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February 1, 2021

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Electromyogram (EMG)
Nerve Conduction Studies (NCV) and Somatosensory Evoked Potentials (SSEP) Report
Upper Extremities

Patient:	**Walls, Darlene**
Sex:	**Female**
Date of Birth:	**03/23/1967**
Date of Testing:	**02/27/2020**
Referred by:	**Harold Iseke, D.C.**

CLINICAL SUMMARY:

- **Clinically Significant radicular upper back pain with radicular upper extremities symptoms (pain, tingling, numbness) and signs. Patient's right hand is dominant. The temperature of the patient's arms was > 32C.**

Patient was referred for the studies to assist in diagnosis and management of probable Carpal Tunnel Syndrome CTS, Cervical Radiculopathy / Brachial Plexopathy, entrapment neuropathy peripheral neuropathy or other nerve injury.

PROCEDURE

- Nerve Conduction Studies of the Median and Ulnar motor nerves with corresponding F-Waves; Ulnar, Median, and Superficial Radial sensory and motor nerves were performed utilizing standard technique.
  Median CMAP was recorded from abductor pollicis brevis muscle with stimulation 8 cm proximally. Ulnar CMAP was recorded from abductor digit minima muscle with a stimulation point 8 cm proximally, below and above elbow, with an across-elbow ulnar nerve segment distance of 10 cm and elbow flexed at 90 degree angle. F-waves were elicited on repetitive stimulation of each motor nerve tested. Radial CMAP was recorded from EDC, stimulation occurs at the elbow, at the joint between the brachioradialis muscle and the biceps tendon, and at the spiral groove (high) in the upper arm. Median sensory peak latency was recorded from the 2nd digit

Patient: **Walls, Darlene**
Date of Exam: **02/27/2020**
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by ring electrodes with stimulation at 7 cm proximally at mid-palm and 14 cm at the wrist. Ulnar sensory peak latency was recorded from the fifth digit with stimulation 14 cm proximally at the wrist.

Utilizing a Cadwell Somatosensory evoked potential averager and computer, the patient's C6, C7 nerve roots were stimulated at the rate of 2.82 per second for a duration of 100 milliseconds. Double trial stimulation of 500 stimuli as tolerated by the patient were done. The low frequency filter was set at 10 Hz and the high frequency filter was set at 2000 Hz. Median / and Ulnar nerves were stimulated at the rate of 2.82 per second for a duration of 100 milliseconds. Double trial stimulation of 500 stimuli as tolerated by the patient were done. The low frequency filter was set at 10 Hz and the high frequency filter was set at 200 Hz. Recordings were taken from cervical C7 area as referenced against FpZ and subsequently over contralateral parietal scalp 2cm behind the C3 or C4 electrode positions of the International 10-20 system of EEG electrode placement.

FINDINGS

EMG

Monopolar needle EMG was performed in selected bilateral upper extremities muscles innervated by C5-T1 nerve roots inclusive. No spontaneous activity was seen in any muscles tested in the form of fibrillations, positive sharp waves, or fasciculations. Voluntary motor unit morphologies are otherwise normal.

All examined muscles (as indicated in the following table) showed no evidence of electrical instability.

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Left	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Deltoid	Axillary	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	Brachialis	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	FlexCarpiUln	Ulnar	C8,T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	ExtIndices	Radial (Post Int)	C7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Triceps	Radial	C6-7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Biceps	Musculocut	C5-6	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	1stDorInt	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	FlexCarpiUln	Ulnar	C8-T1	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	PronatorTeres	Median	C6-7	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	ExtIndicis	Radial (Post Int)	C7-8	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	

Patient: **Walls, Darlene**
Date of Exam: **02/27/2020**
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Dermatomal C6, C7 Somatosensory Evoked Potentials

C6 nerve root was stimulated using the Superficial Radial sensory nerve.
C7 nerve root was stimulated using the 3rd digit.

Cortical responses were normal bilaterally with recording from C6 and C7 nerve roots.

Nerve Conduction Studies (NCV)

Motor Nerve Study:

1. Study of left median motor nerve showed normal distal latency, normal conduction velocity and normal AMPs.
2. Study of right median motor nerve showed normal distal latency, normal conduction velocity and normalAMPs.
3. Study of left ulnar motor nerve showed normal distal latency, *slowing of conduction velocity* and normal AMPs.
4. Study of right ulnar motor nerve showed normal distal latency, *slowing of conduction velocity* and normal AMPs.
5. Study of left radial motor nerve showed normal distal latency, normal conduction velocity and normal AMPs.
6. Study of right radial motor nerve showed normal distal latency, normal conduction velocity and normal AMPs.

Sensory Nerve Study:

1. Study of left median sensory nerve showed normal distal latency on the wrist (compare to mid palm) with *reduced* AMP.
   Median sensory peak latency was prolonged by 0.6ms compared to the radial response, when recorded from the thumb on the left *(NL<0.4ms) at 10cm.*
2. Study of right median sensory nerve showed normal distal latency on the wrist (compare to mid palm) with normal AMP.
   Median sensory peak latency was prolonged by 0.2 ms compared to the Radial response, when recorded from the thumb on the right (NL<0.4ms) at 10cm.
3. Left Ulnar sensory nerve showed normal distal latency with normal AMP.
4. Right Ulnar sensory nerve showed normal distal latency with normal AMP.
5. Left radial sensory nerve showed normal distal latency with normal AMP.
6. Right radial sensory nerve showed normal distal latency with normal AMP.

Patient: **Walls, Darlene**
Date of Exam: **02/27/2020**
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IMPRESSION

- **Abnormal Neurodiagnostic Study of Bilateral Upper Extremities** is consistent with:

  1. ***Mild Left Carpal Tunnel Syndrome involving the sensory fibers only.***
  2. ***Bilateral demyelinating Ulnar motor neuropathy across the elbows.***

Based on the date of injury and as defined by ACOEM Guidelines (p 108) this case is now chronic. Thus, ACOEM guidelines do not apply. Compensation is requested pursuant to Section 4600(a), 4603.(b), and 5402(c) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (p 178, 182) NCV/SEP's and/or NCV/EMG/H reflex is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (pp 293B, 366B, 330, 334B) NCV/SEP's and/or NCV/EMG W/H reflex is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (p 211, 212) NCV/SEP's and/or NCV/EMG/H reflex to the shoulder(s) is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receip of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guideines (p 232, 233, 238, 242) NCV/SEP's and/or NCV/EMG/H reflex to the elbow(s) is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (p 261, 262, 269, 272) NCV/SEP's and/or NCV/EMG/H reflex to the forearm, wrist and hand(s) is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

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Patient: **Walls, Darlene**
Date of Exam: **02/27/2020**
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DISCLOSURE

I declare under penalty of perjury that all opinions stated in this report are mine. The evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of section 139.2 or 5307.6 of the Labor Code.

The nerve conduction studies ordered were performed by Ms. Inna Plotkin, CNCT, R.NCS.T, R.EP.T, Board Certified NCV Technician under the referring doctor's general supervision.

I declare under penalty of perjury that the information contained in this report and its attachment, if any, is true and correct to the best of my knowledge and belief except as to information and I have indicated that I received from others.

As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

Comments: Quality of data obtain, accuracy, different techniques, technical experience, patient history, and physical exam, all play is very critical factor for an optimal interpretation. For a more comprehensive evaluation an EMG, MRI, CAT Scan, and any other diagnostic modality capable of establishing a differential diagnosis is recommended at the discretion of the referring physician, this is only interpretation of data and patient was not examined.

I have complied with the Labor Code 139.3 and I have not offered or received any commissions or inducements for this evaluation. This declaration is executed today in the county of Los Angeles.

As with all electrodiagnostic assessments, clinical correlation is suggested.

Thank you for referring the patient to us.

Sincerely,

Benjamin Gross, M.D.
Diplomate, American Board of Psychiatry and Neurology

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Electromyogram (EMG)
Nerve Conduction Studies (NCV) and Somatosensory Evoked Potentials (SSEP) Report
Lower Extremities

Patient: **Walls, Darlene**
Sex: **Female**
Date of Birth: **03/23/1967**
Date of Testing: **02/27/2020**
Referred by: **Harold Iseke, D.C.**

CLINICAL SUMMARY:

- **Clinically Significant lower back injury with moderate radicular lower back pain with radicular lower extremity symptoms (pain, tingling, numbness) and signs. The temperature of the patient's legs was > 31C.**

Reason For testing: Assist in diagnosis and management of probable Lumbosacral radiculopathy / Lumbosacral Plexopathy, peripheral neuropathy / or other nerve injury.

PROCEDURE

- Nerve Conduction Studies of the Peroneal and Tibial motor nerves with corresponding F-Waves; Sural, Superficial Peroneal and Saphenous sensory nerves and H-reflexes were obtained utilizing standard techniques.
  Peroneal CMAP was recorded from extensor digitorum brevis muscles with stimulation 8 cm proximally and at the fibular head. Tibial CMAP was recorded from abductor hallucis with stimulation at the posterior aspect of the medial malleolus and at the popliteal fossa. Sural sensory peak latency was recorded from the lateral aspect of the heel with the stimulation 14 cm proximally. Superficial Peroneal sensory peak latency was recorded from the dorsum of the foot 2 cm medial to the lateral malleolus with stimulation 14 cm proximally over the anterior edge of the fibula. Saphenous sensory peak latency was recorded from anterior aspect of medial malleolus with stimulation 14 cm proximally. F-waves were elicited on repetitive stimulation of each motor nerve tested. H-reflex was

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elicited with the stimulation at the popliteal fossa and recording electrodes placed over the soleus muscle.

Utilizing a Cadwell Somatosensory evoked potential averager and computer, the patient's L4, L5, S1 nerve roots were stimulated at the rate of 2.82 per second for a duration of 100 milliseconds. Double trial stimulation of 500 stimuli as tolerated by the patient were done. The low frequency filter was set at 10 Hz and the high frequency filter was set at 2000 Hz. Electrodes were placed according to the international 10-20 electrode placement system. Recordings were taken from CZ' as referenced against FpZ.

FINDINGS

EMG

Monopolar needle EMG was performed in selected bilateral lower extremity muscles innervated by L2-S1 nerve roots inclusive.

Needle evaluation of the left anterior tibialis muscle showed moderately increased polyphasic potentials. The left vastus lateralis muscle showed slightly increased polyphasic potentials

The motor units are normal in morphology with full recruitment and normal interference pattern.

Side	Muscle	Nerve	Root	Ins Act	Fibs	Psw	Amp	Dur	Poly	Recrt	Int Pat	Comment
Left	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	2+	Nml	Nml	
Left	Med Gastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Left	VastusLat	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	1+	Nml	Nml	
Left	L4 Parasp	Rami	L4	Nml	Nml	Nml						adipose tissue
Left	L5 Parasp	Rami	L5	Nml	Nml	Nml						polys1+
Left	S1 Parasp	Rami	S1	Nml	Nml	Nml						
Right	AntTibialis	Dp Br Peron	L4-5	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	Med Gastroc	Tibial	S1-2	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	VastusLat	Femoral	L2-4	Nml	Nml	Nml	Nml	Nml	0	Nml	Nml	
Right	L4 Parasp	Rami	L4	Nml	Nml	Nml						
Right	L5 Parasp	Rami	L5	Nml	Nml	Nml						
Right	S1 Parasp	Rami	S1	Nml	Nml	Nml						

Dermatomal Somatosensory Evoked Potentials L5, S1

S1 nerve root was stimulated using the Sural/ankle
L5 nerve root was stimulated using the Superficial Peroneal between 1st and 2nd toe

Cortical responses were normal bilaterally with recording from L5 and S1 nerve root.

Patient: **Walls, Darlene**
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Nerve Conduction Studies (NCV)

Motor Nerve Study:

1. Study of the left Peroneal motor nerve showed normal distal latency with normal conduction velocity and normal AMPs.
2. Study of the right Peroneal motor nerve showed normal distal latency with normal conduction velocity and normal AMPs.
3. Study of the left Posterior Tibial motor nerve showed normal distal latency with normal conduction velocity and *reduced* AMPs.
4. Study of the right Posterior Tibial motor nerve showed normal distal latency with normal conduction velocity and normal AMPs.

Sensory Nerve Study:

1. Left Saphenous sensory nerve showed normal distal latency with normal AMP.
2. Right Saphenous sensory nerve showed normal distal latency with normal AMP.
3. Left Superficial Peroneal sensory nerve showed normal distal latency with *reduced* AMP.
4. Right Superficial Peroneal sensory nerve showed normal distal latency with *reduced* AMP.
5. Left Sural sensory nerve showed normal distal latency with normal AMP.
6. Right Sural sensory nerve showed normal distal latency with normal AMP.

H-reflex Study:

1. Left H-reflex normal latency
2. Right H-reflex normal latency

IMPRESSIONS

- **Abnormal Neurodiagnostic Study of Bilateral Lower Extremities** is consistent with:

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1. ***Mild axonal Post. Tibial motor neuropathy affecting the left lower extremity probably from left L5 radiculopathy.*** *Monopolar needle examination of the lower extremities muscles reveals evidence of the left anterior tibialis muscle showed moderately increased polyphasic potentials. The left vastus lateralis muscle showed slightly increased polyphasic potentials*
2. ***Bilateral Sup. Peroneal axonal sensory neuropathy.***

Based on the date of injury and as defined by ACOEM Guidelines (p 108) this case is now chronic. Thus, ACOEM guidelines do not apply. Compensation is requested pursuant to Section 4600(a), 4603.(b), and 5402(c) of the Labor Code.

If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (p 178, 182) NCV/SEP's and/or NCV/EMG/H reflex is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

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If applicant's condition is in acute or sub acute stage, pursuant to ACOEM Guidelines (p 211, 212) NCV/SEP's and/or NCV/EMG/H reflex to the shoulder(s) is recommended. Certification is mandatory pursuant to section 4610 (g)(1) of the Labor Code. If the statutory time (14 days) to approve has expired, your right to delay, deny or modify is deemed waived and payment within (45) days from receipt of bill and report is required pursuant to section 4603.2 (b) of the Labor Code.

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Patient: **Walls, Darlene**
Date of Exam: **02/27/2020**
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DISCLOSURE

I declare under penalty of perjury that all opinions stated in this report are mine. The evaluation was performed and the time spent performing the evaluation was in compliance with the guidelines, if any, established by the Industrial Medical Council or the administrative director pursuant to paragraph (5) of subdivision (j) of section 139.2 or 5307.6 of the Labor Code.

The nerve conduction studies ordered were performed by Ms. Inna Plotkin, CNCT, R.NCS.T, R.EP.T, Board Certified NCV Technician under the referring doctor's general supervision.

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As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe to be true.

Comments: Quality of data obtain, accuracy, different techniques, technical experience, patient history, and physical exam, all play is very critical factor for an optimal interpretation. For a more comprehensive evaluation on EMG, MRI, CAT Scan, and any other diagnostic modality capable of establishing a differential diagnosis is recommended at the discretion of the referring physician, this is only interpretation of data and patient was not examined.

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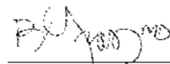
As with all electrodiagnostic assessments, clinical correlation is suggested.

Thank you for referring the patient to us.

Sincerely,



Benjamin Gross, M.D.
Diplomate, American Board of Psychiatry and Neurology

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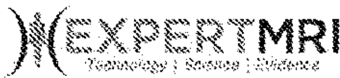
VAN NUYS CA 91405-3730

Walls, Darlene
MRN: 6389733, DOB: 3/23/1967, Sex: F
Visit date: 1/29/2021



Location: BELLFLOWER

PATIENT NAME	: WALLS DARLENE	PATIENT ID	: 43781
D-O-B	: 03-23-1967	ACCESSION NO	: 1914965-1
STUDY DATE	: 07-28-2019	REFERRING PHYSICIAN	: HAROLD ISEKE
APPROVAL DATE	: 07-29-2019	RADIOLOGIST	: AMJAD SAFVI

MRI OF LUMBAR SPINE WITH FLEX-EXT

Technique: Multiplanar multiecho MRI of the lumbar spine without contrast were performed in neutral position. Additional T2-weighted sequences were performed in sagittal flexion and extension and were submitted for diagnostic interpretation.

Clinical History: Lower back pain

Findings: Images are evaluated in the neutral, flexion and extension positions.

Straightening of the lumbar spine seen. No evidence of marrow signal abnormality noted. Normal alignment of the lumbar spine seen. There is no destructive bony lesion. The conus medullaris terminates at L1 and is normal in appearance. The distal spinal cord and cauda equina are normal. The paraspinal soft tissues are unremarkable. Disc desiccation is noted at L4-5 and L5-S1 levels.

Restricted range of motion in flexion and extension positions.

Prominent ovarian follicular cyst measuring 4.5x4.4cm seen on right side, follow up with ultrasound.

T12-L1: There is no significant disc herniation, spinal canal stenosis, or neural foraminal narrowing is visualized. Facet and ligamentum flavum demonstrate normal configuration. Central canal is unremarkable. No sign of lateral recesses stenosis. Exiting nerve root is unremarkable. No change on flexion and extension.

L1-2: There is no significant disc herniation, spinal canal stenosis, or neural foraminal narrowing is visualized. Facet and ligamentum flavum demonstrate normal configuration. Central canal is unremarkable. No sign of lateral recesses stenosis. Exiting nerve root is unremarkable. No change on flexion and extension.

L2-3: There is diffuse disc protrusion with effacement of the thecal sac. Hypertrophy of facet joints noted. Ligamenta flava demonstrate normal configuration. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 2.9 mm; FLEXION: 2.9 mm; EXTENSION: 2.9 mm

L3-4: There is diffuse disc protrusion with effacement of the thecal sac. Hypertrophy of facet joints noted. Ligamenta flava demonstrate normal configuration. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 2.7 mm; FLEXION: 2.7 mm; EXTENSION: 2.7 mm.

L4-5: There is focal central disc protrusion with annular tear effacing the thecal sac. Spinal canal is compromised. Hypertrophy of facet joints and ligamenta flava noted. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: NEUTRAL: 6.2

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mm; FLEXION: 6.2 mm; EXTENSION: 6.2 mm

L5-S1: There is diffuse disc protrusion with effacement of the thecal sac. Hypertrophy of facet joints noted. Ligamenta flava demonstrate normal configuration. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 3.0 mm; FLEXION: 3.0 mm; EXTENSION: 3.0 mm.

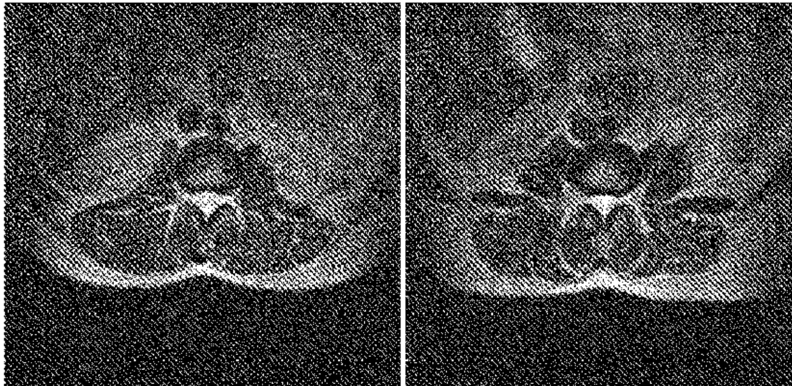
Impression:

1. Straightening of the lumbar spine seen.
2. Disc desiccation is noted at L4-5 and L5-S1 levels.
3. Restricted range of motion in flexion and extension positions.
4. Prominent ovarian follicular cyst measuring 4.5x4.4cm seen on right side, follow up with ultrasound.
5. L2-3: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 2.9 mm; FLEXION: 2.9 mm; EXTENSION: 2.9 mm.
6. L3-4: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 2.7 mm; FLEXION: 2.7 mm; EXTENSION: 2.7 mm.
7. L4-5: Focal central disc protrusion with annular tear effacing the thecal sac. Spinal canal is compromised. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: NEUTRAL: 6.2 mm; FLEXION: 6.2 mm; EXTENSION: 6.2 mm.
8. L5-S1: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina are patent. Disc measurements: NEUTRAL: 3.0 mm; FLEXION: 3.0 mm; EXTENSION: 3.0 mm.

Amjad Safvi MD

AMJAD SAFVI
RADIOLOGIST

Time Finalized: 2019-07-29 13:12:36



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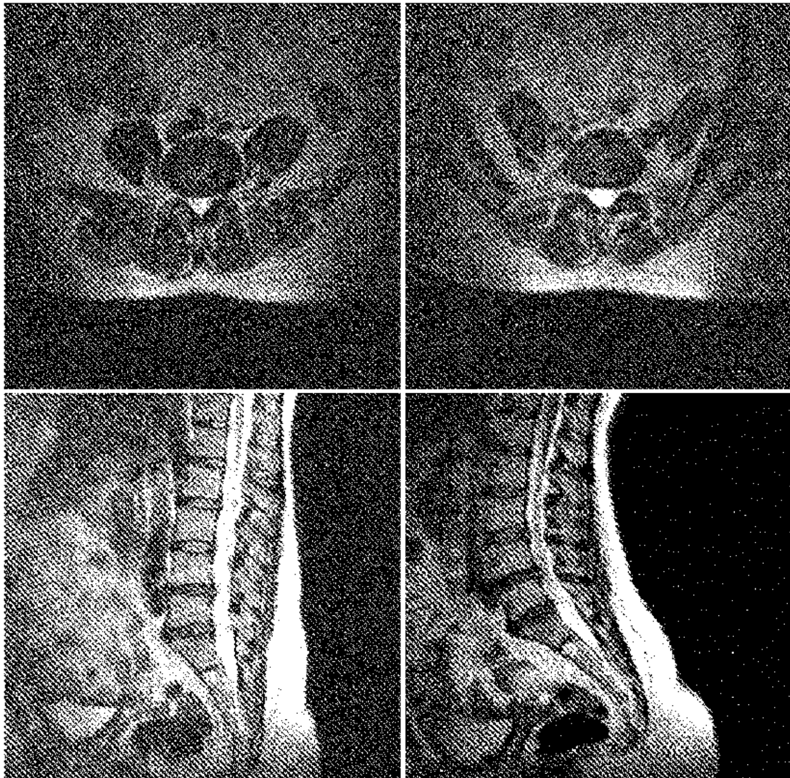
UCLA SCOI VAN NUYS
6815 Noble Avenue
VAN NUYS CA 91405-3730

Walls, Darlene
MRN: 6389733, DOB: 3/23/1967, Sex: F
Visit date: 1/29/2021



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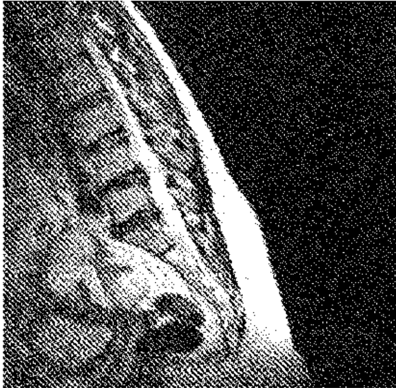
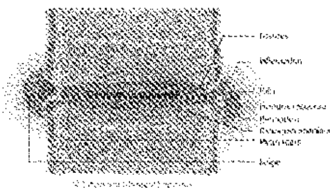


Section through injured disc



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Walls, Darlene
MRN: 6389733, DOB: 3/23/1967, Sex: F
Visit date: 1/29/2021

Results

MRI RIGHT SHOULDER NO CONTRAST (Order 1315045897)

Dates

Date Ordered	Date Performed	Date Resulted
Mar 18, 2019	Mar 31, 2019	Mar 31, 2019

MEDICAL CORRESPONDENCE
& RELEASE OF INFORMATION
9400 EAST ROSECRANS AVENUE
BELLFLOWER, CA 90706

Order Comments

Reason: Persistent right shoulder pain, some impingement

Transcription

Type	ID	Date and Time	Dictating Provider
Diagnostic Imaging	86453395	4/5/2019 10:13 AM	Han, Roger (M.D.), M.D.

Signed by Han, Roger (M.D.), MEDICAL DOCTOR on 04/05/19 at 1014

CLINICAL HISTORY: Reason: Persistent right shoulder pain, some impingement

COMPARISON: No previous study available.

TECHNIQUE: Study performed per protocol.

FINDINGS:
Rotator cuff: There is a low-grade partial-thickness tear at the articular surface of the supraspinatus tendon at the insertion. No evidence of rotator cuff muscle fatty atrophy.
Glenoid labrum and tendon: The long head of the biceps tendon is unremarkable in appearance. No definite evidence of labral tear.
AC joint: No significant degenerative changes are noted about the acromial clavicular joint. No evidence of lateral downsloping. Small inferiorly oriented subacromial spur is noted. Acromion is type I.
Articular Cartilage: No focal cartilage defects are identified.
Bone: No evidence of acute fracture. Nonspecific subchondral cystic changes are noted about the greater tuberosity.
No effusion.

IMPRESSION:
Low-grade partial-thickness tear at the articular surface of the supraspinatus tendon insertion.

This report electronically signed by Roger Han, MD on 4/5/2019 10:08 AM

Display only: Transcription (86453599) on 4/5/2019 10:13 AM by Han, Roger (M.D.), M.D.

4/5/2019 10:14 AM - Interface, Scal_Radiology

Narrative

no [illegible] declined. Spk w/pt ckin@420pm 30min early to fill out MRI questionnaire. [illegible] DOES PT HAVE?->NONE Has the patient ever had an allergic reaction to GADOLINIUM associated with an MRI?->No Has the patient received an IRON INFUSION through a vein (e.g., Ferumoxytol (FERAHEME) during dialysis) within the past 3 months?->No Has the patient worked as a METAL WORKER or WELDER?->No Is the patient CLAUSTROPHOBIC (fear of enclosed places)?->No Is the patient wearing a TRANSDERMAL PATCH?->No

Lab or Imaging

MRI RIGHT SHOULDER NO CONTRAST (Order #1315041892) on 3/18/2019 - Lab or Imaging Information

Result History

MRI RIGHT SHOULDER NO CONTRAST (Order #1315045892) on 3/31/2019 - Order Result History Report

PACS Images

Show images for MRI RIGHT SHOULDER NO CONTRAST

Contact Information

Patient Name	Sex	DOB and Age	SSN	Address	Contact Numbers
Darlene Walls	Female	3/23/1967 (52 year old)	558-37-5679	16323 CORNUTA AVE # 8 BELLFLOWER CA 90706	213-401-8827 (Home Phone) 213-401-8827 (Work Phone) 213-401-8827 (KPNS ONLY TEXT) 213-401-8827 (Mobile)

Routing Report

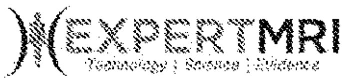
MRI RIGHT SHOULDER NO CONTRAST (Order #1315041892) on 3/18/19

Encounter Report

Patient Encounter Report

Order Report

Order Details



Location: BELLFLOWER CR

PATIENT NAME	: WALLS DARLENE	PATIENT ID	: 43781
D-O-B	: 1967/ 03/ 23	ACCESSION NO	: 198522-1
STUDY DATE	: 2019-04-30 16:42:14	REFERRING PHYSICIAN	: HAROLD ASEKE
APPROVAL DATE	: 2019-05-01 10:12:51.000000	RADIOLOGIST	: AMJAD SAFVI

X-RAY OF LUMBAR SPINE

TECHNIQUE: Anteroposterior and lateral projections of the lumbar spine were obtained.

Clinical History: Low back pain.

FINDINGS:
Normal lumbar lordotic curvature.
The vertebral bodies are normal in height.
Reduced intervertebral disc height is noted at L5-S1 level
No lytic or sclerotic bone lesion.
The prevertebral and the paravertebral soft tissues are normal.

IMPRESSION:

1. Reduced intervertebral disc height is noted at L5-S1 level.
2. No other significant abnormality noted.

Amjad Safvi MD
AMJAD SAFVI
RADIOLOGIST

Time Finalized: 2019-05-01 10:12:51

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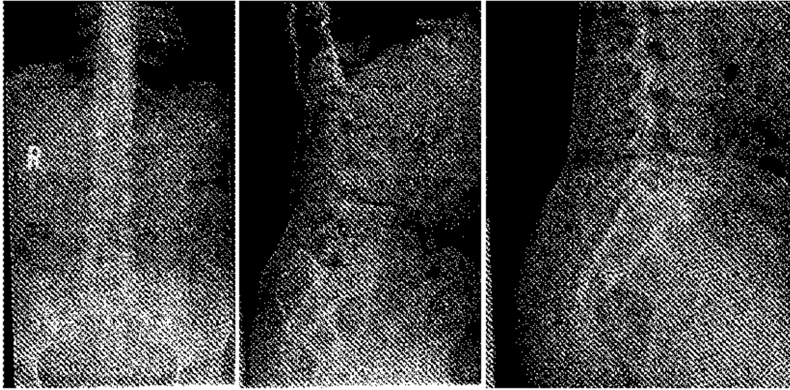

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1/29/2021

ADJ - CARRIE LAKE ROJAS
WC - GENERIC WORKERS COMP
Sedgwick
PO Box 14188
LEXINGTON, KY 40512

RE: Darlene Walls

DOB: 3/23/1967
EMP: KAISER PERMANENTE/HOSPITALS
D/I: 1/24/2019
CL#: 30191913252-0001
ACCT: 6389733

Darlene Walls was seen in our Van Nuys office on 1/29/2021, for Initial Orthopedic Consultation, at the request of the insurance carrier referenced above, for evaluation of this patient's industrial injury.

A comprehensive history was taken, a comprehensive physical examination was performed, and medical decision-making of high complexity was performed in order to complete this evaluation.

HISTORY OF PRESENT ILLNESS: Darlene Walls is a 53 y.o.-old left-handed female who is employed by KAISER PERMANENTE/HOSPITALS as a CNA .

During the course of employment on 01/24/19, Ms. Walls reports that while performing her usual and customary duties she was repositioning a patient when she developed pain in her lower back, right shoulder, and neck. The injury was reported to her employer. The patient was referred by the employer to the industrial doctor. Radiographs were obtained. She received approximately 1-2 weeks of physical therapy to the right shoulder and lower back.

MRIs were obtained of the right shoulder, neck and back. She was administered cortisone injections into both shoulders a few years ago.

She underwent Qualified Medical Examination with Dr. Narendra Gurbani.

The patient requested her medical records be reviewed since she has poor recollection of treatments and doctors.

She has an examination with Dr. Barcohana on January 29, 2020 for her neck and back.

PRESENT COMPLAINTS/REVIEW OF SYSTEMS:

MUSCULOSKELETAL: The right shoulder pain comes and goes. Pain is dull. On a pain scale of 0 to 10, the patient rates the pain as 3. The patient has difficulty with reaching overhead. There is no clicking and popping.

She has a left wrist cyst that is growing in size.

The neck pain comes and goes. Pain is dull and aching depending on movement. On a pain scale of 0 to 10, the patient rates the pain as 4. The patient has difficulty with turning the left. There is numbness and tingling in the left wrist.
The lower back pain comes and goes and is sharp. On a pain scale of 0 to 10, the patient rates the pain as 3. The patient has difficulty with prolonged walking. There is radiating sharp pain in the right leg to the foot.

DAILY LIVING: The patient has pain getting dressed, putting on socks and shoes, doing housework, driving and sleeping through the night.

NEUROLOGICAL: There is left wrist numbness. Her left foot tingles.

CARDIOVASCULAR: There is no swelling.

GASTROINTESTINAL: There is no change in bowel movement.

GENITOURINARY: The patient does not have any changes in bladder functions.

INTEGUMENTARY: The patient is not experiencing any rash, itching or changes in skin color.

RESPIRATORY: The patient does not have a chronic or frequent cough, shortness of breath or wheezing.

HEMATOLOGIC/LYMPHATIC: The patient is not slow to heal after cuts and does not have bleeding or bruising tendencies. There is no past history of clotting abnormalities.

CONSTITUTIONAL SYMPTOMS:
The patient has not had recent weight change, recent fever, chills or headache. The patient has not had a recent flu vaccination.

ALLERGIES:

Allergies

Allergen	Reactions
• Cephalexin	

PAST HISTORY OF PRESENT ILLNESS: The patient had a lower back injury with the same employer. She does not recall the year and recalls having therapy for the injury.

WORK HISTORY: The patient has been employed by the employer for 13 years. As an CNA the patient is required to assist in habit training, toileting, bathing, cleaning, repositioning, escorting, ambulating, assisting in feeding, transferring, dressing and undressing. The patient works full time. She has been off work since 02/14/2020 for "left wrist pain."

HOBBIES/SPORTS: None.

MEDICATIONS:

Current Outpatient Medications

Medication	Sig
• ACETAMINOPHEN-CODEINE #3 PO	Take by mouth.
• cyclobenzaprine 10 mg tablet	Take 10 mg by mouth three (3) times daily as needed for Muscle spasms.

No current facility-administered medications for this visit.

PAST SURGICAL HISTORY:

Past Surgical History:

Procedure	Laterality	Date
• PARTIAL HYSTERECTOMY		

PAST MEDICAL HISTORY:

Past Medical History:

Diagnosis	Date
• Hypertension	

ALLERGIES:

Allergies

Allergen	Reactions
• Cephalexin	

SOCIAL HISTORY:

The patient is a social drinker and smokes.

LEGAL STATUS: The patient has legal representation with Ms. Natalia Foley, Esq.

SOURCE OF INFORMATION: Initial history was recorded by Mary Klemens, a Professional Historian employed by Southern California Orthopedic Institute for this purpose. History was reviewed in detail with the patient by the undersigned.

PHYSICAL EXAMINATION:

This is a pleasant healthy appearing female standing 5 ft 8 in tall weighing 175 lb. The patient is alert and oriented. Extraocular movements are intact. Pupils are equal. There is no respiratory insufficiency. Skin lesions are not seen on the neck or back.

The patient has no gait disturbance. The patient can toe-walk and heel-walk. She has significant reduction in range of motion of the neck particularly with rotation or tilting to the left. She has moderate range of motion lumbar spine. Upper extremity strength appears to be full aside from the left wrist where she is wearing a splint due to wrist pain. Lower extremity strength and sensation appear to be intact. There are no signs of myelopathy. Patient has palpable pulses.

RADIOGRAPHS:

Two views of the cervical spine taken in the office on 01/29/2021 reviewed. There is straightening of cervical lordosis. Disc heights are preserved.

Two views lumbar spine taken the office on 01/29/2021 are reviewed. Pedicle shadows are intact. There is asymmetric disc space narrowing at L4-5 on the left.

July 28, 2019
MRI of the Lumbar Spine, signed by Amjad Safvi, M.D., Radiology, Expert MRI.
Impression: 1) Straightening of the lumbar spine seen. 2) Disc desiccation was noted at L4-5 and L5-S1 levels. 3) Restricted range of motion in flexion and extension positions. 4) Prominent ovarian follicular cyst measuring 4.5 x 4.4 cm seen on right side, follow up with ultrasound. 5) L2-3: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 2.9 mm; Flexion: 2.9 mm; Extension: 2.9 mm. 6) L3-4: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 2.7 mm; Flexion: 2.7 mm; Extension: 2.7 mm. 7) L4-5: Focal central disc protrusion with annular tear

effacing the thecal sac. Spinal canal was compromised. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L4 exiting nerve roots. Disc measurements: Neutral: 6.2 mm; Flexion: 6.2 mm; Extension: 6.2 mm. 8) L5-S1: Diffuse disc protrusion with effacement of the thecal sac. Spinal canal and neural foramina were patent. Disc measurements: Neutral: 3.0 mm; Flexion: 3.0 mm; Extension: 3.0 mm.

February 27, 2020
Electromyogram and Nerve Conduction Velocity Report, Benjamin Gross, M.D., Neurology, Universal Diagnostic Imaging, Inc.
Impression: Abnormal neurodiagnostic study of bilateral upper extremities was consistent with: 1) Mild left carpal tunnel syndrome involving the sensory fibers only. 2) Bilateral demyelinating ulnar motor neuropathy across the elbows.

REVIEW OF RECORDS:
Greater than 30 minutes were spent reviewing outside records in preparation of this dictation.

TREATMENT PLAN:
Please see below.

DIAGNOSTIC STUDIES:
Please see below.

DISABILITY STATUS:
Per QME.

WORK STATUS:
Per QME.

WORK CAPACITY AND RESTRICTIONS:

Per QME.

CAUSATION/APPORTIONMENT:
Per QME.

DIAGNOSIS:
1. Chronic left-sided neck pain.
2. Chronic low back pain.
3. Left lumbar radiculopathy.
4. Asymmetric disc space narrowing on the left at L4-5.

COMMENTS AND CONCLUSIONS:
Darlene Walls is a 53 y.o. left-handed female who is employed by KAISER PERMANENTE/HOSPITALS as a CNA . She was injured during the course employment on 01/24/2019. She underwent Qualified Medical Examination with Dr. Narendra Gurbani and was recommended that she see the undersigned for her neck and low back. The radiographs of the cervical spine show straightening of the cervical lordosis but I do not have a cervical MRI. The lumbar x-ray show asymmetric disc space narrowing at L4-5 on the left. There is an MRI report of the lumbar spine. She has not yet had any spinal injections and I would suggest she see a pain specialist to undergo injections prior to considering any type of surgery for her neck or her lower back. If she fails conservative measures and wishes to undergo surgery then I would be happy to see her again. At that point I will order updated MRI studies. At this time I have not arranged follow-up.

A COVID-19 questionnaire was filled out by the patient including negative responses to the following: a positive COVID-19 diagnosis in the last 14 days, contact with anybody diagnosed with COVID-19 in the last 14 days, fever, headaches, muscle pain, weakness, diarrhea, nausea, vomiting, abdominal pain, respiratory illness, cough, shortness of breath, loss of smell, loss of taste, rash, skin irritation, unexplained hemorrhage, and fatigue. Temperature was taken and it was less than 100F.

Spinal discomfort and radiculopathy is multifactorial. To complete the evaluation, an examination was performed and imaging studies were reviewed. I also had to assess non-spinal related causes of symptoms including vascular causes, visceral causes, infections, endocrine abnormalities, medications, and tumors. This added to the overall medical complexity of this visit.

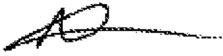
The patient understands our discussion. All questions were answered.

If you have any questions regarding this report, please do not hesitate to contact me.

DISCLOSURE: I declare under penalty of perjury that I have not violated Labor Code Section 139.3.

The contents of this report and bill are true and correct to the best of my knowledge.

Sincerely,



Babak Barcohana, MD.
Orthopedic Surgery

CC: Ms. Natalia Foley, Esq.

Signed by Interface, Transcription Incoming on 01/28/21 1604
Signed by Barcohana, Babak, MD on 01/29/21 1056
Signed by Barcohana, Babak, MD on 01/29/21 1057
Initial consult on 1/29/2021 Note shared with patient