Medilenz

Pre-Hearing Outline

Date:		Hearing Date:		Judge:	

Client Name:	John Doe		
Date of Birth:	06/18/YYYY		
Date of Application:		Protective Filing Date:	
Date of Onset:	03/01/YYYY	Income After Onset:	
Prior Application:		Reopen?	
Date Last Insured:			
Impairment # 1:	Cognitive disorientation and Memory loss	Impairment # 4:	COPD, Asthma
Impairment # 2:	Neck pain, arthritis	Impairment # 5:	Anxiety, depression
Impairment # 3:	Severe headaches	Impairment # 6:	Atonic bladder

DATE	SUMMARY	BATES
10/03/YYYY	SLEEP STUDY REPORT FROM A1 DISORDERS CENTER OF XXXX: 1. Severe obstructive sleep apnea with significant associated oxygen desaturation and arousal. Nasal CPAP at a pressure of 11.0cm/H2O resulted in a reduction in the apnea index to 0 and the abolition of snoring. A large Ultra Mirage mask and heated humidifier were utilized for the evaluation	ARJOHNT00001044-1045
01/03/YYYY	PROGRESS NOTES FROM DAVID xxxx, M.D.: CHIEF COMPLAINT: Rash on left arm and hand ASSESSMENT: Allergic reaction Plan: Ketek	ARJOHNT00001016,1017
01/10/YYYY	PROGRESS NOTES FROM DAVID xxxx, M.D.: CHIEF COMPLAINT: Acute, intermittent shortness of breath, cough congestion, no chest pain Assessment: Acute bronchospasm, bronchitis Plan: Kenalog, Albuterol, Amoxil	ARJOHNT00001014,1015
09/22/YYYY	MRI C-SPINE: Normal MRI c-spine MRI BRAIN: Normal MRI brain	ARJOHNT00001011
11/15/YYYY	CORRESPONDENCE TO STAN xxxx, M.D. FROM ELLEN xxxxx, M.D.: Patient has had headache for a couple of years. He has a pretty high pain threshold so his observational skills as to mode of onset, precipitating factors, etc. are pretty limited despite his intelligence. He is from the xxxx area and grew up as a farm kid with the usual ambitious boyhood activities including a memorable fall off the back of a flat bed truck onto his back when the clutched popped when he was about 15. He can remember lying on the ground unable to move for a while but was able to "shake this off". He also recalls water skiing while a student at College Station on a knee board. There were several falls forward onto his face where he is reasonably sure he sustained a concussion. He is thick set and tough, he doesn't remember neck pain, but I'm sure these injuries involve some element of neck injury. In recent years, he can recall that if he "slept wrong" he would have some neck pain and he has noticed pain and a grating noise with head rotation. He has observed brief sharp pains in either eye in the last year or so, along with brief shocks of pain from the left occiput radiating forward to the temporal region or dissipating somewhere near the vertex. He also has more continuous posterior headache which can be very severe but he is not aware of any particular precipitating factors. He also has intermittent left hand tingling, variable appetite, new onset asthma, but he did not tolerate Advair as it gave him thrush. He	ARJOHNT0000301-303

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	was seen at Dean xxxx which of course did not turn up anything. He notices that if he turns his head too for he will get visual blurring. He has been to physical therapy and the therapist told him that C1, C2, and C3 were close together and the therapist could not successfully manipulate these and get them to move. He never smoked and is a very seldom drinker. He has had an episode of back pain with left leg pain. He has been having early morning awakening but is not sure why. He's not certain about snoring but I suspect that he does, looking at the size of his airway on his supine cervical MRI. He also complains of difficulty with name retrieval, even names of long time friends. He can't remember when the problem started. As a sales representative, this gets to be a problem. He mostly calls on rheumatology researchers at xxxx. He was chemistry major at xxxx and is a pretty smart guy. He had been doing better on Mobic with decrease in headache overall. Your change to Aleve has sustained that improvement. He has been taking Benadryl 50 mg at bedtime for sleep. He is allergic to the "D" in Seldane D. His wife is an art teacher for the xxxx and drives in the xxxx area from school to school. He has a home in xxxx but also one in xxxx City through the week. They have no children. He has an older brother who is a paranoid schizophrenic and rather aggressive and hostile. His mother is living and has some type of brain tumor that is inoperable that was diagnosed in the late 80's. She also has some type of polyarthritis, possibly due to gout. His dad has heart disease. He feels that he tires easily and also has heartburn. On exam, he is a very pleasant gentleman. Height 6'0", Weight 233. His lungs were clear but his breath sounds were markedly decreased. His posture is terrible with marked slumping and his head and shoulders are anterior. If he sits straight, he is uncomfortable at the thoracolumbar junction. He is extremely tight at the anterior chest wall but he does not perceive any pain. He is tender at the first rib insertion at the sternum and at the costovertebral joint. He does notice this and discomfort all along the first rib where he is quite puffy (in the supraclavicular region). He was little sensitive tapping along the clavicle near Erb's point. His forearms were uncomfortable supinated, with positive neural tension signs, but he denied tingling, etc. He was mildly tender at the left C1 transverse process, but not at the C1-2 joint. He was definitely tender at both C2-3 facets, over which light tapping inconsistently caused referred pain to the orbital/frontal regions. Otherwise, the cervical facets were contender, where there was substantial overlying muscular spasm. He could not perceive pain at C7-T1 where there substantial overlying trapezius spasm. Cervical flexion and extension were moderately decreased without pain in the latter. Right rotation was limited by guarding of the left levator scapula, trapezius, scalenus, and splenius capitus. There was a little soreness at the insertion of the splenius capitus. There was a little tenderness over the paravertebral generally, left greater than right. Leftward rotation was not quite as guarded. He had no side bending in either direction. His thoracic spine was extremely stiff, especially in the upper half. In the lower four segments or so on the left, there was significant paravertebral spasm guarding these segments, again without discomfort. After working with these segments in the course of exam, his ability to move air increased, but he could not perceive the difference. In his low back, he had decreased flexion at L4-5 on the right and at L5-S1 on the left, which should have accounted for what discomfort he could perceive in his low back. He had altered sensation which he could not describe in the left L5 distribution in the leg and foot. There was no weakness. Both calves were extremely tight. He sat with his hips widely abducted. Sitting in a more neutral posture was uncomfortable in the low back. He was guarded in both hips, but he could not perceive pain. His gait was unremarkable. His hands were abnormal with peculiar callusing over his PIP and MCP joints with flexion contracture of the right third PIP joint. His palms were also very tight and he could not flatten them. There was no Dupuytren's contracture, etc. His peripheral joints were nontender. He had some blotchy changes in his palms with blanching telangiectasias. His mouth was not dry. His parotids were a little large but not indurated. He brought along a cranial MRI which was negative to my review. I did not see any particular white matter changes that would correlate with his old head injuries and give us a clue about his memory impairment. I told him I would address his memory issue but I preferred to do it when the pain issue is	

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	settled. His cervical MRI was of so-so quality but he clearly had significant facet degenerative changes. There appeared to be facet tropism at C2-3 and synovitis at multiple levels with thickening and substantial spurring. There was posterior disc bulging at C2-3 and circumferential disc bulging of the inferior endplate of C5 and lesser at C6 where there was disc bulging eccentric to the left. Overall, I think Mr. John's headache is coming from the upper cervical spine, especially C2-3 and to an extent from C7-T1 where he is probably triggering trapezius spasm. Overall however he has complex poor posture. Comorbid disc disease is probably adding smother element of pain and guarding. On top of that, there appears to be an undiagnosed rheumatic process which we can see in his hands and in the synovium lining the cervical facets. It may be the cause for some of his fatigue. His high pain threshold does not give us much guidance however. He is definitely feeling better on the anti-inflammatory which lends credence to the inflammatory hypothesis, in combination with mechanical disturbance. The new onset asthma is probably a component of this as well. I sent him for plane films with flexion/extension and lumbar spine to get a handle on his structure. I'd like him to see Mike xxxx for physical therapy. I sent him for some lab and I'd like to see if we can make a rheumatic diagnosis. Since he works with Dr. xxxx at XXXX, he said he was going to show him his hands and see what he thought. I'd like also to get an EEG. He seems to have some mood disturbance that may be related to his concerns about his memory it may be related to poor sleep from pain that he does not perceive. I did not begin him on an anti-depressant as I didn't think he needed to gain weight at this point and we may be able to get around this. I think some positive feedback and positive results would go a long way to relieving what is likely to be a situational depression anyway.	
11/22/ YYYY	LABS FROM A2 HOSPITAL: High: HsCRP 1.40 (0-0.33)	ARJOHN T0000100 2-1006
12/19/ YYYY	OFFICE VISIT TO DAVID xxxx, M.D.: The patient presents with chief complaint of memory loss, painful neck, he has high disc disease in his hack, some question as to whether there were issues with his posterior fossa. I talked with Dr. xxxx, who assures that she does not see any signs of obstruction or need for intervention. We also discussed PET scan in trying to contribute to the memory loss diagnosis and evaluation and treatment of same. Patient is offering a history that states that he has been here in our office, has seen neurology, has seen neurosurgery, and has seen sleep lab and basically the concerns are that we need a neuropsychiatrist. Patient, at this point, has enough memory loss and that he is losing orientation daily and need for evaluation. Assessment: 1. Memory loss. 2. Cervical radiculopathy Plan: 1. I would like to him to see Dr. Julia xxxx who is in speech pathology and neuro diagnostics. She will see him 12/21/YYYY at 8:00. 2. I would like to do a B-12, methylmalonic acid, sed rate, TSH, BMP, and a folate. 3. I would like to call him the lab as soon as we can. 4. I would like to schedule him for a brain PET scan for altered mentation for evaluation. Patient is now demonstrating soft signs with loss of his orientation in public and difficulty with finding his house, difficulty with finding our office and I think it is time to do further studies.	ARJOHN T0000099 8,999
12/20/ YYYY	LABS FROM A3: High: Sed rate by modified - 30 (< OR = 15mm/h)	ARJOHN T0000100 1
12/21/ YYYY	PROGRESS NOTE FROM ELLEN xxxx, M.D., DAVID xxxx, M.D, MIKE xxxx, MS, PT: ASSESSMENT: "Doing pretty well" - Decreased frequency and intensity of headaches - until	ARJOHN T0000099

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	December 19, YYYY "slept wrong" - with severe occipital headache. During the past 2 days has had bilateral cervical through bilateral deltoid "annoyance". Joint ,motion restrictions: T12 extend light, L1 extend left, C2-3 extend right, C7 extend right, Atlas axis right rotation restricted 25% and occiput Atlas forward nodding bilaterally. November 28, YYYY initial evaluation bilateral Atlas axis rotation restricted greater than 90%. Short term memory problem noticed in PT clinic SPEECH AND LANGUAGE PATHOLOGY EVALUATION AND PLAN OF CARE: Date of onset: 06/06/YYYY Primary Diagnosis: Cognitive disorientation and memory deficit Treatment Diagnosis: Cognitive-linguistic-memory disorder Impressions/problems: Mild-moderate memory deficits; mild dysnomia in single word naming tasks; mild-moderate dysnomia in conversation (especially with names of people); reduced cognitive switching; reported difficulty monitoring passage of time and recent onset of difficulty with recognizing familiar pathways Recommendations: It is recommended that this patient undergo further medical evaluation to determine the etiology for his seemingly progressive cognitive-linguistic deficits he is experiencing. Once the etiology is determined he may be a candidate for cognitive-memory-linguistic therapy. It is also felt that he would benefit from a neuropsychological evaluation. Treatment strategies/plan of care: Pending further medical evaluation	2-997
01/17/ YYYY	POSITRON EMISSION TOMOGRAPHY (PET) SCAN OF THE BRAIN USING 10.8mCi OF F-18 DEOXYGLUCOSE (FDG) FROM THE A1 CENTER AT DEACONESS: FDG PET scan requested to evaluate the possibility of a dementia disorder with cognitive dysfunction demonstrates what appears to be a mixed pattern of dementia disorder (i.e., vascular as well as possible an early Alzheimer's type dementia disorder). The plethora of vascular findings are noted in the left middle cerebral artery territory peripherally and the left parietal temporal areas. It might be worthwhile doing Doppler studies of this patient's carotid vessels especially the right carotid vessel to see if there are any stenotic lesions there. Once this is ruled out, placing him on a combination of anti Alzheimer's along with Aspirin might be indicated, if the latter is not clinically contraindicated.	ARJOHN T0000099 1
01/23/ YYYY	US DOPPLER CERV CAROTID BILATERAL FROM A4 HOSPITAL: Normal carotid and vertebral arterial doppler ultrasound. No flow was detected in the left vertebral artery	ARJOHN T0000099 0
01/24/ YYYY	CHART NOTE FROM ELLEN xxxx, M.D.: When he actually had the therapy, it was completely comfortable. He denied pain throughout. In fact he was somewhat negative that the neck had anything to do with his headache. He was quite sore the next day and could hardly move. I called him and encouraged him to return, which he did several times. The dynamics between them improved, and so did his headaches. They are no longer daily or incapacitating. He hardly does the right-left head movement any longer and this problem has moved down the list. When I wrote up my initial consultation, I knew he was concerned about his cognition as much as his headache, and scheduled him for an EEG. EEG report was basically normal although there was equivocal parietal slowing. I asked about sleep apnea. He said that base had been covered and he did not have it. It turns out that he did have a sleep study, but it was not normal, according to his wife who accompanied him today. He had the idea that sleep studies and treatment with CPAP was just a big scam. I assured him it was not. Julia xxxx, a speech/cognitive therapist's testing reflected moderate impairments in Immediate and Recent Memory in the 63rd percentile, Recall of General Information and Problem Solving and Abstract Reasoning in the 75th percentile, Remote Memory, Spatial Orientation, and Auditory Processing and Retention in the 91st percentile. He probably functions as well as he does at work since his Organization	ARJOHN T0000029 8,299

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	was at the 95th percentile. This erratic pattern is consistent with what we see with traumatic brain injury of which he has a significant past history. His wife says he has always been like this, it has just been worse and his customers are noticing it. It may be because of the sleep apnea. He admitted to hating his job, but he "loves his customers." He said he has had some unusual tearfulness and wondered if this was depression. Taken together, there are probably long-standing problems from old head injury, current sleep apnea as Dr. xxxx thought in the first place (that Mr. xxxx wriggled out of having treated due to whatever paranoia or personality quirk he has where he is a little quarrelsome with some providers but not me, Dr. xxxx, Dr. xxxx or some others), and depression. His wife also meets him toe-to-toe and he really spars pretty amicably. He may be misunderstood. Chronic pain may be more of an issue than this old farm boy realizes. If Julia xxxx will see him back, I think we can help him with his cognitive impairments. I'd like him to see Regina xxxx, RN-C, CNS, for counseling. He was actually willing to do that. It is easy for him to go over to the A5 Clinic at University and have them look at his rash. We can see if they think he has psoriatic arthritis. I wrote him a note to take to Dr. xxxx. I will keep all posted as we see what happens on the next round.	
02/08/ YYYY	MRA NECK FROM ELLEN xxxx, M.D.: Occluded left vertebral artery. Otherwise negative.	ARJOHN T0000098 6,987
02/12/ YYYY	OFFICE VISIT TO DAVID xxxx, M.D.: The patient presents with chief complaint of sinus congestion, drainage, and allergies. There is a history of a left vertebral artery occlusion and the more we look it may not be occluded. It may be a congenital change. I have spent some time discussing him with Dr. xxxx. I recommended that we get Dr. xxxx to see him again.\ ASSESSMENT: 1. Sinusitis. 2. Allergic reaction. 3. Left posterior vertebral artery occlusion versus congenital disease PLAN: 1. Avelox 400mg daily for 6 days 2. Kenalog 80 mg IM 3. Dr. George xxxx will see him on 03/09/YYYY at 11:30 for evaluation 4. Dr. Jonathon xxxx will see him for a sleep study and they will call him for an appointment.	ARJOHN T0000098 4,985
02/15/ YYYY	PROGRESS NOTES FROM XXXX: Dr. Ellen xxxx thinks I am depressed - also recently found a blocked ventricular artery in his neck Found himself crying a lot - due to any emotion at all - doesn't usually get angry - embarrassed - cognitive test showed Short Term Memory problems - started with Dr. xxxx, PCP - xxxx - has bulging disc, bone space - last year - did PT a lot of headache - now this year has more headaches - has been under lot of pain - has decreased his activity - has gained weight IMPRESSION: Anxiety disorder, Lexapro 10mg once orally daily #14 samples, follow-up 2 weeks	ARJOHN T0000089 5, 896
02/19/ YYYY	CORRESPONDENCE TO DR. XXXX FROM JONATHAN XXXX, M.D.: He has a history of loud snoring, witnessed apneic events, and daytime fatigue and somnolence. He had a previous sleep study (10/03/YYYY) that revealed obstructive sleep apnea, although he never tried CPAP at that time. He reports that he has gained ten to twenty pounds since that study. He reports a history of depression, asthma, and has intermittent rhinitis symptoms. Physical exam reveals pale edematous nasal mucosa. Cardiopulmonary exam was unremarkable. Spirometry reveals a restrictive pattern; however lung volumes reveal an elevated residual volume consistent with air trapping and his	ARJOHN T0000098 3

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	history of asthma. We have discussed treatment options for Mr. xxxx obstructive sleep apnea and he is now willing to try nasal CPAP. As he has gained weight since his previous study, he will be retitrated with nasal CPAP. I have given a trial of QVAR for asthma and Astelin for rhinitis. He is to monitor peak flow twice daily. I will see him back after his sleep study. I will keep you informed of the results and he will see you for his usual follow-up.	
02/20/ YYYY	OFFICE VISIT TO DAVID xxxx, M.D.: Collapsed last night, legs did not feel like they were working right and he woke up lateral on the floor with towels around him. Still taking Avelox, started Lexapro, saw Dr. xxxx and was given Proventil ad Astelin, checked thyroid lab Patient presents with chief complaint of getting up from steep and taking the Lexapro in the morning with some improvement, began to urinate and had a vagal event and lost consciousness. The patient has restored quickly, no lateralizing symptoms, no other noted change. Assessment: 1. Sleep disturbance 2. Vagal attack Plan: Would like to change the Lexapro to 5mg in the PM and follow results	ARJOHN T0000098 1,982
02/23/ YYYY	SLEEP STUDY REPORT FROM SLEEP DISORDERS CENTER OF XXXX: IMPRESSION: Severe obstructive sleep apnea with significant associated oxygen desaturation and arousal. Nasal CPAP at a pressure of 10.0cm/H2O resulted in a reduction in the apnea index to1. A large Ultra Mirage Mask and heated humidifier were utilized for the evaluation	ARJOHN T0000103 7,1038
02/26/ YYYY	CORRESPONDENCE TO DR. XXXX FROM JONATHAN XXXX, M.D.: He does have significant obstructive sleep apnea with an average of 42 apneic events per hour with the longest lasting 18 seconds and associated with an oxygen desaturation to 86%. Nasal CPAP at 10cm resulted in a reduction in the apnea index to 0 and the abolition of snoring. He is now willing to utilize his nasal CPAP. He does reports improvement in peak flow with QVAR. We have discussed treatment options and I have arranged for a trial of CPAP for home use. I will see him back in the next month. He will continue to utilize QVAR for asthma. I will see him back in the next month and he will see you for his usual follow-up.	ARJOHN T0000098 0
03/01/ YYYY	PROGRESS NOTES FROM DR. REGINA XXXX: Went to see Dr. xxxx, gave him some Proventil - passed on for that night - then went to Dr. xxxx and was told that the Lexapro made him decrease his blood pressure - he changed it to night time - has felt sluggish since then, but now ahs CPAP - inconsistent with it - Lexapro - Takes the voice away - can listen to the radio now - Feels better	Regina xxxx-000055
04/09/ YYYY	CORRESPONDENCE TO DR. xxxx FROM JONATHAN xxxx, M.D.: Mr. John returns for follow-up reporting problems tolerating nasal CPAP. He reports that he is only able to wear the CPAP 1 to 2 hours per night. We have discussed treatment options and he is going to continue to work with the CPAP. He is going to try a different mask. We have again reviewed sleep hygiene measures.	ARJOHN T0000097 9
05/02/ YYYY	CHART NOTE FROM ELLEN xxxx, M.D.: I saw John back looking a lot better. He did well with the counselor, Regina xxxx, who felt he was extremely anxious, began him on Lexapro 10 and increased it to bid. He wonders why no one has ever put him on this. He says she stuck up for him regarding his odd comments to some of our consultants! He had an asthma attack this morning and was given a shot of steroids. He is feeling better now, though he is still short of breath walking and had scattered expiratory wheezes. I encouraged him to follow-up with Dr. xxxx, not just treat on an emergent basis. He says he does not like bronchodilators because they make him jittery (he was given Xopenex) or inhaled steroids which also bother him. I suggested he	ARJOHN T0000029 7

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	could try Intal, a non-steroid anti-inflammatory, or Singulair, a tablet that is not a bronchodilator. I told him to return to Dr. xxxx and give him a chance to do better than just rescue him from disaster. Dr. Jon xxxx had given him a peak flow meter so he could know that he was having declining lung function and know when to increase his medicine. I encouraged him, therefore, to show up. He saw Dr. xxxx to work on his sleep problem. This has been positive. I'm greatful they will get that sorted out. He had an episode where he got up at midnight to use the restroom (which he never does). He felt a "good feeling" when he finished urinating which is unusual. He then noticed his legs were giving out. He recalls reaching for the towel bar and came to on his back on the floor with towels on him. He wisely stayed down quite a while before crawling back to bed. It was right after he started Lexapro. It almost sounds like he had a seizure because of the funny sensory experience just prior to the fall. He recently had an EEG, and it doesn't sound like he strained, so I don't know quite what it was but it hasn't repeated itself. Lexapro could have lowered his questionable seizure threshold. His headaches are still better, occurring weekly, though he has one today. He had difficulty looking left and he was tender at C 1-2 which went away when I put a topical local there. We looked at his plain films which showed some asymmetry of the C1-2 relation and a very straight neck with almost no movement between extension and flexion. There is a lot of arthritis. He saw the dermatologist who told him he merely had dry skin. He clearly has psoriasis and probably psoriatic arthritis. He was given a topical for his nails to clear them up.	
05/02/ YYYY	OFFICE VISIT TO DAVID xxxx, M.D.: Subjective: Asthma, shortness of breath with exertion. When he uses all of his inhalers, feels very jumpy. No congestion but feels restricted. Patient has sleep apnea, has had CPAP for 2 months has only been able to keep mask on 2 nights. Patient says that he is having an acute exacerbation of wheezing Assessment: Acute exacerbation of reactive airway disease, borderline cardiomegaly Plan: ECG on 05/03/YYYY, xxxx	ARJOHN T0000097 6,977
05/07/ YYYY	ECHOCARDIOGRAM REPORT FROM A1 HOSPITAL: 1. Mildly dilated left ventricle at 5.8cm 2. Ejection fraction 55% 3. No evidence of left ventricular hypertrophy or diastolic dysfunction 4. Trace mitral regurgitation 5. Dilated right heart chamber but no Doppler evidence of elevated right heart pressure	ARJOHN T0000097 5
05/18/ YYYY	CORRESPONDENCE TO DR. xxxx FROM JONATHAN xxxx, M.D.: Mr. John returns for follow up today reporting significant improvement both in sleep quality and daytime alertness utilizing nasal CPAP. His CPAP tolerance has improved but he is still only wearing the device for several hours per night. He has also noted significant improvement in his asthma symptoms and his Spirometry has improved today as well. I have recommended continued use of the CPAP, as well as weight reduction. He will continue with his asthma and rhinitis medications.	ARJOHN T0000097 2
05/29/ YYYY	OFFICE VISIT TO DAVID xxxx, M.D.: Subjective: Follow-up echo patient reports that he has difficulty with asthma more than sleep apnea. Patient presents with chief complaint of some minor changes on echocardiogram. I think that all of these will resolve with use of CPAP. We discussed his CPAP and need. At this point, I think he is willing to try again. Assessment: 1. Reactive airway disease. 2. Fatigue. Plan: 1. Recheck in 2 months.	ARJOHN T0000097 0,971