**Professor Sadat**

**Rotation 5 – Family Medicine Site Vist HP 1**

**Jay Kolasinac**

**6/22/2021**

**Identifying Information:**

* Name: G.J.
* Sex: Female
* DOB: \*/\*/1964 – 57-years-old
* Date: 06/21/2021 @ 12:30 PM
* Location: CitiMed – JFK, Queens, NY
* Source of Information: Self
* Source of Referral/Mode of Transport: Car

**CC**:

Neck, right shoulder, middle back, and lower back pain, follow up.

**HPI**:

 57 year old female, right hand dominant, presents for a follow up evaluation for an MVC sustained on 11/28/20, at 7:00pm. Patients states she was the restrained front seat passenger of a Chevy Traverse SUV. Her vehicle was in some traffic on the Verrazano bridge. Her SUV was rear ended by a 4 door sedan. Her body was jolted. She denied head trauma, LOC, bleeding anywhere, air bag deployment, or window glass breaking. She was ambulatory at the scene. The car was drivable afterwards. Her husband then drove her home. Her pain persisted, so her husband drove her to Northwell Franklin ER the following day. There she had a chest Xray, and as discharged on methocarbamol. Her pain persisted so she drove herself on 12/1/20, to this facility, for further evaluation and treatment. Denies prior injuries or pain to eh body parts affected.

 Today her neck pain is 6/10, constant, dull, non-radiating, and worse with movement of her neck.

 Her right shoulder pain is 8/10, constant, “pressure”, non-radiating, and worse with raising her right arm.

 Her middle and lower back pain are 10/10, constant, dull, non-radiating, and worse with bending and twisting.

 Denies any numbness, tingling, weakness in extremities, headaches, vision changes, chest pain, SOB, fever, chills, bowel/bladder changes, nausea, vomiting, or diarrhea. Patient ambulates to the office without any assistive devices.

 Patient is taking Ibuprofen 800 mg 2-3x/day, about 4-5 days per week, with relief. She takes Flexeril 7.5mg 3 times a week, with relief. She uses Lidoderm patches 5% 2-3 times per week, with relief. She is doing physical therapy and seeing the chiropractor 3 times per week, with relief.

 She is being followed by pain management for continued neck and back pain. She saw Dr. Goodstein and his PA Laura, on 2/5/21. It was advised to continue PT and get cervical and lumbar medial branch blocks.

 She is being followed by orthopedics for continued right shoulder pain. She saw Dr. Lee on 2/3/21, 5/12/21. It was advised to continue PT and have a right shoulder arthroscopy.

 She is a home health aide and usually works 37 hrs per week. She also works for Amazon as a Shopper, for about 20 hrs per week. Is not working due to continued pain.

**Past Medical History:**

Obesity

HTN

**Medications** –

 Metoprolol, Losartan, Ibuprofen, Lidoderm patch, Flexeril

**Past Surgical History:**

Denies

**Allergies**-

Denies any known drug allergies.

**Past Family History:**

**Father –** Deceased at 75 due to MI.History of HLD and obesity.

**Mother –** 81-years-old. History of DM, HTN, and obesity. Alive and well.

No siblings, or children.

**Social History:**

G.J. is a 57-year-old, African American, female, who works as a home health aide and Amazon shopper, currently not working due to continued pain, who suffered an MVC in November, 2020. She is currently experiencing continued neck, shoulder, and T/L spine pain. She visits PT and the chiropractor 3 times a week, with relief. She is a former smoker of 1 pack a day for 20 years who quit 10 years ago.

**Review of Systems:**

General:(-) fatigue, chills, nausea, vomiting, weight gain or loss.

HEENT:(-) any headache, sore throat, visual changes, auditory changes, rhinorrhea, or epistaxis.

Respiratory: (-) any SOB, cough, dyspnea, or sputum production.

Cardiac: (-) any chest pain, palpitations, murmurs or dyspnea on exertion.

Msk: (+) Joint pain, myalgias, dec ROM. (-) redness, swelling, or instability.

Neuro: (-) Denies any syncope, decreased sensation, tingling, numbness, or weakness.

Psych: (-) Denies any depression, anxiety, or mood changes.

**Physical Exam**

Vitals: P: 84 bpm RR: 16 T: 98.4F BP: 123/75 H: 5’6’’ Wt: 223lbs BMI: 36

General: Patient is AOx3. Appears stated age, properly dressed/groomed, well nourished, and in no acute distress. Obese.

Skin: No masses, lesions, scarring noted. Skin is warm.

Neck: Supple. No masses/lesions. Trachea is midline.

Cardiac: No masses/lesions noted on chest. No visible lifts, heaves, or thrills. Heart rate and rhythm are within normal limits. Distinct S1/S2 are heard with no murmurs, gallops, or rubs.

Lungs: Chest wall is symmetric with no deformities. Nontender. No signs of respiratory distress. Lungs are clear to auscultation bilaterally. No wheezing, rhonchi, or crackles heard.

Abdomen: No masses/lesions/scarring noted. Abd is protuberant and nontender with no distention. Bowel sounds are normoactive in all four quadrants. No hepatosplenomegaly appreciated.

MSK:

 Cervical – No ecchymosis, edema, or deformities. Tender generalized to right paracervical muscles and right trapezium, with spasm. Decreased ROM secondary to pain. Flexion 50/60, Extension 40/50, Left rotation 70/80, right rotation 70/80, left lateral flexion 30/40, right lateral flexion 30/40.

 Right shoulder – No ecchymosis, edema, or deformities. Generalized tenderness to posterior shoulder. Decreased ROM secondary to pain. Flexion 150/180, Extension 30/50, abduction 160/180, adduction 40/50, internal rotation 50/70, external rotation 60/90, negative drop arm test and negative cross arm test.

 Back – No ecchymosis, edema, deformities. Generalized tenderness to spine and bilateral paravertebral muscles of thoracic and lumbosacral region. Decreased ROM secondary to pain. Flexion 60/90, extension 20/25, left rotation 30/40, right rotation 30/40, bilateral + SLR.

 Full ROM of all other extremities. Strength – 5/5 both upper and lower extremities. Grip – 5/5 bilaterally.

Neuro: Alert and oriented, cranial nerves 2-12 grossly intact, gait normal, sensory exam intact.

Extremities: No clubbing, cyanosis, or edema. Pulses are 2+ bilaterally.

Psych: Alert, oriented, cooperative with exam, appropriate mood/affect, speech clear.

**Assessment**:

57-year-old female with PMH of obesity and HTN presents with complaints neck pain, right shoulder pain, and middle/lower back pain following MVC sustained in 11/2020.

DDx:

1. Sprain of ligaments in cervical spine/strain of muscle/tendons at neck level
2. Strain of muscles/tendons of right rotator cuff of right shoulder
3. Sprain of ligaments in thoracic spine
4. Strain of muscles/tendons in posterior wall of thorax
5. Sprain of ligaments in lumbar spine
6. Strain of muscles/tendons of lower back

Imaging:

* + Xray cervical [12/01/2020]: Negative study.
	+ Xray right shoulder [12/01/2020]: Negative study
	+ Xray thoracic [12/02/2020]: Negative study. MRI should be considered if clinically warranted. Cardiomegaly.
	+ Xray lumbar [12/01/2020]: Negative study
	+ MRI cervical [12/04/2020]: Cervical spasm; no fracture or focal bony lesion. Small central and left-sided herniation of the nucleus pulposus at the C4/C5 level with impingement of the left-sided nerve roots. Central and left-sided hernation of the nucleus pulposus at the C6/C7 level, with impingement of the nerve roots centrally and on the left and mild central stenosis. Mild bulging of annulus fibrosis of the C5/C6 disc. Normal appearance of the cervical cord.
	+ MRI right shoulder [12/08/2020]: Intact right shoulder; spurring of the colon prickly joint. Tendinopathy partial tear of the supraspinatus tendon. Tendinopathy of the subscapularis tendon. Minimal tear of the anterior/superior glenoid labrum. Small effusion.
	+ MRI thoracic [12/04/202]: Intact thoracic vertebral bodies; no fracture or focal bony lesion. Mild degenerative changes at the findings pronounced at the C4/C5, C5, and C6/C7 levels, bulging of the annulus fibroses of the discs. Normal appearance of the thoracic cord.
	+ MRI lumbar [12/08/2020]: Intact lumbar spine; no fracture or focal bony lesion. Focal acute central herniation of the nucleus pulposus at the L5/S1 level, with impingement of nerve roots centrally and with mild central stenosis. Mild central stenosis at the L4/L5 level related to bulging of the annulus fibrosis of the dsic and facet joint hypertrophy. Normal conus medullaris.

**Plan:**

* Continue taking current medications as prescribed
* Not fit for duty
* 100% temporary disability
* Work status: Not working
* OTC Tylenol, arnica gel, and ICY HOT
* PT, Acupuncture, chiropractor, 3 times a week for 4 weeks, to decrease pain and improve ROM
* Pain management follow up for continued neck and back pain
* Orthopedics follow up for continued right shoulder pain
* Return in 3 weeks for follow up
* Nearest ER for worsening symptoms.