Independent Medical Transcription, Inc.

"Detailed RR Summary" Sample Document

RECORD REVIEW:

I have reviewed the following records:

1. Friendly Falls Diagnostic Imaging
2. Neurological Associates of Marzipan City
3. Urgent Injury Care
4. Jellystone Medical Center
5. Fish City Chiropractic
6. Police Traffic Collision Report
7. Transcript of claimant's Deposition
8. Transcript of claimant's Recorded Statement

DEPOSITION:

August 1, 2021: Videoconference Deposition of Ian Lightfoot. This is a 98-page document which is read in its entirety. The reader is referred to the original document.

RECORDED STATEMENT:

February 19, 2020: Recorded Statement of Ian Lightfoot. This is a 64-page document which is read in its entirety. The reader is referred to the original document.

POLICE TRAFFIC COLLISION REPORT:

December 6, 2019: Unit one is a 2001 Chevrolet Impala, license plate ABC123, driven by Colt Bronco. Unit two is a 2012 Mitsubishi Outlander, license plate XYZ789, driven by Ian Lightfoot. Narrative:

> On 6 December 2019, I was working as uniformed patrol in the City of Camberwick. At approximately 2035 hours I was dispatched to a blocking collision at Heatherfield Ave S/S Bookworm St. Upon arrival, Unit 1 said that he was driving SE on Heatherfield Ave S when Unit 2 slammed on its breaks [*sic*]. Unit 1 said he rear-ended Unit 2. Unit 1 said his neck and back of head hurt but that he did not need emergency medical services. I did not observe any visible injuries. Unit 1 identified himself with driver's license #123456789 and also said that his insurance just expired. DOL inquiry revealed Unit 1 is DWLS/3rd. Unit 1 said that his son, passenger [*redacted*] was sitting in the back seat. [*Redacted*] was not on-scene upon arrival. Unit 1 said that [*redacted*] had to leave, but did not have any injuries.
>
> Unit 2 told me that he was driving SE on Heatherfield Ave S and stopped for traffic when he was rear-ended by Unit 1. Unit 2 identified himself with driver's license #987654321 and provided valid insurance for the listed vehicle. Unit 2 also declined emergency medical service but reported that his neck and back were soar [*sic*]. I did not observe any visible injuries to Unit 2. I observed Unit 1 to have significant front-end vehicle damage as well as a deployed air bag. I observed Unit 2 to have minor rear-end vehicle damage. Unit 2 was drivable.

MEDICAL RECORDS:

February 15, 2016: Brock Pearson, MD, Townsville Emergency Department. Chief Complaint: chest pain. Mr. Lightfoot is a 61-year-old male with a history of diabetes mellitus and hypertension. Remote history of smoking but quit 16 years ago. Now with one day of intermittent chest pain. Woke him up this morning, sternal, dull. Episodes last 5 to 15 minutes. No other symptoms. Has had this five times this morning. No history of coronary artery disease. No prior stress test. Past medical history of muscle weakness and unspecified visual loss. Past surgical history of gallstone removal, gallbladder removal, L5 fusion. Former smoker; quit on October 3, 1998. One glass of wine and one beer per week.

Physical examination appears completely normal. Heart with regular rate and rhythm. Alert and oriented times three. Normal strength and sensation. Cranial nerves intact. Lungs clear. No chest wall tenderness.

Electrocardiogram showed rate 64 with normal sinus rhythm; normal axis; normal PR, QRS, and QT intervals; no atrial or ventricular hypertrophy; nonspecific ST-T changes. Otherwise normal 12-lead electrocardiogram. Unchanged from last electrocardiogram.

Chest x-ray showed no acute disease in the chest.

Assessment: chest pain. Disposition: Patient will be admitted to the hospital.

February 15, 2016: Carrie Williams, MD, Jellystone Heart and Vascular. History and Physical: 61-year-old male with no known cardiac history, presenting with new-onset chest pain described as an ache, began this morning, woke him from sleep. Pain waxed and waned for one hour,

lasting a few minutes each episode. There were no aggravating or alleviating factors noted. The pain subsided on his way to the emergency department. He has otherwise been in good health. In the last few weeks, he has not felt well but cannot explain specific symptoms. He has chronic back pain, status post L4-5 fusion. No history of hypertension, dyslipidemia, or diabetes. No history of coronary artery disease, although states he had a cardiac catheterization here 10 years ago.

Physical Examination: neck supple without masses. Chest wall nontender. Heart with normal S1 and S2 with regular rate and rhythm. Radial and pedal pulses 2+ bilaterally. No calf tenderness. Cranial nerves intact. Examination is unremarkable.

Assessment/Plan:

1. Chest pain. Rather atypical but still concerning for angina. Electrocardiogram is without changes from previous in 2015, and initial enzymes are negative. He is pain free presently. Admit for observation. Serial cardiac enzymes and electrocardiograms today.
2. Elevated creatinine. No known history of chronic kidney disease, although his creatinine was up slightly at 1.4 in 2013.
3. Lumbar disc disease, status post fusion. No daily pain medications. Usually takes as-needed nonsteroidal anti-inflammatory medications. Given renal dysfunction, will avoid nonsteroidal anti-inflammatory medications and order as-needed acetaminophen.

February 15, 2016: Chest x-ray, one view, read by Ellie Fredricksen, MD, for history of chest pain. Comparison to October 3, 2013. Impression: no acute disease in the chest.

February 15, 2016: Treadmill stress echocardiogram, performed by Debbie Gabler, MD. Summary:

1. Trace mitral regurgitation.
2. Normal pulmonary artery systolic pressure estimated at 29 millimeters of mercury.
3. Trace tricuspid regurgitation.
4. Normal resting echocardiogram.
5. Normal stress echocardiogram without evidence for ischemia.

February 16, 2016: Robert Parr, PA-C, Jellystone Heart and Vascular. Discharge Summary. Discharge Diagnoses:

1. Chest pain – likely noncardiac based on normal stress echocardiogram completed this admission. Cardiac enzymes were normal and electrocardiograms without dynamic change. Consider gastrointestinal etiology.
2. Dyslipidemia – low-density lipoprotein 180 this admission. He does not have a primary care physician. Discussed lifestyle modification, and statin therapy can be considered. He will establish with a primary care physician to review treatment options.

Stress echocardiogram on February 15, 2018, is reported to have shown trace mitral and tricuspid regurgitation.

Hospital Course: Patient is a 61-year-old male with no past cardiac history who presented to Jellystone having experienced resting chest pain that woke him from sleep. He was admitted for observation. Electrocardiogram was unchanged, cardiac enzymes were negative times two, and stress testing was negative for ischemia. He remained free of chest symptoms while admitted. His lipid profile was abnormal and warrants follow-up with a primary care physician. Disposition: home with spouse.

April 9, 2016: Francesco Bernoulli, MD, Splittsboro Emergency Department. Chief Complaint: abdominal pain. Mr. Lightfoot is a 61-year-old male with greater than one week of epigastric pain, history of same, likely due to gastritis or peptic ulcer disease. He has mild epigastric tenderness to palpation without periumbilical or lower abdominal tenderness to palpation. Electrocardiogram is unchanged from previous. Labs stable. Chronic kidney disease. Guaiac is negative. Symptoms resolved after intravenous fluids, Zofran, and Protonix. Physical examination unremarkable. At this time, there is no evidence of an emergency condition warranting further intervention, though close follow-up with Gastroenterology and primary care physician necessary and emphasized. He will continue prescribed omeprazole. Final Diagnosis: epigastric pain.

April 12, 2016: Hector Rivera, MD, Splittsboro Emergency Department. Chief Complaint: abdominal pain. Mr. Lightfoot is a 61-year-old male presenting with abdominal pain. This is a sharp epigastric pain that is worse at night. He was here yesterday for similar symptoms. Workup with serum studies was negative, and he improved with gastrointestinal medications and was discharged home. Tonight, he had further symptoms and presents for care. No fevers. Nauseous but no vomiting. Has been taking Pepcid which he got from his primary care doctor three days ago.

Labs obtained. White blood count within normal limits. Creatinine is 1.49, which is chronic for him. Complete metabolic panel and rest of complete blood count unremarkable. Lipase within normal limits. Still having pain despite gastrointestinal cocktail and Pepcid intravenously. Sent for CT imaging.

Work-up here without acute findings, imaging is reassuring, and his examination does not raise suspicion for intra-abdominal catastrophe. Suspect this is all related to gastroesophageal reflux disease. He will continue Pepcid. Prescribed a small amount of Vicodin. He is to follow up with his primary physician. Patient is stable for discharge.

April 12, 2016: CT abdomen and pelvis with contrast, read by Finn McMissile, MD. Comparison to October 3, 2013. Stable posterior L5-S1 fusion is noted. No acute osseous abnormality. Impression: mild postcholecystectomy biliary ductal dilatation is probably a normal variant. Correlation with bilirubin recommended. Otherwise negative CT of the abdomen and pelvis.

April 13, 2016: Randall Boggs, MD, Splittsboro Emergency Department. Chief Complaint: abdominal pain. Mr. Lightfoot is a 61-year-old male who complains of epigastric abdominal pain for over a week. The patient was first seen at DPS Central for about a week of epigastric pain. The patient was then seen two days later at the Splittsboro Emergency Department, where he had normal labs and stable creatinine, and symptoms resolved with intravenous fluids, Zofran, and Protonix. The patient was again seen the next day at Splittsboro Emergency Department with normal labs and a CT of the abdomen/pelvis that showed mild postcholecystectomy biliary ductal dilatation. The patient was felt to have abdominal pain secondary to gastroesophageal reflux disease and was to continue his proton pump inhibitor. He was seen yesterday at DPS Central and told to increase omeprazole to 20 mg twice daily.

The patient notes that he has had near-continuous epigastric discomfort for the past one to two days, formerly primarily after eating. He has nausea without vomiting. Not having fevers, shaking, or chills. He is status post laparoscopic cholecystectomy.

Physical Examination: abdomen soft, nontender, except midepigastric area. Bowel sounds normal. No masses or organomegaly. Neurologic examination unremarkable.

Assessment and Disposition: Patient presents with progressive abdominal pain for a two-week period and today has an elevation of liver function tests and additionally lipase and amylase. Ultrasound is consistent with a distally impacted common duct stone. Discussed the patient with gastroenterologist on call, Dr. Darla Sherman, who agreed with admission and endoscopic retrograde cholangiopancreatography.

April 13, 2016: Miles Axlerod, MD. History and Physical Mr. Lightfoot is a generally well 61-year-old male, status post uncomplicated laparoscopic cholecystectomy in 2003, who presents for epigastric pain that has progressively worsened over the past month, acutely worse this morning. Today he woke up at 6:00 a.m. with severe pain that did not improve with Norco times two. History of epigastric/chest pain since February is reviewed. He notes the pain is worse with eating but progressively has been less food dependent. Review of systems positive for nausea, abdominal pain, and increased salivation.

Physical Examination: abdomen soft, nondistended, mildly tender in epigastric region, no rebound tenderness or guarding, positive bowel sounds, no obvious organomegaly or masses. Remainder of examination is unremarkable.

Labs and imaging are reviewed.

Assessment and Plan: 61-year-old male with worsening abdominal pain this morning and a third emergency department presentation in the past week, found to have 12-millimeter common bile duct dilation and mildly elevated liver enzymes. Gastroenterology to take him for endoscopic retrograde cholangiopancreatography tomorrow.

April 13, 2016: Chest x-ray, one view, read by Evelyn Deavor, MD, for history of abdomen and flank pain. Comparison to similar study of February 15, 2016. Impression: unremarkable chest for age and body size, stable. No acute cardiopulmonary process or demonstrated cause for the patient's symptoms.

April 13, 2016: Limited right upper quadrant abdominal ultrasound, read by Don Carlton, MD. Impression: stable 12-millimeter dilatation of common bile duct since CT prior day. Mild intrahepatic biliary ductal dilatation on both examinations. These changes are somewhat more pronounced than expected for prior cholecystectomy. Consider abdominal MRI with magnetic resonance cholangiopancreatography versus endoscopic retrograde cholangiopancreatography to exclude distal common bile duct stone or obstructing ampullary lesion.

April 15, 2016: Darla Sherman, MD. Operative Report. Postoperative diagnosis: bile duct obstruction, status post sphincterotomy and dual stent placement. Procedure: endoscopic retrograde cholangiopancreatography with sphincterotomy and stent placement.

April 15, 2016: Darla Sherman, MD. Gastrointestinal Postprocedure Note/Discharge Note. Preoperative and postoperative diagnoses: abdominal pain, pancreatitis. Primary procedure: endoscopic retrograde cholangiopancreatography. Findings: dilated common bile duct. Double stents placed. Findings: The esophagus, stomach, and duodenum appeared normal. The pancreas appears normal, and common bile duct appears dilated but without evidence of choledocholithiasis. There is evidence of previous cholecystectomy. Impression: likely sphincter of Oddi dysfunction versus ampullary stenosis and possible reflux of bile into the pancreatic duct causing pancreatitis, status post sphincterotomy and dual stent placement. Plan: anticipate removal of stents with simple upper endoscopy in two to three weeks.

April 16, 2016: Karen Graves, MD. Family Medicine Team Discharge Summary. Admission date: April 13, 2016. Discharge date: April 16, 2016. Principal diagnosis: biliary dilation/pancreatitis. Mr. Lightfoot is a 61-year-old man with chronic kidney disease who presented with progressively worsening abdominal pain, found to have 12-millimeter common bile duct dilatation and mildly elevated liver enzymes. Pain improved status post double stenting for pancreatitis that was performed on April 15, 2016. Thought to be secondary to common bile duct dilatation. Required oral and intravenous opiate pain medications, which have contributed to his constipation. Condition on discharge is improved.

May 2, 2016: Darla Sherman, MD. Endoscopy Procedure Note. Primary Procedure: upper endoscopy. Indication: removal of foreign body. Impression: successful stent removal.

February 3, 2018: Mike Wazowski, MD, Splittsboro Emergency Department. Chief Complaint: dizziness, resolved; visual problems, blurry both eyes, now resolved; extremity weakness, bilateral, now resolved. Mr. Lightfoot is a 64-year-old male with past medical history of hypertension, hyperlipidemia, and chronic kidney disease who presents to the emergency department with complaints of dizziness. Patient reports that he had two episodes of dizziness earlier today and one since arriving here in the emergency room. He reports that he has had a lot of stress today because he was attending the funeral of a family member earlier this morning. He reports the first episode occurred as he was leaving the church. He began to feel foggy in his thinking, heavy-headed, and dizzy. He reports that he felt his vision started to go black, and he felt that he was going to faint. Symptoms improved after several minutes. He said he never lost consciousness but felt dizzy for several minutes. Had a third episode after arriving in the emergency room while on the monitor. Denies chest pain or shortness of breath. No syncope. Denies melena or hematochezia. No recent nausea or vomiting. Denies history of cardiac disease. Review of systems positive only for dizziness.

Initial Evaluation: Physical examination unremarkable, with regular rate and rhythm, clear lungs, and normal neurologic examination. Differential diagnoses include arrhythmia, anemia, hypovolemia/dehydration, orthostatic or vasovagal episode, acute stress reaction. Low suspicion for valvular disease.

Emergency Department Course/Medical Decision Making: Mr. Lightfoot presented to the emergency department with complaints of dizziness. Physical examination unremarkable. Labs notable for stable chronic kidney disease, otherwise unremarkable. Electrocardiogram with sinus rhythm, no changes from prior. Highly doubt pulmonary embolism given no reports of dyspnea or tachypnea. Very low suspicion for acute coronary syndrome. Cardiac monitor reviewed and no evidence of events while patient here despite having a symptomatic episode while on telemetry. Chart review suggests the patient had a prior stress echocardiogram in the recent past, with no evidence of cardiomyopathy or significant valvular disease. Patient reports feeling better after intravenous fluids. Ambulated to the bathroom with a steady gait and no feelings of dizziness or lightheadedness. Patient discharged home with plan for primary medical doctor follow-up.

Impression: presyncope. Plan: supportive care, close primary medical doctor follow-up, return for worsening symptoms.

December 6, 2019: On intake paperwork for Fish City Chiropractic, on a Car Accident Information Form, the accident is described as: "I was driving on the inside road, the car behind strucked [*sic*] to my car." Mr. Lightfoot was driving a 2012 Mitsubishi Outlander, wearing lap and shoulder belt. Airbags did not deploy. He was traveling at 25 to 30 miles per hour, struck by another car from

the rear, unknown at what speed. The impact came as a complete surprise. Mr. Lightfoot's head and neck were straight forward prior to impact. His left hand hit the door, and he was disoriented. He did not receive medical attention at the scene and did not go to the hospital. Police came to the accident site, and a police report was filed.

Pain diagram shows head pain rated 8/10 occurring 51 to 75 percent of the time; left shoulder pain 7/10 occurring 51 to 75 percent of the time; neck pain rated 7/10 occurring 76 to 100 percent of the time; bilateral elbow pain rated 7/10 occurring 76 to 100 percent of the time; bilateral upper lumbar pain rated 7/10 occurring 76 to 100 percent of the time; and left hand pins and needles rated 5/10 occurring 26 to 50 percent of the time.

December 7, 2019: Rod Redline, DC, Fish City Chiropractic. He was the belted driver of a vehicle involved in a motor-vehicle-versus-motor-vehicle collision yesterday on December 6, 2019. He claimed he was driving on Heatherfield Avenue when another vehicle suddenly rear-ended his vehicle. He was not aware of the collision, and he hit his left hand on the left door. The police came to the scene, and a report was filed.

Since the collision, he developed immediate pain in his neck, left shoulder/elbow, and mid/low back region. He also complained of frontal headache and numbness in left arm/hand since the collision; achy, tender, and straining pain which is fairly constant. Pain increases with active/ passive range of motion of neck/low back/left shoulder. Pain increases with extended periods of standing/walking.

Surgeries: gallbladder removal about 10 years ago, L5 disc in 1995. No fracture before. Taking medication for hypertension and high cholesterol. No major accident/injury before. Works as a general contractor.

Physical Examination: deep tendon reflexes 2/5 in bilateral upper and lower extremities. Upper and lower extremity strength 5/5 bilaterally. Kemp test positive on the left, with localized moderate pain on the left. Apley scratch test positive for the left shoulder.

Cervical range of motion: flexion 38 degrees, extension 50 degrees, lateral flexion right 40 degrees and left 37 degrees, rotation right 72 degrees and left 70 degrees. Lateral flexion/cervical compression test positive on the left, negative on the right. Maximum cervical compression test positive bilaterally. O'Donoghue test positive bilaterally. Shoulder depression test positive on the left, negative on the right.

Lumbosacral range of motion: flexion 36 degrees, extension 18 degrees, lateral flexion right 13 degrees and left 16 degrees, rotation right 33 degrees and left 38 degrees.

Shoulder range of motion: abduction 180 degrees right and 172 degrees left, adduction 45 degrees bilaterally, flexion 90 degrees right and 83 degrees left, extension 45 degrees bilaterally, internal rotation 55 degrees bilaterally, external rotation 45 degrees bilaterally.

Straight leg raise positive on the left, negative on the right. Goldthwaite test positive on the left, negative on the right. Patrick test positive bilaterally.

Subluxation, muscle spasm/tenderness, and vertebral tenderness noted C3 to C7 bilaterally, T8 to T11 bilaterally, and L3 to the sacrum bilaterally. Muscle spasm/tenderness to palpation noted in levator scapulae; trapezius; supraspinatus; cervical, thoracic, and lumbar paraspinal muscles; gluteus; and hip abductors.

Assessment Information: motor vehicle accident. No preexisting conditions, this injury only. The likelihood of some symptomatic relief within four to five weeks is high.

Diagnoses:
1. Cervical sprain/strain.
2. Thoracic sprain/strain.
3. Lumbar sprain/strain.
4. Shoulder sprain/strain.
5. Sacrum sprain.
6. Elbow sprain/strain.
7. Neck pain.
8. Thoracic pain.
9. Lumbar pain.
10. Shoulder pain.
11. Muscle spasm.
12. Cervical subluxation.
13. Thoracic subluxation.
14. Lumbar subluxation.
15. Sacrum subluxation.
16. Tension headache.

Today, patient reports having pain in neck, upper/midback, lower back, headache, shoulder region, and elbow. It is Dr. Redline's opinion on a more-probable-than-not basis that this patient suffers injuries as a result of a motor vehicle collision.

Plan is cervical and lumbar x-rays. Schedule chiropractic treatment three times per week for four weeks. Refer for massage therapy one time per week for four weeks.

Approximately 32 chiropractic visits are recorded through April 2, 2020.

December 17, 2019: Smitty Needleman, LMP, Fish City Chiropractic. Pain level 7/10 in back, hips, and neck. Pain is constant, moderate to severe intensity. Therapist Note: careful with screws in lumbar spine to sacrum in midline of spine. Eleven massage therapy visits are recorded through February 21, 2020.

January 12, 2019: Rod Redline, DC. Reevaluation. Neck pain 7/10, shoulder pain 5/10, upper/midback pain 3/10, lower back pain 7/10.

Physical Examination: Cervical range of motion: flexion 43 degrees with pain, extension 56 degrees with pain, right lateral flexion 45 degrees, left lateral flexion 42 degrees with pain, right rotation 80 degrees, left rotation 80 degrees with pain.

Dorsolumbar range of motion: flexion 45 degrees with pain, extension 21 degrees with pain, right lateral flexion 20 degrees with pain, left lateral flexion 22 degrees with pain, right rotation 42 degrees with pain, left rotation 45 degrees with pain.

Shoulder range of motion: abduction 180 degrees bilaterally with left pain, adduction 45 degrees bilaterally, flexion 90 degrees bilaterally with left pain, extension 45 degrees bilaterally, internal rotation 55 degrees bilaterally, external rotation 45 degrees bilaterally.

Tenderness noted at C5, C6, C7, T10, T12, L3, L4, L5, and sacrum. Straight leg raising positive on the left. Patrick test positive bilaterally. Cervical spine compression positive on the left. O'Donoghue test positive bilaterally. Shoulder depression positive on the left. Kemp positive on the left. Deep tendon reflexes 2+ in upper and lower extremities bilaterally.

Comments: Patient showed slight improvement. Range of motion of cervical and lumbar spine and left shoulder has increased. He claimed moderate pain in his neck, left shoulder/elbow, and low back and mild pain in his midback region. No headache reported today.

Assessment: Since last evaluation, patient has improved slightly. Plan: Schedule chiropractic two times per week for five weeks. Refer for massage therapy one time per week for five weeks.

February 28, 2020: Rod Redline, DC. Reevaluation. Neck pain 5/10, shoulder pain 3/10, upper/midback pain 0/10, lower back pain 7/10.

Physical Examination: Tenderness noted at C6, C7, L3, L4, L5, sacrum.

Cervical range of motion: flexion 50 degrees with pain, extension 60 degrees with pain, right lateral flexion 45 degrees, left lateral flexion 45 degrees with pain, right and left rotation 80 degrees.

Dorsolumbar range of motion: flexion 48 degrees with pain, extension 22 degrees with pain, right lateral flexion 25 degrees with pain, left lateral flexion 25 degrees with pain, rotation 45 degrees, left rotation 45 degrees with pain.

Shoulder range of motion: abduction 180 degrees bilaterally, adduction 45 degrees bilaterally, flexion 90 degrees bilaterally, extension 45 degrees bilaterally, internal rotation 55 degrees bilaterally, external rotation 45 degrees bilaterally.

Straight leg raise positive on left. O'Donoghue positive bilaterally. Kemp positive on left. Deep tendon reflexes 2+ bilaterally in upper and lower extremities.

Comments: Midback pain and left elbow pain had resolved, but he still claimed mild left shoulder pain, mild to moderate neck pain, and moderate low back pain.

Assessment: Since last evaluation, patient has improved slightly. Plan: schedule chiropractic treatment one to two times per week for four weeks. Refer for massage therapy one time per week for four weeks.

March 13, 2020: MRI of cervical spine without contrast, read by Jackson Storm, MD. History: neck pain, left upper extremity pain and paresthesias, motor vehicle accident. Comparison not noted. Findings: no vertebral compression or destructive lesion. No prevertebral or ligamentous edema. Visible posterior fossa, craniocervical junction, and C1-2 level are unremarkable. No spinal cord signal abnormality, atrophy, or expansion. Diffuse cervical mild/moderate disc degeneration, greatest at C5-6. Trace edematous (type 1) discogenic endplate marrow degeneration at C5-6. Grade 1 (2 millimeters) degenerative anterolisthesis at C7-T1. Otherwise normal alignment. By level:

- C2-3: No disc herniation or spinal stenosis.
- C3-4: Shallow (2 to 3 millimeters anteroposterior) central protrusion causes mild central stenosis and trace spinal cord flattening. Minimum anteroposterior midline space

available for the cord measures approximately 9 millimeters. Small uncovertebral osteophytes cause mild bilateral neural foraminal stenosis.

- C4-5: Shallow (2 to 3 millimeters anteroposterior) right central protrusion causes mild central stenosis and trace right hemicord flattening. Minimum anteroposterior midline space available for the cord measures approximately 9 millimeters. Small uncovertebral osteophytes cause mild bilateral neural foraminal stenosis.
- C5-6: Diffuse disc osteophyte complex causes mild central stenosis and trace spinal cord flattening. Minimum anteroposterior midline space available for the cord measures approximately 9 millimeters. Uncovertebral osteophytes cause marked bilateral neural foraminal stenosis and exiting C6 nerve root encroachment.
- C6-7: Shallow (2 to 3 millimeters anteroposterior) right central protrusion causes mild central stenosis but does not contact the spinal cord. Minimum anteroposterior midline space available for the cord measures approximately 9.5 millimeters.
- C7-T1: Disc bulge causes mild central stenosis and abuts the spinal cord. Minimum anteroposterior midline space available for the cord measures approximately 9.5 millimeters. Marked left/moderate right facet joint arthrosis causes moderate left/mild right neural foraminal stenosis and exiting left C8 nerve root encroachment.

Impression:

1. C5-6 uncovertebral osteophytes cause marked bilateral neural foraminal stenosis and exiting C6 nerve root encroachment.
2. C7-T1 marked left facet joint arthrosis causes moderate left neural foraminal stenosis and exiting left C8 nerve root encroachment.
3. Mild neural foraminal stenosis at bilateral C3-4 and C4-5 and right C7-T1.
4. Mild central stenosis at C3-4 through C7-T1. Resulting trace spinal cord flattening at C3-4 through C5-6.
5. Grade 1 (2 millimeters) degenerative anterolisthesis at C7-T1.

April 2, 2020: Rod Redline, DC. Final visit. Neck pain 4/10, shoulder pain 2/10, upper/midback pain 0/10, low back pain 8/10. Tenderness noted at C7, L4, L5, and sacrum.

Cervical range of motion is normal, with pain on flexion and extension. Dorsolumbar range of motion: flexion 45 degrees with pain, extension 22 degrees with pain. Right and left flexion and right and left rotation are normal without pain. Shoulder range of motion is normal throughout.

Straight leg raising positive on the left. O'Donoghue positive bilaterally. Kemp positive bilaterally. Deep tendon reflexes 2+ bilateral upper and lower extremities.

Comments: Patient showed slight improvement in his neck and left shoulder, but he claimed aggravating pain in his low back yesterday.

Assessment: Since the last evaluation, patient has improved slightly in neck and left shoulder, became worse in low back.

Plan: He claims he is going to see the specialist for low back referral by his family doctor next Monday. He was given McKenzie exercise for his neck and low back disc condition.

April 3, 2020: Lanky Schmidt, MD, Jellystone Medical Center. Emergency Department Note. Chief Complaint: vomiting. A 65-year-old male with history of hypertension, hyperlipidemia, chronic renal insufficiency, and cholecystectomy, presenting with abdominal pain, nausea, and

vomiting. The patient reports feeling mild midepigastric abdominal pain beginning yesterday, which persisted but was not bothering him too much. Also had similar mild episodes of pain off and on over the past two weeks. However, the pain significantly worsened this evening at about 7:00 p.m. About 30 minutes prior to arrival, he also developed nausea and had several episodes of nonbilious, nonbloody vomiting. Denies chest pain, shortness of breath, dizziness, light-headedness, fevers, or chills. Urination and bowel movements have been normal. No recent gastrointestinal surgeries or invasive procedures.

Physical Examination: mild bradycardia with mild sinus dysrhythmia. Pulses intact and symmetrical. Abdomen with moderate midepigastric tenderness to palpation, mild bilateral upper quadrant tenderness to palpation. No significant lower abdominal tenderness to palpation. No obvious pulsatile mass. Bowel sounds present. Mild voluntary guarding but no rigidity. Moving all extremities equally, with full range of motion. No focal neurologic deficits.

Labs and chest CT angiogram results are reviewed.

Emergency Department Course/Medical Decision Making: Vital signs noted initially for bradycardia, also transiently hypotensive but with normal mean arterial pressure. The patient had marked upper abdominal tenderness. With concomitant bradycardia, elected to obtain CT angiography of the chest, abdomen, and pelvis to exclude acute aortic pathology. No evidence of acute vascular pathology. CT did note new moderate pneumobilia in the intrahepatic and extrahepatic bile ducts of uncertain etiology. The patient had ongoing common bile duct dilation of 1 centimeter, decreased from prior studies. Discussed significance of this finding with on-call gastroenterologist. The patient's bradycardia resolved after his pain and nausea were controlled. Electrocardiogram showed sinus bradycardia without evidence of block. He had no anginal chest pain, and troponin was negative. Suspect this could be related to his pain and nausea, perhaps from parasympathetic activation. On review of records, this was also noted during his prior hospitalization in 2016. Did not feel further management of this was indicated at this time but will continue to monitor with telemetry.

Patient admitted to the hospital for further evaluation and care. Per Gastroenterology, no immediate surgical plans or indication for antibiotics.

Impression:

1. Abdominal pain with nausea, vomiting.
2. Moderate intrahepatic and extrahepatic pneumobilia, uncertain etiology.
3. Chronic common bile duct dilation.
4. Asymptomatic sinus bradycardia.
5. Incidental right middle lobe opacification.

Plan:

1. Transfer and admit to Townsville Family Medicine Team, medical bed with telemetry.
2. Gastroenterology consultation; patient able to eat/drink, no immediate surgical plans or other recommendations at this time.
3. Supportive care.

April 4, 2020: Heather Olson, MD. Jellystone Gastroenterology Consult Note. He is a 65-year-old male seen for further evaluation and management of a two-week history of intermittent upper abdominal pain. States pain lasts an hour or so and then resolves without intervention and is asymptomatic between episodes. Pain became severe yesterday, with subsequent emergency department evaluation. Also had an episode of vomiting yesterday but none since and is pain

free at this time. States his urine has been intermittently dark in the last few weeks. He is post cholecystectomy in 2002 and had endoscopic retrograde cholangiopancreatography in 2016 for pancreatitis with subsequent stent placement and removal. He is constipated and passed small hard stool yesterday. Last colonoscopy in 2016 with polyps, one of which was a tubular adenoma.

Physical Examination: abdomen with normoactive bowel sounds, soft, nontender, nondistended. Remainder of physical examination unremarkable.

Labs and imaging reviewed.

Assessment: 65-year-old male post cholecystectomy in 2002, with two weeks of intermittent abdominal pain with elevated liver function tests, normal bilirubin, and pneumobilia noted on CT; asymptomatic at this time. Possibly passing sludge or small stones over the last few weeks. Constipation likely adding to discomfort. Personal history of adenomatous colon polyps.

Plan/Recommendation: Reviewed with Dr. Gunderson, who does not feel the pneumobilia on CT is a new finding given prior endoscopic retrograde cholangiopancreatography in 2016. The patient is scheduled for endoscopic retrograde cholangiopancreatography April 5.

April 3, 2020: CT angiogram of chest and abdomen, read by Omar Harris, MD. Clinical History: severe midepigastric abdominal pain, nausea and vomiting, bradycardia. No comparison. Lumbosacral hardware noted. No acute bone findings. Impression:

1. No aortic aneurysm or dissection.
2. New moderate pneumobilia in the intrahepatic and extrahepatic bile ducts. The common bile duct is mildly dilated at 1 centimeter, decreased from the prior, tapers distally.
3. Normal appendix. A few descending colon diverticula. No acute bowel findings are seen.
4. Right middle lobe irregular-shaped opacification measuring 1.9 centimeters. This could represent a malignant pulmonary nodule versus infectious/inflammatory process. Further workup is recommended. A positron emission tomography (PET) CT scan could further evaluate.

April 5, 2020: Gary Grappling, MD. Procedure Type: endoscopic retrograde cholangiopancreatography and endoscopic ultrasound. Impression:

1. Biliary obstruction is secondary to choledocholithiasis in the setting of re-stenosed papilla.
2. Successful removal.
3. Abdominal colic and resolution of pain due to ball-valving stones.

Recommendation to avoid aspirin and nonsteroidal anti-inflammatory medicines for seven days. He is returned to hospital ward for ongoing care. Okay to discharge from a gastrointestinal perspective if he is asymptomatic and able to tolerate diet.

April 5, 2020: Tony Trihull, MD. Discharge Summary. Principal Diagnosis: epigastric pain. Secondary diagnoses: Active Hospital Problems: biliary sludge, dilated bile duct, status post cholecystectomy, abnormal liver function tests, epigastric pain, calculus of bile duct without cholecystitis with obstruction, ampullary stenosis. Patient reports that he has had mild episodic epigastric pain over the past couple weeks that would last 30 minutes to 1 hour and then go away for one to two days. Did not seem to be associated with food intake. Had mild improvement with Tums. The pain suddenly became very severe April 3, and he experienced nausea and nonbloody, nonbilious vomiting prior to presenting to emergency department. Has had some constipation; last bowel movement April 3.

Endoscopic retrograde cholangiopancreatography with biliary obstruction secondary to choledocholithiasis in the setting of re-stenosed papilla; successfully removed 9-millimeter stone. He is to avoid aspirin and to not take nonsteroidal anti-inflammatory medications for seven days. Follow up with primary care physician in one week. Discharged to home.

April 9, 2020: New Patient Form at Urgent Injury Care. Main Concerns: neck and back pain. Started after a car accident. It is worse. The current episode of back pain occurs with lifting, twisting, pushing, and bending. Has numbness in the left hand and leg every few days, worse with walking. Tingling in the left hand. Has pain at night; getting three to four hours of sleep. No symptoms prior to motor vehicle accident. Standing, walking, bending forward and backward, coughing/sneezing, and chiropractic make the pain worse. Back pain rated 7/10 to 8/10. Has seen chiropractic at Fish City and primary care physician for the condition and has had x-rays and an MRI. During the past year has had stomach pain, problems with sexual function, and urinary incontinence.

On a Patient Function Survey, worst low back/leg symptoms in the last 24 hours were 8/10, worst neck/arm/upper back symptoms were 4/10. Personal care requires slow, concise movements due to increased symptoms. Symptoms greatly disturb sleep. Mr. Lightfoot can do most of his usual work but no more. He can lift only very light weights and can hardly do any recreational activities because of increased symptoms.

Mr. Lightfoot was the driver of a four-door sport utility vehicle. The other vehicle was a four-door sedan. Vehicle speed was 25 to 30 miles per hour. Estimated damage is $6000. It was a rear-end collision. Mr. Lightfoot is self-employed as a handyman. His job is of light physical demand, lifting 10 pounds.

April 9, 2020: Roy O'Growlahan, PA-C, Urgent Injury Care. Mr. Lightfoot is a pleasant 65-year-old gentleman here with neck, upper back, and low back pain as well as left upper and lower extremity numbness, tingling, and pain following a motor vehicle collision that occurred on December 5, 2019. According to the patient, he was the restrained driver of a 2012 Mitsubishi Outlander going about 25 to 30 miles per hour when he was rear-ended by a Mercedes going an unknown speed. Airbags did not deploy. Police were on the scene. There were no emergency medical services or two on scene. Damage to the car is $6000. He was seen at Fish City Chiropractic by Rod Redline, DC, where he received chiropractic adjustments for approximately four months. He saw no improvement in symptoms. He was referred for MRI of his cervical spine and is here with those results. He was also seen by his primary care physician, Dr. Waternoose, who provided pain medication as well as muscle relaxers.

Denies loss of consciousness or hitting his head. He is experiencing night pain. He is sleeping three to four hours a night. Denies symptoms prior to the motor vehicle accident. He is experiencing numbness and tingling in his left hand and leg every few days, and it is aggravated by walking. Symptoms made worse with standing, walking, bending forward and backward, coughing, and sneezing, as well as chiropractic adjustments. He rates his pain 7/10 to 8/10 in his low back. He did have x-rays of his spine that according to the patient were negative for fractures. Also had an MRI of his cervical spine performed on November 13, 2020 [*sic*]. The MRI is reviewed.

Review of systems, past medical/surgical history, medications, allergies, social history, functional history, and occupational history are per the intake forms reviewed above.

Physical Examination: Cervical range of motion is slightly tight with rotation to the right and left. He has moderate discomfort with extension and rotation, mild with forward flexion and lateral rotation. Able to reproduce cervical facet pain bilaterally as well as cervical paraspinal discomfort that extends into both trapezii. There is lumbar paraspinal discomfort as well but no thoracic paraspinal pain. No scapular winging.

Upper extremity strength is 5/5 throughout. Sensation is intact to light touch. Deep tendon reflexes are symmetrical at bilateral biceps, brachioradialis, and triceps. Negative Tinel with percussion over both midvolar wrists; no subjective numbness, tingling, or pain. Shoulder range of motion is within normal limits. Impingement test and Speed test negative bilaterally. No tenderness to palpation throughout the cervical spine.

Lower extremity strength is 5/5 throughout. Sensation is intact to light touch diffusely throughout bilateral lower extremities. Deep tendon reflexes are symmetrical at bilateral knees and ankles. Tension signs are negative. Severe discomfort with low back extension and moderate to severe with forward flexion.

Trunk range of motion is within normal limits with flexion and extension. Hip range of motion is within normal limits. Slump test negative bilaterally. No tenderness to palpation throughout sciatic notch, sacroiliac joint, or trochanteric bursa. Able to walk on heels and toes without difficulty. No focal motor weakness or sensory loss in either upper or lower extremities.

Assessment/Plan: Cervical and lumbar sprain along with occasional radicular symptoms in the left upper and lower extremity following a motor vehicle collision that occurred on December 5, 2019. "The MRI of his cervical spine has a lot of information to decipher and certainly can be responsible for the symptoms he is experiencing." Mr. Lozano thinks he would benefit from an EMG of left upper and lower extremities to better define symptoms. Physical therapy is prescribed for the cervical and lumbar sprain. He was given a prescription of oxycodone 5 mg to take one at bedtime as needed for pain and instructed to use the muscle relaxers primarily at night. He will be seen in 10 days for reevaluation.

April 14, 2020: Massage therapy at Urgent Injury Care, unknown provider (signature illegible). Seen for cervical and lumbar sprains. Has 8/10 neck and back pain and stiffness. Activities affected by condition are sleeping, lifting, driving, and sitting. Tender in neck and low back with light pressure. This handwritten note is mostly illegible. Additional massage therapy visits are noted on April 19 and 22, 2020.

April 15, 2020: Lewis Hamilton, PT, DPT, Urgent Injury Care Physical Therapy. Initial Evaluation. Functional score is 52 percent. Pain 8/10. Mr. Lightfoot is a 65-year-old male who was involved in a motor vehicle collision on December 5, 2019, in which he was the driver of a vehicle that was struck from the backside. Following collision, patient went to see a chiropractor, where he was treated and released. Since collision, patient has had cervical and lumbar pain and stiffness with radicular symptoms in the left upper and lower extremities and down the anterior thigh. Patient denies cervicogenic headaches but reports bladder dysfunction since the accident.

Physical Examination: increased tone and tenderness of cervicothoracic and thoracolumbar paraspinal muscles and bilateral piriformis and gluteus medius.

Active thoracolumbar range of motion: flexion 40 percent with low back pain, extension 25 percent with low back pain, external rotation right 40 percent with right-side low back pain, external rotation

left 25 percent with left-side low back pain, right side bending 50 percent with right-side low back pain, left side bending 25 percent with left-side low back pain.

Active cervical range of motion: flexion 60 percent with central lower cervical pain, extension 50 percent with upper and lower cervical pain, right rotation 75 percent with right side upper cervical pain, left rotation 60 percent with left side upper cervical pain, right side bending 50 percent with right side lower and midcervical pain, left side bending 50 percent with left side upper cervical pain.

Core strength and deep cervical strength are poor. Patellar reflexes within normal limits. Hoffmann and clonus tests negative. Straight leg raise; Slump test; repeated flexion; quadrant (facet); flexion, abduction, and external rotation (FABER); and sacroiliac joint tests all positive. Cervical compression and quadrant (facet) tests are positive.

Impression: Patient was found to have limited range of motion in the lumbar spine, with pain and stiffness before end ranges. Palpation revealed tenderness to cervicothoracic and thoracolumbar paraspinal muscles and bilateral piriformis and gluteus medius. The patient's rehabilitation potential is good. He will benefit from physical therapy. Plan of care is two to three times per week for eight weeks.

Physical therapy visits are noted through May 9, 2020.

April 16, 2020: Kari McKeen, DO. Mr. Lightfoot was seen in consultation as requested by Dr. Edna Mode for abnormal chest imaging. Mr. Lightfoot is a 65-year-old gentleman who seems to have a history of some abdominal complaints, including a cholecystectomy a number of years ago as well as some pneumobilia. He came into the hospital on April 3, 2021, due to abdominal pain and ongoing vomiting. The reason he was referred is because during part of his workup, he had a CT of the chest which noted an abnormality in the right middle lobe. He says that since he has been home, he has been feeling a little bit better. From a respiratory standpoint, if he never had the scan done, he would have no idea that he had this. He said he does not really have a cough, no shortness of breath, not many respiratory symptoms. He does note that he spent a fair amount of his life in Woodcrest, Celesteville, and Tremerton, but since he moved to Camberwick a few years ago, anytime he takes a hot shower, he has coughing episodes. Other than that, he does not have coughing episodes.

Mr. Lightfoot has spent the majority of his life doing construction work. He has helped build bridges. He works as a general contractor and builds houses. He is around a lot of building materials. He does not do any demolition work but has done a few remodels where he may be removing some stuff. Denies any known tuberculosis exposures.

He is a former smoker, quitting in 1996, starting at the age of 19. He said he smoked probably about a half pack or so of filtered cigarettes each day. Does not drink alcohol or do illicit drugs. Currently lives with his wife and has four children. No known drug allergies. Medications are atorvastatin, lisinopril, and cyclobenzaprine.

Past medical history includes hypertension and hyperlipidemia. He has had his gallbladder removed in 2011 and had stones removed from his bile duct in 2016 and again in 2020. He had back surgery in 1995. Family history significant for his mother dying of lung cancer. His father lived to age 100, and his grandmother was also over 100 and died of old age.

Physical examination is unremarkable.

Dr. McKeen personally reviewed the chest CT done on April 3, 2020, and reviewed the report. It is notable for an irregular-shaped area in the right middle lobe that is around 2 centimeters. It has been described as a potential malignant pulmonary nodule versus infectious/inflammatory process. There are no other large lesions seen in his chest. There does not appear to be a significant amount of mediastinal or hilar adenopathy present.

Impression:

1. Abnormal CT chest with pulmonary nodule.
2. History of tobacco abuse.
3. History of significant construction work experience as well as travel.
4. Abdominal complaints with recent endoscopic retrograde cholangiopancreatography and multiple episodes of nausea and vomiting.

Plan: Discussed with Mr. Lightfoot and his wife today about proceeding forward. His CT of the chest is clearly abnormal, as noted. He has an irregular-appearing abnormality that has some areas of opacification and some areas of ground glass within it. It is just under 2 centimeters in size and located in the middle lobe. Mr. Lightfoot was unfortunately a smoker and is at some risk for the development of lung cancer. This nodule was found incidentally, although his coughing history with exposure to hot showers is somewhat interesting.

Discussed the general workup for pulmonary nodules, including plans for repeat imaging versus biopsy as well as surgical intervention. Discussed risks and benefits of these approaches, including watchful waiting with a close interval repeat CT versus moving forward with biopsy. Dr. McKeen's inclination is to perform a short-interval follow-up. He has a fair number of exposures as well as he was admitted to the hospital for recurrent vomiting, and this could represent an area of aspiration pneumonitis as well. Discussed that if the lesion goes away or gets smaller, then they will likely be doing little else. However, if the lesion remains the same will probably get additional imaging versus if it grows bigger would likely move forward with some type of biopsy at that point. Mr. Lightfoot thinks he would be able to tolerate waiting another few weeks to months to get repeat imaging.

April 16, 2020: Beatrice Miller, MD, Urgent Injury Care. Electrodiagnostic Medicine Consultation. Mr. Lightfoot is a 65-year-old gentleman seen for updated electrodiagnostic testing of the left upper and lower limbs. He sustained injuries to the spine from a motor vehicle collision on December 5, 2019. He was seen in clinic last week and referred for electrodiagnostic testing to rule out left cervical and lumbar radicular issues. Impression: normal study. There are no EMG findings consistent with left cervical or lumbar radiculopathy. There are no electrodiagnostic findings of left carpal tunnel syndrome, ulnar neuropathy, lower limb compression neuropathy, or a generalized peripheral neuropathic process.

April 24, 2020: James P. Sullivan, MD, Urgent Injury Care. He states that low back pain has been worse. He has tried chiropractic treatment along with massage in the past, with residual symptoms. He has just started physical therapy and had four treatment sessions so far. Denies significant improvement as yet.

Physical Examination: Trunk range of motion is severely painful with extension in comparison to flexion. Palpation does reveal moderate tenderness over the lumbosacral junction. No significant tenderness to palpation over the cervical facets, although he does have some tightness and pain with lateral rotation of the cervical spine predominantly. Upper and lower extremity strength is intact.

Assessment/Plan: At this time, the patient's symptoms are still significant in nature. Dr. Sullivan adjusts his physical therapy with more manual therapy rather than therapeutic exercises for the next two to four visits. If he is not making significant improvement, it may be reasonable to consider epidural steroid injections, possibly starting with a facet joint injection above the fusion. Mr. Lightfoot is given oxycodone 5 mg per his request, 20 tablets, along with a trial of Neurontin 300 mg at nighttime. Dr. Sullivan is hoping to decrease oxycodone and switch him to Neurontin gradually.

May 30, 2020: CT chest without contrast, read by Jeff Gorvette, MD, performed for follow-up of incidentally identified indeterminate lung nodule. Comparison to CT angiogram of the chest April 3, 2021, from Jellystone. Impression: stable 1.6-by-0.7-centimeter lobular peribronchovascular ground-glass nodule of the right middle lobe. Continued surveillance recommended.

June 1, 2020: Kari McKeen, DO. Mr. Lightfoot is seen in follow-up in the Interventional Pulmonary Clinic. He is a 65-year-old gentleman seen last month with a lung nodule. He notes that there have been no other new changes; however, at the end of the visit he told Dr. McKeen that he has noticed some recurrent epistaxis, particularly from his left nostril. He said sometimes he wakes up with a bloody nose. He said that most of the time the bleeding is not aggressive and tends to resolve, but he never had this issue before, and it has been recurring over the last few months.

Physical Examination: Today, his blood pressure is 156/96, oxygen saturation 99 percent on room air, pulse 74, weight 160 pounds. He is awake and alert, appears comfortable. His sclerae are anicteric. He is moving all four extremities. He has eyeglasses in place. He has appropriate mood and affect.

Dr. McKeen personally reviewed a CT of the chest done today as well as compared it to the one done at the beginning of April. The CTs are about eight weeks apart, and there appears to be no significant difference. The right middle lobe has a ground-glass abnormality present. There does not appear to be a large, if any, solid component to it.

Impression:
1. Abnormal CT of the chest, right middle lobe nodule.
2. Epistaxis.
3. Former smoker.

Plan: The nodule persists on repeat CT. It therefore seems less likely that it is of inflammatory/ infectious etiology. However, it also did not seem to change all that much, although it has been two months. Dr. McKeen suggested presenting Mr. Lightfoot at an upcoming Tumor Board to see about opinions regarding further evaluation. Dr. McKeen suspects this abnormality will persist and/or continue to get bigger and is likely a precursor to carcinoma at some point. Dr. McKeen will try to present him in the next week or two and will call Mr. Lightfoot with the results of the Tumor Board discussion and make a plan moving forward. Mr. Lightfoot says if it was a 50/50 opinion with regard to radiographic observation versus biopsy/resection, he would likely lean toward repeat radiographic imaging at this point.

August 19, 2020: Donna Soohoo, MD, Jellystone Emergency Center. Chief Complaint: back pain, onset Monday night, increased since then. Patient has had left flank pain starting two days ago that is worse with movement. It is nonradiating. No abdominal discomfort, leg discomfort, loss of function, bowel or bladder dysfunction. Patient has not tried any medicine, including over-the-counter medicines. He last had central back pain in December. He has a history of sciatica.

Physical Examination: neck supple. Abdomen benign and soft. Neurologic: alert and oriented, gait baseline, conversant, no focal deficits noted. Extremities atraumatic. Back with no midline tenderness.

Clinical Summary: Mr. Lightfoot presents to the emergency department with left flank pain that is significantly worse with movement, consistent with musculoskeletal pain. Patient points out that he has a history of "kidney problems," and chart review shows that he has a history of renal insufficiency. For this reason, we are avoiding nonsteroidal anti-inflammatory medications. Patient is showing no neurologic signs or symptoms and no abdominal signs or symptoms. This is most likely musculoskeletal, very unlikely to be from a renal or intra-abdominal source. Given lack of neurologic impairment, emergent back imaging is not clinically indicated. Patient and his wife will return if worse and requiring further assistance. Clinical Diagnosis: acute left-sided low back pain without sciatica. He is discharged to home in stable condition and provided Ultram 50 mg, one to two tablets by mouth every four to six hours as needed for pain.

September 29, 2020: Kari McKeen, DO. He is back today for additional follow-up. He notes no new changes and otherwise feels relatively well. On examination today, his pulse is 65, weight 167 pounds, and blood pressure 125/65. He is at 98 percent on room air. He is awake and alert. He appears comfortable. He is moving all four extremities. He has appropriate mood and affect. Dr. McKeen reviews the CT of the chest done earlier this year as well as one done today. It is notable for what Dr. McKeen's believes to be a right middle lobe ground-glass abnormality that seems to be stable.

Impression: abnormal CT of the chest, history of tobacco abuse. Plan: Discussed that Dr. McKeen will wait for the official radiology read to come back; however, to him it seems about the same. He had been presented at the Tumor Board, and most felt comfortable with continued surveillance. If there are any other changes, maybe some change in density, Dr. McKeen will likely place him on for Tumor Board in the next few weeks. Again discussed options of continued surveillance or consideration for biopsy or surgical resection. Mr. Lightfoot was fairly noncommittal in any particular way and said he feels comfortable with Dr. McKeen making an appropriate decision. Dr. McKeen will call Mr. Lightfoot in a few weeks after discussing his case at the Tumor Board. Plans for follow-up may depend on those discussions as well.

September 29, 2020: CT chest without contrast, read by Victoria Rivera, MD. Comparison to May 30, 2020. Impression: Ill-defined nodule in the right middle lobe adjacent to vessels may be part solid, with up to a 6-millimeter solid component versus artifact. Overall size is roughly unchanged. Continued attention to this area on future follow-up imaging is recommended. Positron emission tomography (PET) CT could be considered for more complete evaluation.

October 20, 2020: Kari McKeen, DO. Dr. McKeen presented Mr. Lightfoot at the Tumor Board, and during discussions, while most generally were of the opinion that the lesion itself does not really seem to have changed all that much, they also brought up the fact that it does appear to be a bit abnormal and seems to be likely potentially a fairly straightforward operation to both sample and therapeutically deal with it. Concern is that likely this would require resection at some point but not entirely clear. He has only had short-interval follow-up. Mr. Lightfoot was brought back to go over these results and to try to get a sense to which way he would be interested in moving forward.

Physical examination is unremarkable. Pulse 85, weight 166 pounds, blood pressure 127/710, 98 percent on room air. Awake and alert. Otherwise appears within normal limits without clear evidence of distress.

No new imaging to review. Reviewed with Mr. Lightfoot the results of the previous Tumor Board discussion. Mr. Lightfoot notes that he is very comfortable with continuing to watch this. Mr. Lightfoot was informed that many of the surgeons at the Tumor Board would be willing to see him now to consider resection. Mr. Lightfoot was told that it is still not clear what this is and could be benign, but if it is carcinoma, then it is often of benefit to find this out and deal with it sooner rather than later. After discussions with Mr. Lightfoot and wife, the plan will be to repeat CT in a few months to confirm stability. If it remains stable, they will likely push out to six months at that point. Otherwise, he will continue to follow along.

July 10, 2021: Dean Hardscrabble, MD, Neurological Associates of Marzipan City. Mr. Lightfoot is a 67-year-old gentleman who was working as a handyman. He underwent low back surgery in 1995 at Petropolis Hospital and recovered well. He was able to return to work as a janitor and handyman. He unfortunately was involved in a rear-end car accident on December 5, 2019. Another car hit the back of his car, and his car sustained $5000 to $6000 of damage. He was healthy before this accident and was able to live a normal life, but after the accident, he developed a sudden onset of low back pain, bilateral leg pain left worse than right, chronic neck pain, and left-sided-worse-than-right-sided arm pain with numbness and tingling. He has tried physical therapy, massage therapy, and chiropractic treatment and went to see a doctor at Urgent Injury Care.

Eventually, he obtained an MRI of the cervical spine, which showed clear-cut evidence of C5-6 broad-based disc bulging and a bone spur that caused severe C6 nerve root foraminal stenosis. He was scheduled to undergo a lumbar myelogram CT, but it has never been done at Friendly Falls Diagnostic Imaging.

The patient continues to have left-more-than-right-sided arm pain and left-sided leg pain. He has not been able to work since the accident due to the neck and back pain.

The patient is left handed. He quit smoking in 1995. He does not drink alcohol. He has no known allergies to medication. He has a history of high cholesterol, high blood pressure, and neck injury. Current medication is Tylenol.

Physical Examination: Motor is 5/5. Decreased pinprick sensation in both arms and left leg in a nondermatomal distribution. Reflexes 1+ throughout. Babinski with downgoing toes bilaterally.

Impression: This patient presented with cervical and lumbar radiculopathy which happened after a car accident. He did not have all of these symptoms before the accident.

He is recommended to undergo a C5-6 anterior discectomy and arthrodesis using tricortical cancellous allograft, implantation of titanium plate and locking screws, and autologous bone marrow. Risks and benefits are reviewed. He understands and wishes to proceed. He should obtain a lumbar MRI scan as well. He will return when the MRI is complete.

August 3, 2021: Dean Hardscrabble, MD. Mr. Lightfoot plans to undergo C5-6 anterior discectomy and fusion in the near future. He continues to have low back pain at the lumbosacral junction and bilateral leg pain, with more pain in the left leg, with numbness as well. He has difficulty walking. He underwent L5-S1 fusion in 1995 at Petropolis Hospital and did really well after surgery for all these years until he got involved in a rear-end car accident.

Dr. Hardscrabble advised Mr. Lightfoot to try an epidural steroid injection because the new lumbar MRI scan which was done today shows bilateral L2-3, L3-4, and L5-S1 lateral recess stenosis.

The hope is that he will not need surgery in the low back area. He agrees with the plan. Dr. Hardscrabble wrote a referral for an epidural steroid injection at Friendly Falls Diagnostic Imaging.

August 3, 2021: MRI of lumbar spine, read by Nancy Kim, MD. Clinical Information: radiculopathy. Back and leg pain. Motor vehicle accident. No comparison. Findings: Lumbar lordosis maintained. Mild retrolisthesis at L2-3. Background marrow signal within normal. Negative for fracture or destructive lesion. Postoperative change with laminectomy at L5-S1 with pedicle screw instrumentation. Fusion across margins of disc space suggested. Probable dorsal fusion across facet joints. No edema at this level to suggest hardware failure. Disc spaces demonstrate desiccation with spondylosis throughout the spine, most severe at L2-3 through L4-5. Degenerative endplate changes, predominantly Modic type 2. Schmorl node superior endplate of L5. Conus and cauda equina intact without mass or signal abnormality. By level:

- L1-2: Disc bulge with mild subarticular recess stenosis.
- L2-3: Disc bulge, shallow central 1-to-2-millimeter protrusion, retrolisthesis, and facet arthrosis with mild central/moderate subarticular recess stenosis with impression on L3 nerve roots. Mild to moderate foraminal stenosis.
- L3-4: Disc bulge with facet arthrosis. Mild subarticular recess and foraminal stenosis.
- L4-5: Disc bulge, annular fissure, spondylosis, and facet arthrosis. Mild central/moderate subarticular recess stenosis. Impression on L5 nerve roots. Mild to moderate foraminal stenosis.
- L5-S1: Decompression, instrumentation, and likely fusion without stenosis.

Impression:

1. Postoperative change at L5-S1 with laminectomy, instrumentation, and likely fusion without stenosis.
2. Lumbar spinal stenosis, most prominent at the L4-5 and L2-3 levels, with moderate subarticular recess stenosis at both levels.
3. No fracture or destructive bone lesion.
4. No intradural mass.

BILLS:

Bills are reviewed and are consistent with the treatment provided.

Documents identifying balance due and insurance payments are reviewed.