ORTHOPEDIC PROTOCOL EXAMINATION REPORT

ON

[redacted]

DATE OF EXAMINATION: FEBRUARY 23, 2005

PLACE OF EXAMINATION:

[redacted]

The last VA directed medical examination was in 2001 at the VA MC Louisville, KY.

Occupational History:
22 Feb. 1982 - 28 Feb. 2002, active US Army Service.

[redacted]

Description of the present work:
He works 8-12 hours a day on 5-6 days a week. He has to drive 23 minutes (1 way) to work. Has to walk over 5 steps to his office, but from next month on he has to climb 3 flights of steps due to a change of his job location. Sometimes, he has to lift or carry equipment of up to 80 lbs..

Times of incapacitation/prescribed sick leave:
He lost 7 days of work within the last 12 months for back pain.

Main health problems at work:
Sitting for 45 minutes hurts in his back. He has to shift his weight a lot. For about 6 months, he feels any sneezing in his back.

SPINE PROTOCOL EXAMINATION REPORT

A. Review of Medical Records:

MAP-D

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There is noted one entry dated **07 May 2001** [redacted],
Primary Care:
Seen for back pain. Has pain on and off since 1987. X-rays in 1998: degenerative disc disease.
X-rays: 3 views, same date: Mild disc narrowing and anterior osteophytes are present at L3-4. The L4-5 and L5-S1 discs are minimally narrowed. There is no fracture or subluxation.
Was diagnosed with chronic back pain.

MRI of the lumbar spine dated **06/13/03**: Check the results below, please.

August 06, 2003: Epidural steroid block, lumbar spine.

B. Present medical history (subjective complaints):
The veteran is s.c. for degenerative disc disease with currently 0 % disability rating.

Narrative history:
Onset of lower back pain in 1987 while changing an extremely heavy track of a tank. The track fell down and pushed him to the side.
The veteran fell and landed on the ground. He was taken to the health clinic and had pain for a few days. He kept having recurrent lower back complaints throughout the years ever since. Pain attacks came through more and more frequent and more intense, though.
He underwent lumbar epidural steroid blockage on 26 August 2003, which relieved the pain for approximately one year.
In August 2004, he wanted to pick up the phone, reached out and felt a shooting pain into bilateral buttocks and could not stand straight any more. He sat in a recliner chair for 3 days. Used NSAIDs and muscle relaxers. The attack lasted 3 weeks, though.
A dull pain is still constantly there since.

1. Pain: Is always there with **2**/10 in intensity, in average, it is a stationary lower back pain.
-Stiffness: Yes, every morning for 4 hours.
-Back weakness: None.
a. onset: 1987.
b. Location and distribution: L3-S1.
c. Duration: Permanent complaints.
d. Characteristics and quality: Dull, achy pain.
e. Intensity: Pain of **2**/10 in intensity.

2. Treatment: Nothing regularly.

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3. Flare-ups:
Severity: Pain of 9/10 in intensity.
Frequency: 1-2 x per year, meanwhile.
Duration: Pain decreases after 3 weeks, in average.

b. Precipitating factors: Trivial motions.

Alleviating factors: Half-sitting position, no movement, analgesic medication.

c. Additional limitation during flare-ups: Stiff, frozen back so that he cannot move.

4. Associated symptoms:
No weight loss.
No fevers.
No malaise.
No dizziness.
No visual disturbances.
Numbness: Yes, in the anterior right thigh.
No weakness.
No vertebragen bladder complaints.
No vertebragen bowel complaints.
Sneezing aggravates the lumbar pain.
No erectile dysfunction.

5. Walking and assistive devices: None.
The veteran can walk unaided.
Walking distance: No limit. During flare-ups, he cannot walk more than 2 steps.

He has no orthosis in use.
The veteran is not unsteady.
There is no history of falls.

6. Previous traumata to the spine: Back injury in 1987 as mentioned above.

7. Surgery: None.

8. Functional assessment:
Mobility: Not disturbed.
Transfers: Undisturbed.
Bed activities: Undisturbed.
Grooming, bathing, toileting, dressing: No problems.
Usual occupation: The veteran is fully employed.
Driving: 2-3 hours maximum before he needs a break for back pain.

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Recreational activities: None any more.

C. Objective Findings

Height: 73"
Weight: 236 lbs.

The veteran is right hand dominate.

Inspection:
No limp.
Posture unremarkable. No antalgic scoliosis. No anterior pelvic tilt.
Gait: Normal.
Position of the head: Normal.
Flattened physiological curvatures.
Symmetry in appearance and rhythm of spinal motions: Normal.

Ranges of motion
C-spine:

Normal excursion,	
Flexion of the head:	*0°-45°*
Backward extension of the head:	*0°-45°*

FINDINGS:
Goniometer measurements:

Forward flexion of the head:	0-66°
Extension of the head:	0-48°

Points when the pain sets in:	Flexion: No pain on motion. Extension: No pain on motion.
Incoordination:	None.
Weakness/fatigability:	After repetitive motion, the ROM are:
Forward flexion of the head:	0-60°
Extension of the head:	0-48°
Abnormal movements:	None.
Instability:	None.

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Lateral flexion of the head

Normal excursion:	
Cervical lateral flexion to left	*0°- 45°*
Cervical lateral flexion to right	*0°- 45°*

FINDINGS:
Goniometer measurements:

Lateral flexion of the head to left:	0°-51°
Lateral flexion of the head to right:	0°-29° (without pain at the end of the motion).

Pain on use, points when the pain sets in:	Motion to left: No pain on motion. Motion to right: No pain on motion.
Incoordination:	None.
Weakness/fatigability:	After repetitive motion, the ranges of motion are: Lateral flexion to left: 0-56°. Lateral flexion to right: 0°-31°, without pain at the end of the motion.
Abnormal movements:	None.
Instability:	None.

Rotation of the head

Normal excursion:	
Rotation of the head to left	*0°- 80°*
Rotation of the head to right	*0°- 80°*

FINDINGS:
Goniometer measurements:

Rotation of the head to left:	0-78°

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Rotation of the head to right: 0-65° (without pain at the end of the motion).

Pain on use, points when the pain sets in: On the left side, no pain on motion.
On the right side, no pain on motion.

Incoordination: None.

Weakness/fatigability: After repetitive motion, the ranges of motion are:
On the left side, from 0°-78, with no pain.
On the right side, 0°-59°, without pain at the end of the motion.

Abnormal movements: None.

Instability: None.

Strength of the spine: Slight limitation of the right-sided motions but yet no significant loss of function.

Speed of motions: All motions are conducted in normal speed.

Endurance: Subjectively, the veteran had no cervical complaints today.

Muscle spasm: Paraspinal muscles between C4 and C6 level on the right side tight, hard and tender on firm palpation and pressure.
There is muscle spasm palpable.

No structural weakness of the cervical musculature.

Pain on tapping: The spinous processes are not painful on tapping.

No fixed deformity of the C-spine determinable. No ankylosis. No evidence of atlanto-occipital or cervical subluxation or dislocation.

Neurologically: DTR 2+/2 + (right arm), 2+/2+ (left arm).
No segmental sensorimotor disturbances determinable.
Gross power of arms and hands with 5+/5+ w.n.l..

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Orthopedic diagnosis:

Right-sided paraspinal muscle spasm, C-spine,
resulting in predominant slight limitation of the right-sided cervical motion but no significant function loss nor pain on use.

T- and L-spine

Alignment:

Straight spine with flattened thoracic kyphosis and straightened lumbar lordosis.
No externally visible structural scoliotic curvature. No lumbar bulging or protruding of the ribs seen when bending over.
No antalgic scoliosis when standing.
No anterior pelvic tilt.
Scapulae symmetrical and in equal position.
Waist folds equal.
No leg length discrepancy.
Normal gait.

Flexion/extension

Normal excursion:	*Flexion:*	*0° - 90°*
	Extension:	*0 - 30°*

FINDINGS
Goniometer measurements in standing position:

Forward flexion: 0-42°, with pain.
Extension: 0-8°, with pain.

Points when the pain sets in: Flexion: Onset of pain at 0-28°, motion ends painfully at 0-48°.
Extension: Onset of pain at 0-2°, motion ends painfully at 0-8°.

Incoordination: None.

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Weakness/fatigability: After repetitive motion, the ranges of motion are:

Flexion: 0°- 40° (maximum), with pain.
Extension: 0°-10° (maximum), with pain.

Abnormal movements: None.

Instability: None.

Lateral flexion of the spine to right and left:

Normal excursion: *to left: 0° - 30°*
to right: 0° -30°

FINDINGS:
Goniometer measurements

Lateral flexion to left: 0-20° (with pain)
Lateral flexion to right: 0-24° (with pain)

Pain on use,
points when the pain sets in: To left: Onset of pain at 0-18°, the motion ends with pain at 0-20°.
To right: Onset of pain at 0-20°, the motion ends with pain at 0-22°.

Incoordination: None.

Weakness/fatigability: after repetitive motion, the ranges of motion are:

To left: 0-17° (maximum), with pain.
To right: 0-22° (maximum), with pain.

Abnormal movements: None.

Instability: None.

Rotation of the spine:

Normal excursion: *to left: 0-45°*

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to right: 0-45°

FINDINGS:
Goniometer measurements

Left lateral rotation:	0-52° (without pain)
Right lateral rotation:	0-46° (without pain)
Pain on use, points when the pain sets in: bilaterally.	Currently no pain during rotatory motions,
Incoordination:	None.
Weakness/fatigability:	After repetitive motion, there is not noted: Rotation to left: 0-50°, painless. Rotation to right: 0-50°, painless.
Abnormal movements:	None.
Instability:	None.
Strength of the spine: lumbar	There is noted a severe restriction of the motion and function.

The painfully and severely limited forward flexion has the major functional impact.

Speed of motions:	All thoracolumbar motions are conducted slowly and carefully.
Muscle spasm: paravertebrally	Paraspinal muscles soft, bilaterally. There is no defined muscle spasm palpable.
	Guarding: None, except of careful and slowed motions. In particular, no guarding resulting in abnormal gait. Postural abnormalities: Straightened spine. No fixed deformity of the back. No ankylosis. No abnormality of the back musculature.

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No localized tenderness with preserved spinal contour is noted along the T- and L-spine.

Pain on tapping: Bilateral SI-joints nontender on tapping.

Neurologically:
a) Sensory exam: Segmental sensory disturbances follow the distal vertebragen dermatome L4 on the right side (anterior right thigh). Sacral segments unremarkable.
b) Motor examination: No atrophy, tone and strength of the musculature all over normal with 5+/5+. Standing and walking on toes and heels possible. Motor deficits: None.
c) Reflexes: Right-sided knee and heel reflex normal with 2+/2+. No pathological reflexes.
d) Rectal examination: Not conducted. No vertebragen bladder or bowel disturbances.
e) Lasegue sign negative, bilaterally.

4. No history of vertebral fractures.

5. Non-organic physical signs:
Waddell tests (three or more would be significant):
a) Palpation tenderness: No widespread, nonanatomic tenderness nor tenderness to light touch.
b) Stimulation tests: Negative (no mimicking but non-performance of painful motion).
c) Distraction: Straight leg raising in the sitting position possible, bilaterally.
d) Regional disturbances: No evidence of weakness, especially none in non-organic distribution. No evidence of sensory loss in stocking or glove pattern.
e) No evidence of overreaction (no excessive verbalization, no grimacing, no collapsing nor theatrics).

D. Radiological findings:
MRI of the Lumbar spine dated 13 June 2003
(obtained from the veteran's SMRs)
The study is done without contrast enhancement. The patient has low back pain and left radiculopathy [Remark→ meanwhile, radiculopathy is located on the right side!]. The patient had injury with large object falling on the patient.

FINDINGS:
The sagittal images reveal no abnormal signal from the conus or the vertebral bodies.
There is desiccation of the lowest three intervertebral disc spaces that appear to

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be at L3-4, L4-5 and L5-S1.

There is a moderate sized central and left lateral disc herniation at L5-S1 that starts just to the right of midline and extends into the lateral recess and neural foramen on the left at this level.
At L4-5, there is a small central disc herniation with slight impression on the dural sac with minimal lateralization to the level of the neural foramina, bilaterally.
At L3-4, there is central disc herniation with extrusion of the disc fragment inferiorly near the midline. This extends on either side but probably slightly greater to the right.

IMPRESSION:
Disc herniation at L3-4 with inferior extrusion centrally.
Central disc bulging and I think a small herniation at L4-5. This does extend bilaterally somewhat a little greater to the left midline.
More moderate sized central and left lateral disc herniation with left foraminal stenosis at L5-S1.

E. Orthopedic diagnosis:

Chrnoc lumbar DDD, now associated with HNPs L3-4, L4-5, and S1 and chronic radiculopathy L4 on the right
(combat training injury, 1987)
resulting in severe limitation of motion and function, continuous pain on use and recurrent severe flare-ups after trivial motions requiring administration of prescribed medication during the flare-ups.

Medical opinion:
The present status (→ herniation of 3 lumbar discs with radiculopathy on the right side) is consistent with worsening of the established sc degenerative disc disease of the lumbar spine.

[redacted]

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