Eastern Anesthesiology Associates, Incorporated
PAIN MANAGEMENT SERVICES

ROUTING SLIP

PROVIDER

NAME:	Thomas Johans, M..D.
UPIN:	A11111

PATIENT DEMOGRAPHIC

NAME:	Imaginary, John R.
ADDRESS:	333 Cedar Street Any City, AS 89898
SSN:	565099000
MRN:	0000000001
DATE OF BIRTH:	11-17-1949

SERVICE INFORMATION

DATE OF SERVICE:	7/6/2004
PLACE OF EXAMINATION:	Office
LEVEL OF SERVICE:	99204

ICD 9 DIAGNOSIS CODES:

Lumbar Post Lam (722.83)

CPT PROCEDURES CODES:

Lumbar SESI (64483)

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6320 Canoga Avenue, Suite 1500
St. Louis, Missouri 63131
(800) 985-6016

John R. Imaginary MRN: 000000001 Date of Service: 7/6/2004

John Imaginary is a 54 yr. old male

Adverse Drug Reactions

Penicillin,
Demerol.

Current Medications

Amitriptyline HCI oral tablet 10mg. (Ten mg.) Take one tablet at bedtime for 4 nights, increase to two tablets at bedtime; thereafter as tolerated. #60 sixty No refills.
Quinine 325MG PO HS # NO REFILL

Subjective

This encounter was conducted at the West County Office 2/6/03.
The history of present illness begins 3-4 years ago with the gradual onset of pain that starts in the low back and radiates into the left leg.
Patient feels that an unknown cause caused this pain. The pain is best described as: shooting, dull, aching, sharp, electric shock, painful.
The pain is also described using the following effective descriptors: Terrible, nauseating, miserable, agonizing. The timing of this pain is: constant, mostly in the morning, very variable. This pain is associated with: numbness, weakness, headache, nausea/vomiting.
This pain is NOT associated with: numbness, weakness, aura, headache, nausea/vomiting, bowel/bladder dysfunction.
The pain is made worse with: coughing, sneezing, exercise, walking, sitting, standing, lying down, sexual activity, weather changes, bright lights, noise, cold, driving, menstrual cycle, touch, rolling in bed, moving from sitting to standing, taking stairs, stress/fatigue.
Factors that seem to relieve the pain include: sitting, standing, lying down, alcoholic drinks, sexual activity, heat, massage, medicines, walking, ice, relaxation.
Previous treatments have included : physical therapy, chiropractic care, acupuncture, biofeedback, psychologic intervention, TENS unit, cold therapy, bed rest, surgery, traction, nerve blocks, trigger point injections, relaxation training, occupational therapy, cortisone injections, epidural steroid injections, heat.
Past chronic pain medications include: narcotic, muscle relaxants, anticonvulsants, tricyclic antidepressants NSAIDs. These have generally been of limited benefit.

1. **Past Medical History**
   Cardiovascular. Hypertension.
   Endocrine. Diabetes.
   Malignancies: None.
   Hematologic: None.
   Autoinmune. Osteoarthritis. Fibromyalgia.
   Renal: None.
   Genitourinary: None.
   Central nervous system: Headaches. Migraines.
   Gastrointestinal. GERD.
   Pulmonary. Chronic bronchitis COPD. Tobacco abuse.
   Infectious disease. None.
   Psychiatric. Depression. Anxiety.
2. **Past Surgical History**
   Hysterectomy.
   Tonsillectomy.
   Adenoidectomy.

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3. **Family History**
   No past family history that is significant to the patient's history. Mother is alive.
4. **Social History**
   The patient is married. He has 2 children. The patient education level is to the trade school level. He is currently a retired secretary. His habits include no smoking, social consumption of alcohol, 2 beverages /day/ containing caffeine.

Review of Systems
The patient reports:
General: weight or appetite changes.
Respiratory: cough.
Neurologic: headaches, dizziness.
Psychiatric: Depression, anxiety.
The patient denies:
General: fever, chills, disturbed sleeping habits.
Eye: eye infections, blurred vision, double vision, blindness.
ENT: hearing loss, inflamed nose, sinusitis.
Cardiac: chest pains, heart murmur, skipped beats.
Respiratory: coughing up blood, wheezing, shortness of breath, difficulty breathing on exertion.
GI: constipation, diarrhea, blood in the stools, nausea/vomiting.
Neurologic: falling, seizures, numbness, tremor.
Endocrine: hot and cold flashes.
Hematological: easy bruising, difficulty in clotting the blood.
Joints: Joint or muscle limitation and pain other than the present illness.
Psychiatric: mood swings.
Skin: lacerations, abrasions, pustules, nodules, tumors, breast changes.

Oswesterey Score
Responses to the Oswesterey Questionaire (version 2).
(2 points) The pain is moderate at the moment.
(3 points) I need some help but manage most of my personal care.
(1 point) I can lift heavy weights but it gives extra pain.
(4 points) I can only walk using a stick/crutches.
(4 points) Pain prevents me from sitting more than 10 minutes.
(4 points) Pain prevents me from standing more than 10 minutes.
(3 points) Because of pain I have less than 4 hours of sleep.
(2 points) My sex life is nearly normal but is very painful.
(2 points) Pain has no significant effect on my social life apart from limiting my more energetic interests for instance sports.
(1 point) I can travel anywhere but it gives extra pain.

Objective:
Vital signs
Height 65 inches; Weight 250 pounds; Temperature 99.5°; Blood Pressure 145/90 torr; Pulse 90 bpm; Respiration 22 bpm;
Clinical Parameters
Oswesterey Pain Disability Score 45 of 100 points.
General
The Patient is well nourished and physical development appears appropriate for the patient ´s stated age.
HEENT

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Normocephalic/ atraumatic head. Pupils are normal react to light and accommodation. Extra ocular muscles are intact. Conjunctivae are clear and sclera anicteric. Nose is clear of obstruction and septum is midline. The ear canals and throat are clear of obstruction.

Neck

Neck is supple without masses or adenophaty. Cervical range of motion reveals normal flexion, extension and lateral rotation. The fact joints are nontender. The spinous processes are nontender. There were no trigger points elicited in the muscles. Carotids showed good upstroke without bruits. The thyroid is nontender and shows no enlargement or nodules.

Cardiovascular

Heart shows a regular rate and rhythm without murmur. S2 was not noted.

Respiratory

Lungs are clear to auscultation and percussion. Diaphragmatic excursion appears normal. The patient has rales in the bases.

Musculoskeletal

The patient ´s gait was antalgic. There was no cyanosis or clubbing of the nails. There is a full range of motion of all extremities. There is minimal pain with back extension or flexion. There is no muscular flaccidity, paralysis or spasticity. Gaenslens test (affected knee is flexed and unaffected thigh is hyper extended) did not provoke sacroiliac joint pain on the right side. Patrick test (flexed knee is pushed lateral ward to rotate head of femur outward) did not cause pain in the hip joint. There is no paraspinous muscle tenderness or trigger points palpated. Palpation of the right posterior iliac spine was somewhat painful.

Skin

The skin is of poor turgor, pale color and dry. Skin appears parchment. Bruising evident. There were no pathologic lesions noted.

Neurologic

Cranial nerves 2-12 were tested and were grossly intact. Deep tendon reflexes reveal biceps reflex (C5-6) 2+ on the left and right, pronator reflex (C6-7) 2+ on the left and right, and triceps reflex (C7-8) 2+ on the left and right. Patellar reflex (L4) 2+ on the left and 2+ on the right. Extensor hallucis longus extension strength was judged to be 5/5 on the left and 5/5 on the right. Dorsiflexion of the foot is 5/5 on the left and 5/5 on the right. Normal sensations to alcohol wipe in all lumbosacral dermatomes. Hip flexion on the left is 5/5 and 5/5 on the right. Plantar flexion is 5/5 on the left compared to 5/5 on the right. Straight leg raising. Left leg is not painful at 80 degrees elevation. The right leg is not painful at 80 degrees elevation.

Psychiatric

The patient appeared alert and oriented to person and time and was well groomed. The patient showed good memory capabilities and reasoning appeared normal. The affect was appropriate. The patient did not exhibit undue depression, anxiety or agitation.

Procedures

Lumbar SESI

Assessment

Lumbar Post Lam

Assessment:

Post lumbar laminectomy syndrome.

It was explained to the patient that pain syndrome occurs from the repeated injury to their nerve roots before their corrective surgery (laminectomy) from either displaced discs irritating the nerve root or compression from enlarged arthritic joints. In addition, the nerve roots may be inflamed and irritated from the normal healing processes occurring after their surgery. Scar formation may at least theoretically tether or encase the nerve roots. This is manifested as pain in the legs and buttocks. An anatomic model was used to show them the pathophysiology of these processes.

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Our first goal is to identify the nerve root that is responsible for causing the pain. This is done by injecting small doses of local anesthetics that will temporarily inhibit the ability of the nerve root to conduct pain allowing the patient to asses their pain. So as to decrease the number of injections, a small amount of corticosteroid is added to the injectate such that if the nerve root being investigated is indeed the nociceptive root, this will decrease the inflammation resulting from this irritation and compression and allow the nerve root to heal and provide long term relief. This injection procedure is named selective nerve root steroid and local anesthetic injection. Since only the patients can describe their pain, radiologic imaging pales in comparison to the value of this diagnostic block.
Our second goal is to assess the extent of the damage to the nerve. It was stressed to the patient that relief sustained after this treatment does not mask the pain but allows for healing to occur and long term relief is expected. If the patient received NO relief from the block, we can conclude that the nerve root is not responsible for the pain and we need to continue with an injection of another root. If the patient exhibits progressive relief, then we can conclude that the pain was associated with an inflammatory response and some recovery could be anticipated. On the other hand, if the patient only receives short term relief, then one can suspect that the nerve roots are irreparably damaged and techniques such as spiral cord stimulator or pulse radiofrequency neuromodulative techniques could be offered.
The risks and complications of this procedure were discussed openly and candidly with the patient. These include nerve root damage, infection as meningitis or abscess, bleeding which could result in spinal cord damage and paraplegia.
A brochure outlining the risks and benefits of a pulsed radiofrequency technique was given to the patient for his referral.
Plan:

1. Fluoroscopically guided right L4 selective nerve root steroid injection. The risks and benefits were discussed with the patient and the patient wishes to proceed.
2. Return to the clinic in 7 to 20 days for follow-up and possible repeat.
3. In the event he is no better at all any time, even while the nerve root is numb, we will offer a left L4 selective nerve root injection.
4. Start low dose hydrocodone.

Plan

Rx.

Hydrocodone Apap 5/325 HALF to whole PO Q 4h#120 No refills Substitution allowed.

Referral

Cover letter

Thomas G. Johans, M.D.
Electronically signed at the time of Timestamp

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Procedure Note

Lumbar SESI
Left L4 Fluoroscopically Guided Selective Nerve Root Steroid Injection.

The patient was identified in the holding area and the potential risks and complications of the procedure were reviewed.
The patient verbalized his understanding of the procedure and gave consent. The patient was transferred to the fluoroscopy suite and monitors were applied including NIBP, pulse oximetry. A nurse was available for the duration of the procedure to carefully monitor the patient. Please refer to the nursing record for vital signs graphic for doses of sedatives and analgesics. In addition, a radiology technician was present for assistance with the C- arm fluoroscopic unit.

The lumbosacral area was painted with Betadine and allowed to dry. The fluoroscopic unit was then manipulated in the caudad/cephalad position until the disc spaces of the joints were in clear focus. The unit was then put in the oblique position until the articulating processes were visible. A 25 gauge, 3.5 inch Quincke spinal needle was then placed using the "through the needle technique" onto the six o'clock position of the pedicle. It was then slowly walked off the lamina into the L4-5 intervertrebal foramen. The C- arm was then placed into the lateral projection and the needle was advanced until its tip was in the superior dorsal part of the foramen. At this time, 0.1-0.3 cc of Omnipaque dye at 300 mg/cc was injected through the needle and a neuroprogram was produced. The dye was seen to enter the epidural space. The L4 injection did reproduce the patient´s pain. After negative aspiration of CSF and blood, 1.5cc of Celestone 6mg7cc followed by 1.5 cc of 0.5% Lidocaine per the needle. The needle was withdrawn intact.

The patient tolerated the procedure well and was transported to the recovery area. After receiving postoperative instructions from the nurse, and after all residual neuromuscular weakness had recovered, the patient was discharged in satisfactory condition.

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