upper extremity pain
Neurologic - Negative for sensory change and focal weakness

PMH:

Norman has a past medical history of Anal prolapse, Anemia (2016), Arthritis, Blood transfusion without reported diagnosis, Carpal tunnel syndrome, Cataract, Colon cancer (CMS code) (2016-12-17), Colon cancer (CMS code), Colon polyp, Esophageal dysmotility, Fecal incontinence (2015), Fractures, Gangrene (CMS code), GERD (gastroesophageal reflux disease), GI bleed, Hemiparesis, left (CMS code), Hemorrhoids (2016-12-17), Hiatal hernia (2016-12-16), History of alcoholism (CMS code), Neurogenic bladder, Open angle with borderline findings, high risk, Psoriasis, Seborrheic keratosis, Thoracic spinal cord injury (CMS code) (1969), Tinea pedis, and UTI (lower urinary tract infection) (2009).

He has no past medical history of Allergic state, Alteration of consciousness, Anal cancer (CMS code), Anal condyloma, Angina pectoris (CMS code), Anxiety, Arrhythmia, Asbestos exposure, Atrial fibrillation (CMS code), Autoimmune disease (CMS code), Bladder cancer (CMS code), Blood disorder, Bone cancer (CMS code), Brain cancer (CMS code), Breast cancer (CMS code), Cervical cancer (CMS code), Chest pain, Chronic bronchitis (CMS code), Cirrhosis (CMS code), Clotting disorder (CMS code), Constipation, COPD (chronic obstructive pulmonary disease) (CMS code), Crohn's disease (CMS code), Depression, Difficult intubation, Diverticulitis, Diverticulosis, Easy bruising, Esophageal cancer (CMS code), Fissure, anal, Fistula, anal, Heart murmur, Hepatitis, chronic (CMS code), History of motion sickness, Immune deficiency disorder (CMS code), Leukemia (CMS code), Local recurrence of rectal cancer (CMS code), Lung cancer (CMS code), Lung disease, Malignant hyperthermia, Malignant neoplasm of skin, Melanoma (CMS code), Meningitis, Metastasis to liver (CMS code), Metastasis to lung of unknown origin (CMS code),

Migraine headache, Morbid obesity (CMS code), Nonmelanoma skin cancer, Osteoporosis, Ovarian cancer (CMS code), Palpitations, Pancreatic cancer (CMS code), Pancreatitis, Peripheral vascular disease (CMS code), PONV (postoperative nausea and vomiting), Prostate cancer (CMS code), Psychiatric illness, Pulmonary embolus (CMS code), Rectal cancer (CMS code), Renal insufficiency, Sickle cell anemia (CMS code), Sinus disorder, Small intestine cancer (CMS code), Stomach cancer (CMS code), Stomach ulcer, Substance abuse (CMS code), Thyroid cancer (CMS code), Thyroid disease, Tuberculosis, Ulcer of skin (CMS code), Ulcerative colitis (CMS code), or Uterine cancer (CMS code).

PSH:
Norman has a past surgical history that includes Lumbar spine surgery; Arm amputation at elbow (Left, 1959); Femur fracture surgery; laminectomy; Spinal fusion; back surgery; Hip Arthroplasty (Right, 2015); joint replacement (2015); Tonsillectomy (1951); Bladder stone removal; Colon surgery (01/2017); and Inguinal hernia repair (06/14/2019).

Medications:

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• ascorbic acid, vitamin C, 500 mg CHEWTAB	Chew 500 mg by mouth 2 (two) times daily		
• cholecalciferol, vitamin D3, 1000 UNITS tablet	Take 1,000 Units by mouth daily		
• ciclopirox (PENLAC) 8 % topical solution	Apply topically nightly at bedtime to affected nails for fungal infection	6.6 mL	11
• clotrimazole (LOTRIMIN) 1 % cream	Apply 1 Application topically 2 (two) times daily		
• esomeprazole (NEXIUM) 40 mg capsule	TAKE 1 CAPSULE(40 MG) BY MOUTH DAILY	90 capsule	0
• ketoconazole (NIZORAL) 2 % shampoo	USE TO SCALP TWICE A WEEK	120 mL	5
• pantoprazole (PROTONIX) 20 mg tablet	Take 1 tablet (20 mg total) by mouth		
• triamcinolone (KENALOG) 0.1 % cream	Apply twice daily as needed for rash on body (never face/armpits/groin)	454 g	5

No current facility-administered medications for this visit.

Allergies:

Norman is allergic to esomeprazole magnesium.

FH:
His family history includes Alcohol abuse in his father; Cancer in his father; Colon polyps in his sister; GU problems in his maternal grandmother; Glaucoma in his sister and sister.

SH:

Norman reports that he quit smoking about 31 years ago. His smoking use included cigarettes. He started smoking about 8 years ago. He has a 40 pack-year smoking history.

He has never used smokeless tobacco. He reports current alcohol use of about 10.0 - 15.0 standard drinks of alcohol per week. He reports that he does not currently use drugs. The remainder of the patient's history was reviewed and is noncontributory to this illness or injury.

Occupation/Recreational Activities: walks for exercise for fun. Does elbow pushups as well. Self employed as a software engineer.

Tobacco/EtOH/Drug Use: quit 1993

Physical Exam:

There were no vitals filed for this visit.
Wt Readings from Last 3 Encounters:
10/26/23 81.6 kg (180 lb)
10/22/20 83.9 kg (185 lb)
07/31/20 83.9 kg (185 lb)

Estimated body mass index is 35.15 kg/m² as calculated from the following:
Height as of 10/26/23: 152.4 cm (5').
Weight as of 10/26/23: 81.6 kg (180 lb).
Estimated body surface area is 1.86 meters squared as calculated from the following:
Height as of 10/26/23: 152.4 cm (5').
Weight as of 10/26/23: 81.6 kg (180 lb).

MSK:
Right Upper Extremity:
Skin: Intact
Swelling/Efusion: None
Deformity: None
ROM: Full painless ROM of neck, shoulder, elbow, wrist. Full composite fist.
Tenderness: NTTP base of thumb CMC, TTP radiocarpal joint, NTTP snuffbox, DRUJ, fovea, or midcarpal joints
Vascular: less than 2s capillary refill in all digits
Sensation: SILT m/r/u
Strength: 5/5 APB, 5/5 FDIO, 5/5 EPL
Watson shift test negative
Positive extension/adduction test, neg CMC grind.
Mild pos Durkan at carpal tunnel
Neg Tinel carpal and cubital tunnels, neg flexion compression test
No pain along palpation of course of radial nerve at elbow
No pain / burning / tingling w/ resisted supination

Imaging:
I personally reviewed and interpreted the radiographs obtained.
Multiple views of the R forearm demonstrate abnormal carpus with degenerative changes, better evaluated on XR R hand and wrist.

XR R hand and wrist show moderate CMC degenerative changes of thumb, SLAC wrist.

NCS/EMG:
None

Labs / Path:
None

Outside Records:
I have reviewed the following outside notes and records:
None

Assessment:

1. R SLAC wrist
2. R Possible CTS

Plan:
The patient was educated extensively about their condition, including the pathology, etiology, natural history and treatment options. Non-operative measures as well as surgical interventions were both addressed. He voiced understanding, and all questions were answered.

I recommend initial treatment to include the following:

1. **SLAC wrist**: we discussed the management options in detail. Given his reliance on his R wrist for ambulation, we do not currently recommend surgical management with prolonged recovery. For initial management, we recommend wrist brace to stabilize him during cane use. We would then consider a cortisone injection. Should these fail, we would next consider AIN/PIN neurectomy to allow him to get back to hygiene and ADLs as soon as possible.
2. We have also referred him to O&P for the removable wrist brace and for evaluation for a new left arm prosthetic.
3. For the numbness in his dorsal hand at night we were unable to provoke any significant neurologic symptoms of carpal tunnel or cubital tunnel or neck arthritis on exam today. Plan to start w/ wrist brace at night.

Follow-up:
6 weeks without XRs

All of the patient's questions were answered and He agrees with this plan.

I, Rohan Bin Sarwar am acting as a scribe for services provided by Igor Immerman, MD on 02/29/24, 12:27 PM.
03/04/24

ATTESTATION:

My date of service is 3/4/2024. I was present for key portions of the visit, either virtually or physically, and am personally involved in the management of the patient. I reviewed, verified, and revised the note as necessary. The above scribed documentation as annotated by me accurately reflects the services I have provided.

Igor Immerman, MD
3/4/2024

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