THE XXXX FIRM, LLC

Memo

To: xxxxx, Esq.

From: Leigh Fava, Paralegal

CC: File

Date: 9/16/2013

Re: xxx Medical file review

Name:	XXXXXXXX
Date of Birth:	06/09/1955
Social Security No.:	XXXXX
Date of Accident:	05/17/2003

05/17/2003 Fire Protection District No.: 4 St. Tammany Parish EMS

Complaints: Jaw Pain
Limb Pain

From the Summary: Patient complains of: Right jaw pain, right leg pain. Has no other complaints. Oriented to Person/Place//Time/Situation. Denies LOC. No trauma noted to right lower leg. No other trauma noted.

There are no complaints of head pain, no complaints of neck pain, no mention of tasting blood, no complaints of knee pain.

05/17/2003 St. Tammany Parish Hospital Emergency Department

Entry Dx: MVA
Contusion Face
Neck Sprain

TRIAGE: Chief Complaint: Unrestrained front seat passenger. Airbag deployed

The patient is a 47-year-old Female who was the front-seat passenger in a Suburban that struck another car broadside when it had pulled out in front of them as they were traveling at a high rate of speed. She was not wearing her seatbelt. Her airbag did deploy. At this time, she is primarily complaining of some pain and swelling to the right submandibular area, some mild pain to the right chin, and some right-sided neck pain. There was no loss of consciousness. She denies any chest or abdominal pain. There are no other complaints.

HEIGHT: 5 feet 3 inches
WEIGHT: 180 lbs. / 81.64 Kg

HEENT: Head is normocephalic and otherwise atraumatic. Eyes - Pupils are equal, round, and reactive to light. Extraocular muscles are intact. Nose is clear. Mouth is moist and pink. Mandible is nontender, but there is some soft tissue swelling and a slight tenderness to the right submandibular area. No fluctuance or induration is noted. There is no discoloration.
NECK: There is a mild right lateral tenderness; but otherwise, there is no spasm.

CHEST: Nontender.

NEUROLOGICAL: Within normal parameters? Y
Motor sensory examination is nonfocal in her extremities. Gait is normal as witnessed later walking in the Emergency Department.

RADIOLOGICAL DATA: Cervical spine films as well as mandible films were unremarkable.

EMERGENCY DEPARTMENT COURSE/MEDICAL DECISION MAKING: On reexamination of the patient at 12 a.m., she also is reporting some back stiffness at this time but defers any workup for this as she states she feels this is most likely just stiffening of her muscles. She was given prescriptions of Lortab and Flexeril for her symptoms as needed. She was advised to follow up with her primary physician in three to five days.

DIAGNOSES:
1) Facial contusion.
2} Cervical strain.

No mention of knee pain, no indication of blood filling the neck cavity, no indication of head trauma. Chest is listed as non-tender which disputes a “breast injury” in the accident.

RADIOLOGY

Cervical Spine/Mandible Imaging:

CERVICAL SPINE

Indication: Neck pain

There is no evidence of prevertebral soft tissue swelling. The predental space is unremarkable in appearance. Disc spaces are fairly well preserved. Anterior tracts and spur formation are noted in the endplate of the C6 vertebral element. No bony fracture or lux recorded. Odontoid process as well as the ring of C1 are grossly intact. There is straightening of the normal posture of the cervical spine.

IMPRESSION:

1. **Subtle cervical spondylosis, osteochondrosis;**
2. **Loss of cervical lordosis which could be due to muscle spasm or patient positioning.**

MANDIBLE

No definite bony fracture is appreciated. I see no evidence of focal, pathologic, osteolytic or osteoblastic process. If clinical symptomatology persists, then the panorex would represent our next logical imaging alternative.

DISCHARGE Dx:

1) Facial contusion
2) Cervical strain

05/19/2003 St. Tammany Physician's Network Elizabeth White, MD

Follow up post MVA

Complains of: Neck Pain
Pain under chin
Pain/Soreness right arm
Swelling in neck in the morning, better as day goes on

Doctor's observation: **Looks OK, tender over right jaw**
Jaw moves well

Tender swelling below R mandible
Ecchymosis lower anterior neck
Great range of motion neck
Ecchymosis R upper arm with tenderness

S/P MVA Hematoma

06/09/2003 NORTH Institute Susan Bryant, MD

CHIEF COMPLAINT: Ms. Barnett is referred by a friend who may provide her legal counsel complaining of right shoulder and arm pain, which she describes as 1 to 2/10.

HISTORY OF PRESENT ILLNESS: The pain does not disturb her sleep. She does describe some weakness to the right arm. She was involved in a motor vehicle accident May 17th, seat belted driver involved in a head-on collision. Her neck hit the dashboard. She was given medications, which she took briefly as she was treated and released. Since then she has had significant episodes of neck swelling diagnosed as a hematoma. She also describes a couple of episodes where she awakes unable to breath relieved with drinking water. She reports a history of panic attacks and these current symptoms are unrelated to her panic attacks. She denies any bowel or bladder incontinence, foot drop, spasticity or dropping things.

This is a well-developed, well-nourished female who appears to be slightly younger than her 38 years in no acute distress. She is alert, oriented x 4 in good spirits, cooperative in no acute distress. Blood pressure 124/82, temperature 98. 7°, weight 172 lbs. Cranial nerves II-XII are intact to examination. Oropharynx is clear, nasopharynx is clear. Neck is supple with no masses and no JVD. Extraocular muscles intact. Pupils equal round and reactive to light and accommodation. Gait and station is without abnormality. Head and neck range of motion reveals minimal muscle spasm to the right paraspinal cervical muscles, the right proximal trapezius and sternocleidomastoid. She does have pain to right lateral rotation and lateral bending though range of motion appears to be within functional limits. Range of motion is within normal limits for flexion-extension. Spine, rib, pelvic evaluation was cursory and showed no abnormalities. Bilateral upper extremity inspection, palpation and range of motion was without abnormality. Right upper extremity shoulder abduction, elbow flexion, elbow extension and grip was 4+/5 with left upper extremity strength 5/5 for the

same dermatomes. Coordination is intact. She has reduced pinprick and light touch on the right in a C4-5 distribution with proximal C5 involved only. There are no dural tension signs positive and no sign of carpal tunnel syndrome, thoracic outlet syndrome or shoulder impingement. Cardiovascular, lymphatic and skin evaluation otherwise is without abnormalities. She does have some old healed scars over both forearms that she describes as occupational in nature with no injuries or surgeries.

X-RAYS: There are x-rays available from May 2003 at the time of the accident. They show no fracture, subluxation, dislocation or significant disc space narrowing.

IMPRESSION:
I. Acute cervical disc injury, mild.
2. Cervical myofascial pain.
3. Cervical soft tissue hematoma by history with possible airway edema and related sleep apnea.

- **Order for Sleep Study**

No mention of memory loss, headaches, knee pain, breast/chest pain

- The health survey filled out by the patient states that during the past 4 weeks (May 12-June 9) her daily activities have not been very much impacted.
- Pain during these weeks is listed as 3
- During these weeks she is "full of pep, not nervous, peaceful, has a lot of energy, is happy and is only minimally affected by physical/emotional pain.
- Patient pain drawing shows pain at the shoulders only

06/17/2003 Northlake Pulmonary Associates Lauren Davis, MD

Screening Polysomnography

Patient weight is listed as 150 pounds, but this may be as a statement from the patient. She was weighed in the ER one month prior and was 180 pounds.

ASSESSMENT:
1. No evidence of significant obstructive sleep apnea or periodic leg movements of sleep.

2. Mildly decreased sleep latency at 10.5 minutes, however no complaints on prescreening questionnaire of excessive daytime somnolence and arousal index within normal limits.

3. Questionnaire with possible insufficient sleep syndrome.

4. Significant caffeine intake on a daily basis.

5. Some inconsistencies on past medical history and medications.

Plan: Would not pursue any treatment for obstructive sleep apnea or periodic leg movements of sleep. If further evaluation of patients sleep is required, would be happy to evaluate the patient. May want to counsel in regards to sleep need and effect of caffeine on sleep and get some clinical correlation in regards to possible etiologies of the slightly decreased sleep latency.

Unremarkable study

06/17/2003 Neurology Clinic, EMG &EEG Laboratory Rex Hauser, MD

"Difficult historian"

Complains of:
Left facial weakness
Restrained passenger
She reports she struck her chest, neck, and the right side of her head against the car
She denies any associated headache

SUMMARY: The patient is a 48-year-old white female with a history of hypothyroidism and depression presenting with complaints of left facial numbness and weakness as well as balance difficulty subsequent to a head-on collision one month ago. Neurologic examination demonstrates the patient to have very bizarre affect with a slight myosis of the left pupil and brisk deep tendon reflexes throughout but is otherwise unremarkable.

IMPRESSION:
I. Post-concussive syndrome.
2. Hypothyroidism.
3. Depression.

DISCUSSION: With the patient's history of depression and her bizarre affect, I am suspicious of a functional disorder.[1] Her neurologic examination is unremarkable. However, given her complaints of awakening from sleep with jerking-type movements, we will obtain an EEG to rule out evidence of her seizures. I will also obtain an MRI of the brain secondary to her focal neurologic complaints. We will have Ms. Barnett back to the office after her tests for reevaluation and discussion of MRI and EEG. At this point in time, I have no treatment recommendations but did discuss seizure precautions with her since I am entertaining the diagnosis, although I do have a very low suspicion. Also of note is that she is on Topamax but she does not know the dose, which is a seizure medication.

Conflicting reports of restrained/unrestrained
No breast/chest injury reported to EMS/STPH/White, MD
Airbag deploys, how does she strike her chest against the car?

07/29/2003 NORTH Institute Susan Bryant, MD

Mr. Barnett (sic) reports that overall her neck is improved but she continues to have right shoulder pain limiting her overall activities. She reports that the brain MRI was not approved by the insurance. She continues to have ongoing right eye complaints and describes a recent one vehicle MVA in which she side-swiped her vehicle against an object. She remains on Celexa and Topamax as well as thyroid medication and is on no other medication. She is having trouble sleeping. She is off all pain medication. We discussed several other issues including ongoing depression for which she is requesting a psychiatrist closer to home.

PHYSICAL EXAMINATION: Her physical examination is handwritten and available in the chart. She appears to have right shoulder impingement affecting the right shoulder bursa and rotator cuff with no specific limitations to strength and no indication that there is ongoing problems from her neck.

IMPRESSION:
1. Right shoulder impingement syndrome with tendinitis and bursitis.
2. A history of depression.
3. Vague right eye complaints.

[1] Functional or psychogenic neurological disorders are conditions with neurological symptoms that are thought to be due to psychological dysfunction rather than an underlying neurological disorder. http://www.ohsu.edu/blogs/brain/2013/07/03/functional-psychogenic-neurological-disorders/

No mention of memory loss, headaches, knee pain, breast/chest pain

No longer needs pain medication

04/16/2004 St. Tammany Physician's Network Ronald Elisoff, MD

262 DAYS SINCE LAST MEDICAL RECORD

PHYSICAL EXAMINATION

VITAL SIGNS BP 116/60 PULSE 72 WT 192 HT 5' 4" BMI 33. Generally looked well

DSM-IV depression: Poor mood, little enjoyment, even looking after horses, fatigue, great difficulty sleeping, no enthusiasm, did not have difficulty concentrating, does have feelings of guilt, no excessive thoughts of death. Mood Disorder Questionnaire negative.

ASSESSMENT: Psychiatric disorder NYD. Plan: Advised continue Lexapro 10 mg q a.m. for 2 more weeks and reassess.

PROBLEM LIST & PLAN
1) Fatigue.
2) Depression.
3) Hypothyroidism.
Blood tests done.

No mention of knee, back, neck, chest, breast, head or mouth pain.
No mention of memory loss, balance issues or vision issues

09/09/2004 SPIDER BITE

146 DAYS SINCE LAST MEDICAL RECORD

PHYSICAL EXAMINATION

VITAL SIGNS BP 140/96 TEMP 98.6 PULSE 80 WT 198

ENT normal, PERLA, no neck stiffness, chest clear, heart sounds normal, abdomen soft, nontender, no CVT. Speech, gait normal. There is a cluster of 6 red papules on mid-back, mostly on right but 2 on left side of spine.

PROBLEM LIST & PLAN
1) Febrile illness with headache and papules on back NYD, possible reaction to spider bite, probable viral illness including West Nile.

Given Avelox 400 mg q a.m. on spec, Medrol Dosepak, Lortab 5 one tab q 4 h p.r.n. #20.

Blood tests, CT scan brain and will reassess by phone in 24 hours.

09/10/2004 St. Tammany Parish Hospital

Complaint: Headache

Clinical History: 784.0 HEADACHE
CT HEAD W/0 CONTRAST • 09/10/2004
*****Final Report*****
09/10/2004

Sequential axial images were obtained from the skull base to the vertex. Contrast was not administered due to history of iodine allergy. A few of the images are somewhat degraded by patient motion. There are no intra-axial or extra-axial collections. The ventricular system is normal in size and configuration. There is no shift of the midline structures or other evidence of intracranial mass effect. There is no intracranial hemorrhage. Examination of the visualized orbits and paranasal sinuses reveals no abnormalities.

IMPRESSION:
1. Negative non contrast CT head.
2. If a post contrast examination is desired, the patient could receive pre-medication. Alternatively, MRI could be performed.

10/15/2004 St. Tammany Physician's Network Ronald Elisoff, MD

She has not been taking her thyroid Amnour for several months. TSH was in fact normal. Feels cold, little energy. As a child from age 4 to 8 was repeatedly sexually abused by an uncle, did not disclose until about 10 years ago when she told her husband. Has

used Adipex for weight control in the remote past, did not enable sufficient weight loss.

PHYSICAL EXAMINATION

VITAL SIGNS- BP 130/84, pulse 68, weight 217, height 5' 4", BMI 37

PROBLEM LIST & PLAN
1) Hypothyroid in remission.
2) PTSD Continue Lexapro 10 mg q a.m. which she feels is helping her.
3) Weight gain. Given Adipex 37.5 mg one tab q a.m.

RTC Reassess in 2 weeks.

No mention of accident related issues.

06/15/2005 The Breast Center Marie Lagarde, MD FIRST BREAST PAIN

243 DAYS SINCE LAST MEDICAL RECORD

- New Patient
- Breast pain
- Probable damage to implant L
- Hypoechoic mass[2]
- Plan: Mammo

06/28/2005 NORTH Institute Susan Bryant, MD

- **Mid-Back dysesthesia**
- **Mild Impingement Sign**
- **Mild dural tension**
- **Limited T-Spine Range of Motion**

Impression:
- **R Shoulder Impingement Syndrome**
- **Cervical Disc Radiculitis**
- **Breast soft tissue injury**

[2] A mass determined to be solid based on its ultrasonographic sound penetration level

Two years post-accident and now we have breast injury and cervical radiculitis (MRIs will show DDD)

06/29/2005 The Breast Center Marie Lagarde, MD

Bilateral diagnostic mammogram with CAD.
Patient has bilateral implants. left implant is smaller and slightly irregular. Cannot rule out leakage on the left side.

There are no masses seen. There are no clustered microcalcifications noted.

Impression: No evidence of malignancy seen at this time. This would be a BI-RADS category 1 negative. Recommend yearly screening.

No mention of trauma to the breast

07/05/2005 Premier MRI 4U Susan Bryant, MD

Thoracic Spine
Cervical Spine
Right Shoulder

MRI OF THE THORACIC SPINE
Clinical history: Patient fell in 1987 and had shoulder pain. The patient has had two years of mid back pain as well.

IMPRESSION:
MRI scans through the thoracic spine demonstrate a fair hydration of the intervertebral discs with normal preservation of disc space height. No posterior disc protrusion. No other soft tissue or bony abnormality is seen. The cord appeared unremarkable.

No mention of MVA
Unremarkable study

MRI OF THE CERVICAL SPINE

CLINICAL HISTORY: pain for 2 years. Patient fell in 1987. The patient with neck and mid back

The visualized portions of the cervical spinal cord and posterior fossa demonstrate normal shape and signal intensity. The paraspinal soft tissues are unremarkable.

IMPRESSION:

1) **Minimal degenerative changes of the cervical spine are identified as described above. The sagittal images demonstrate a circumferential disc bulge at C6 -7 as well as a focal area of ligamentum flavum thickening which appears to produce mild narrowing of the spinal canal at the C6- 7 level on the sagittal images. However, this is not confirmed on the axial images and the canal does not appear significantly narrowed on the axial images, nor does there appear to be any neural foraminal narrowing.**

No mention of MVA
Unremarkable study

MRI OF THE RIGHT SHOULDER
Clinical history: Patient fell and fractured her shoulder in 1987. Patient now has right shoulder pain.

IMPRESSION:

1. **Small linear signals are appreciated in the distal aspect of the rotator cuff tendon reflecting very mild tendinitis. There also is a bright signal approximately 1 – 2 mm in size representing a geode at the insertion of the rotator cuff tendon with the proximal humerus. No bone bruise, no joint effusion, no other more significant pathology to the rotator cuff tendon is seen. Note is made I can appreciate metallic warping artifacts in the subcutaneous fat just above the right shoulder. This is reflective of post-surgical changes reflecting small bits of metal in the soft tissue from previous surgery I suspect.**

No mention of MVA

Mild tendinitis

All spine issues are degenerative in nature

08/01/2005 NORTH Institute Susan Bryant, MD

Exam unchanged from 07/15/05 (I do not have records for that day)

Complaints:

- **Shoulder**
- **Insect bite**
- **Depression**

Impression:

- **Cervical Disc DD with Radiculitis**
- **Shoulder tendinitis**
- **Breast (illegible)**

08/24/2005 Richard Celentano, M.D. Plastic Surgery

HISTORY OF PRESENT ILLNESS: Amelia is 50-years-of-age and she is 5 feet 4 inches tall and weighs 21 0 pounds. She has had a previous implant placed and has requested that we remove her 16-year-old silicone implant due to left breast pain and the possibility of rupture.

PHYSICAL EXAMINATION: Physical examination reveals the patient to have bilateral Baker grade III capsular contractures, she also has ptosis. The possibility of implant removal along with ruptured implants in possible, and repair of this may require placement of larger implants or a combination of implant plus mastopexy.

PLAN: I have asked the patient to consider saline implants rather than placing silicone implants back into these areas. A new pocket may be chosen. Dr. Lagarde needs to be involved with the case as surgical biopsy may also be necessary do to some lesions seen on ultrasound.

Two years post-accident, no definitive rupture
No mention of the accident
Implants are 16 years old

12/02/2006 Advanced Neurodiagnostic Morteza Shamsnia, MD

Neurological Consultation

465 DAYS SINCE LAST MEDICAL RECORD

The patient is a 51-year-old female who is status post a motor vehicle accident on 05117/03. The patient was a passenger when this accident had occurred. The patient had a head injury, which resulted in loss of consciousness. This was a significant accident and the patient had a significant head trauma. She was seen at Lakeview Hospital and has received treatment for her injuries. We have been provided with some of her medical records from that accident. The patient's complaint on her visit to our clinic is pain in her limbs. The patient also complains of edema in the left leg, and pins and needles sensation in the cervical area. The patient also complains of memory problems and forgetfulness since the accident. These memory problems are interfering with her work. The patient also complains of pressured sensation behind her eyeball. She feels emotional since the accident. She has also developed some fluid retention since the accident.

Now claiming LOC
No trauma to the head noted in the records
Limbs? All of them?
First mention of memory problems
Has been emotional most of her life (see psychiatric history)
Now claiming Fluid retention since the accident, never mentioned before

IMPRESSION:
1. Postconcussion syndrome.
2. Pain and paresthesias in the limbs.

PLAN AND RECOMMENDATION:
I am recommending for this patient to have an MRI done of her brain as well as an MRI of the spine, probably the cervical area with flexion and extension. The patient later on will need an EMG/NCV/DEP of the upper extremity as well as an EEG. She will continue the present treatment and see us for a follow-up evaluation after her workup is completed.

Rx for Neuropsychological exam with Dr. Andrews

Not sure how he arrived at Post-Concussion Syndrome since there was never a diagnosis of concussion.

12/14/2006 Stand Up Open MRI Centers of La. Shamsnia, MD

MR EXAMINATION OF THE BRAIN PERFORMED WITHOUT THE ADMINISTRATION OF INTRA VENOUS CONTRAST MEDIA

INDICATION:
MR FINDINGS: I see no evidence of intra-axial or extra-axial mass producing lesion. The basilar cisterns, subarachnoid spaces, and ventricular system are grossly unremarkable in appearance. I see no evidence of pathologic effacement or distortion of the ventricular system. No definite discrete focus of abnormal brain parenchymal signal intensity is appreciated on the pulse sequences submitted without the administration of intravenous contrast media. Unremarkable gray/white matter differentiation is recorded on appropriate pulse sequences submitted. Normal signal void is appreciated bilaterally within the parasellar internal carotid arteries, within the basilar vertebral arteries, and the basilar artery. The patient appears to be right vertebral artery dominant, a normal anatomic variant. The paranasal sinuses is without significant mucosal defect.

RADIOGRAPHIC SUMMARY:

1. **Right vertebral artery dominance. This is considered a normal anatomic variant.**

Unremarkable study

12/14/2006

1. ERECT WEIGHT-BEARING MR EXAMINATION OF THE CERVICAL SPINE PERFORMED WITHOUT THE ADMINISTRATION OF INTRA VENOUS CONTRAST MEDIA.

2. MULTI-POSITIONAL MR EXAMINATION OF THE CERVICAL SPINE CONSISTING OF ERECT WEIGHT-BEARING PASSIVE FLEXION, NEUTRAL, AND EXTENSION SAGITTAL T2 WEIGHTED IMAGES PERFORMED

WITHOUT THE ADMINISTRATION OF INTRA VENOUS CONTRAST MEDIA.

INDICATION: Neck pain *I* Right arm pain.

RADIOGRAPHIC SUMMARY:

1. **Bulging of the C3-4, C4-5, C5-6, C6-7, and Tl-2 intervertebral discs as detailed above[3].**

2. Subtle loss of the cervical lordosis with the erect weight-bearing passive neutral posture which may be due to muscle spasm.

3. Pathologic ligamentous laxity is not demonstrated.

Degenerative disc problems

01/09/2007 Stand Up MRI Centers Peter Blessey, MD FIRST KNEE

MR EXAMINATION OF THE RIGHT KNEE PERFORMED WITHOUT THE ADMINISTRATION OF INTRAVENOUS CONTRAST MEDIA

RADIOGRAPHIC SUMMARY:

1. Tears of degenerate medial meniscus.

2. Cystic degeneration of the medial collateral ligamentous complex.

3. Knee effusion with complex popliteal cyst formed.

4. Marked thinning and loss of articular cartilage on the patellar facets.

5. Soft tissue swelling and edema superficial to the os patella and patellar tendon.

The tear is of a degenerative meniscus. At most, there was an exacerbation of an existing meniscus issue. However, this MRI is taken 4 years post-accident.

[3] Dessication is noted at every level. Damage is degenerative, not traumatic

01/22/2007 Advanced Neurodiagnostic Morteza Shamsnia, MD

The patient returned for her follow up visit. The patient continues to complain of low back pain. The patient's MRI of the brain, obtained on 12/14/2006, was reported to be normal. MRI of the cervical spine shows bulging disc in multiple levels in the cervical spine with loss of lordosis indicative of spasm in the cervical spine. The patient's other diagnostic testings, EMGs and EEGs are still pending. She has seen orthopedic and received injection in the right knee with some improvement in her symptoms. She also had an MRI done from her knee.

PLAN AND RECOMMENDATIONS:
Our plan is to change her medications from Celebrex to Gel Advil and request a consultation with Dr. Jackson for depression. The patient also will need further workup including EMG/NCV /DEP of the upper extremities for evaluation of her neck pain. The patient should return to our clinic for follow up evaluation after her workup is completed.

The above doesn't mention that all of the disc issues are listed in the MRI report as "dessication" and therefore are degenerative in nature.

02/08/2007 Paul M. Doty, MD Knee

- Seen by Dr. Blessey one month ago
- Degenerative tear medical meniscus
- Plan: Arthroscopy

05/12/2007 Advanced Neurodiagnostic Morteza Shamsnia, MD

Upper Extremities Nerve Conduction Study

No interpretative report present in this file

06/11/2007 Paul M. Doty, MD Knee

- Bilateral Knee pain
- Prior arthroscopy (?)
- Degenerative changes

07/26/2007 Paul M. Doty, MD Knee

- Illegible as to which knee she is complaining most about
- Pain – needs ____ to work
- ___knee partial ___stable for ___
- Internal derangement L knee
- MRI Rt knee
- 1st Synvisc

08/02/2007 Paul M. Doty, MD Knee

- 2nd Synvisc injection to right knee
- Patient feels better with ___ pain relieved
- Also, leg better with last injection
- Lortab

08/09/2007 Paul M. Doty, MD Knee

- Left knee hurting same as right knee
- Patient would like to treat similar to right knee
- Painful range of motion left knee
- ____without range of motion

09/27/2007 Advanced Neurodiagnostic J. Kevin Jackson, MD

CHIEF COMPLAINT: The: patient reports coming in for a neuropsychiatric evaluation for closed head injury and

posttraumatic stress disorder. The patient reports being sent by her lawyer.

- **She reports also during the accident hurting her knee and it is now giving her problems.**

- **She said due to problems with her legs, she has gained more than 30 pounds, which has increased problems with ambulation.**

- **She reports that she has had problems with her memory. Since the accident, she forgets what she says in the middle of a conversation. Again on her job, she will try to type and will give letters out of sequence.**

- **The patient reports her appetite is currently under better control; previously it was out of control craving sugar and eating much more than she should.**

- **However, she does report that she will need breast surgery again due to the way that seatbelt hit her left breast.**

- **The patient reports auditory hallucinations and visual hallucinations. Prior to the accident, she reports she has heard voices of spirits. She believes that she can hear voices of spirits and saw angels in her home. She reports that some of these have occurred around the time of sleep, so this may be either a cultural phenomenon or it may be possibly hypnagogic or hypnopompic hallucinations.**

I. Traumatic brain injury with cognitive and mood sequelae[4].

PLAN: We will consult Phillip Griffin at LSU for a neuropsychological testing. We will consider an MRI of the head. We will also increase Cymbalta to 90 mg q. day times seven days, then 120 mg q. day. Return to clinic in approximately one month.

[4] **1.** (Medicine / Pathology) any abnormal bodily condition or disease related to or arising from a pre-existing disease
2. (Medicine / Pathology) any complication of a disease

11/07/2007 Tulane University Medical Group Mark J. Hontas, MD

HISTORY: Ms. Amelia Barnett presents to the office today on 11/07/2007 for right knee pain. She initially had problems with her right knee following a motor vehicle accident in 2004.

Her second injury was in November of 2006 when she was putting a microwave on a counter. She was standing on a step stool and she started to experience excruciating pain in her knee.

She has been seen for her right knee since the day of her accident in the Lakeview Emergency Room then she saw Dr. Blessey for her knee and also saw Dr. Doty for her knee. These visits were in January and February of 2007.

DIAGNOSTIC STUDIES: I don't have her old MRI report but her x-rays· show some degenerative changes.

The accident was four years prior to this visit, not three
This second injury is likely where the tear of her degenerated medical meniscus occurred
Her knee care did not begin in the ER after the accident, first complaint is 01/09/2007

12/11/2007 Neuropsychological and Psychological Services Susan Andrews, Ph.D

REFERRAL QUESTION AND RELEVANT HISTORY: Amelia Barnett is a 52- year-old married woman who was referred for a neuropsychological evaluation by Dr. Jackson. Mrs. Barnett sustained a head injury, with alteration in consciousness, during a motor vehicle accident on 5-17-2003.

SUMMARY:
Generally, Mrs. Barnett is showing significant impairment in attention and concentration. There are also mild deficits for executive functioning, naming, and some perceptual tasks. Overall, memory functioning is Average, with the exception of a relative weakness in Visual Delayed Memory. Mrs. Barnett reports significant depressive symptoms and history of premorbid anxiety and panic attacks and also reports chronic sleep disturbance. She has gained about 100 pounds since the accident, which is likely exacerbating her physical discomfort, knee pain, fatigue, and sleep disturbance.

RECOMMENDATIONS:

1. Mrs. Barnett needs to continue with medical monitoring/management of her thyroid condition. She reported gaining 1 00 pounds since her accident in May 2003.

2. Continued treatment of depression and anxiety is recommended. Mrs. Barnett would benefit from Cognitive-Behavioral therapy to address depressive and anxious symptoms, and to learn adaptive strategies for managing stress.

3. Sleep hygiene training may be beneficial for Mrs. Barnett. A screening polysomnography completed on 6-17-2003 was interpreted as essentially negative for sleep apnea but noted possible insufficient Sleep syndrome, and heavy daily caffeine usage.

4. Evaluation of knee pain is recommended.

5. Cognitive rehabilitation may help Mrs. Barnett to learn adaptive strategies to compensate for her residual cognitive deficits in attention and executive functioning.

Discrepancies contained within this report:

- She stated she hit the metal handle over the glove box with her neck, was thrown back and to the side, and then hit the right door window with her head **(how did she do this if the air-bag deployed?)**

- Mrs. Barnett stated she does not remember what happened after she hit her head. The next thing she remembers is being helped out of the car **(previously she stated she woke up on the ground)**

- Mrs. Barnett reported her 15-year-old daughter was riding in a car with two male friends and passed the scene of the accident and saw the Barnetts on the ground **(she recalls being helped from the car but was found on the ground? Was she taken from the car and placed on the ground?)**

- Mrs. Barnett's former business, a horse farm, went bankrupt after the accident. **(I thought the bankruptcies were already in progress?)**

- Mrs. Barnett stated she experiences knee pain daily, stated she hit her knee during the accident **(no mention at accident scene or hospital)**

- Mrs. Barnett was evaluated by Dr. Bryant of The North Institute in June 2003. Dr. Bryant's impressions were acute cervical disc injury, mild; cervical myofascial pain, cervical soft tissue hematoma by history **(cervical disc imaging revealed desiccation/degenerative disease, not injury)**

01/15/2008 Tulane University Medical Group Mark J. Hontas, MD

HISTORY: Ms. Barnett is here today two months from her last visit. We aspirated her knee approximately two months ago and it gave her minimal if any relief. She states today that the knee is extremely painful.

PHYSICAL EXAMINATION: Her right knee is also continuing to bother her. We know that this also has degenerative changes as well.

X-RAYS: She requested.an x-ray of the left knee and we have done so. There are degenerative changes seen in the knee on the left and they are very similar to the changes seen on the right. There is narrowing of the joint space, ridging and osteophytes and varus angulation of the knees.
RECOMMENDATIONS: At this point she needs to consider knee replacements. I have injected her in the knees today so she could at least get some relief, but I think at this point she is headed for a knee replacement for both of her knees.

Changes are degenerative in nature
Knee complaints began 01/09/07

04/08/2008 Tulane University Medical Group Mark J. Hontas, MD

Ms. Barnett is here today. She has pain in both of her knees. She has tried injections and anti-inflammatories, but she is continuing to have more and more pain. We have gone over risks and. benefits. We are going-to set her up for knee replacements.

05/28/2008 The Breast Center Marie Lagard, M.D.

- Pain right to left
- Distortion implants secondary to trauma
- Plan: Implants removal/mastopexy

When was this breast trauma reported?

06/13/2008 Tulane University Medical Group Mark J. Hontas, MD

Patient called to cancel her surgery. She needs to accrue more sick time. She will call back in January of 2009.

06/17/2008 Richard Celentano, M.D. Plastic Surgery

- Breast surgery quote sheet
- $22,065.00

06/18/2008 UNKNOWN Health Care Provider re Cosmetic Surgery Cost

> **Mr. Damico asked if our office accepted a Letter of Guaranty. I explained to him that it is office policy to not accept a Letter of Guaranty. Again explaining that payment for cosmetic procedures is due in advance. He requested documentation from Dr. Lagarde and *I* or Dr. Celentano that the patient's implants ruptured due to an automobile accident. I explained that medical records could be made available; there was no way that the doctors could determine the cause to the rupture. I recommended that if the patient had and ID card from her original surgery, she could contact the implant company and start a warranty claim. That way at time of removal the original implants could be returned and undergo microscopic examination.**

The procedure is billed as cosmetic, not as repair or needed
No one can say what caused the rupture
I see no objective testing that says there is a "rupture" as opposed to a leak
Warranty info is discussed, suggesting product failure, not damage

06/23/2008 Lakeview RMC's Women's Center Celeste Lagard, M.D.

MAMMO SCREEN DIGITAL BILAT

> **Cranial caudal and oblique projections were obtained using full field digital technology and computer over read. Implant displacement views were obtained. The patient presently has .no complaints. Compared to previous exam dated 6/29/2005 Implants are unremarkable in their appearance. The overlying breast tissue**

is moderately dense. There is no dominant mass or clustered microcalcifications. There is no skin thickening or retraction. There is no architectural distortion or significant axillary adenopathy. There is no adverse interval change.

Impression:* No *mammographic evidence* for *malignancy in* these augmented *breasts. Continued yearly follow-up is* recommended *unless clinically necessary otherwise.

04/01/2009 NORTH Institute Richard Texada, MD

282 DAYS SINCE LAST MEDICAL RECORD

No records for this provider since 08/01/2005 (1339 days / 3 years, 8 months)

Weight: 237

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 53 year old w/f complaining of bilateral knee pain stemming from a MVA in 2003. She has been treated by Dr. Hontas, who informed her that she would need knee replacements. She failed to bring any films with her.

She describes her pain as constant, stabbing pain. She states that she can't extend her legs. She rates her pain a 1 0/10. Pain increases with walking or when she attempts to stand after sitting for prolonged periods.

IMPRESSION/PLAN: I told Ms. Barnett that she has significant arthritic disease. She has failed conservative measures and has pain on a daily basis, worse with any and all activities. I do not think anything short of total knee arthroplasty will afford her much relief. We went over the surgery in great detail today, the risks, the benefits, the procedure itself, and the extensive postoperative course, and she is very interested in proceeding. In speaking with her further, she says she was having absolutely no discomfort in her knees before her 2003 motor vehicle accident. I do not have any x-rays available from that time period, but she may have had some preexisting arthritic disease before her injury. Regardless of that, she was completely asymptomatic before her motor vehicle accident, and I do not doubt that her motor vehicle accident aggravated her preexisting condition, and she is unable to regain her pre-injury level of activity and comfort. Basically it seems that

all of her current problems stem from her motor vehicle accident. I think that she is an excellent candidate for total knee arthroplasty. I think she would gain significant relief and have an increase in activity. She understands and wishes to proceed. We will try to get this set up at her convenience.

Report states the knee pain stems from the MVA, yet this facility saw her then and she never reported knee pain.

06/01/2009 NORTH Institute Donald Dietze, MD

Weight: 243

HISTORY OF PRESENT ILLNESS:
Amelia Barnett is a 53 year old female here with complaints of neck and back pain that started in 2003 when she was in a MVA. She was the restrained driver of a vehicle in a head on collision. She was last seen here for neck and back in 2005 by Dr Bryant. No treatment since then.

Pain is in neck and shoots down back to left leg. Complaining of finger numbness in both hands. Pain is worse with sitting up straight. Complaining of swelling in hands and feet. Pain is rated at a 10/1 0.

She also admits to forgetfulness.

She states that she was healthy without memory, neck or back problems prior to the MVA on May 17, 2003.

General Neurologic Exam:

Speech:
Speech is fluent.

Cognition:
Cognition is intact. Recalls 0/3 words at 5 minutes. Abstraction concrete.

CN 2-12:
CN 2-12 are grossly intact.

Cerebellar:

Finger to nose and heel to shin are normal Rapid alternating movements are normal Finger dexterity is normal Tandem gait is normal

Additional Neurologic Testing:
Rhomberg is normal
There is no pronator drift.

Problems Added:
1) Dx of Degenerative Joint Disease, Knees, Bilateral (ICD-715.96)
2) Dx of Obesity, BMI 41 (ICD-278.00)
3) Dx of Hypothyroidism (ICD-244.9)
4) Dx of Spondylosis Cervical (ICD-721.0)
5) Dx of Spondylosis Lumbar (ICD-756.11)
6) Dx of Postconcussion Syndrome (ICD-310.2)
7) Dx of Mitral Valve Prolapse (ICD-424.0)
8) Dx of Anxiety Depression (ICD-300.4)
9) Dx of Panic Disorder (ICD-300.01)
10) Dx of Motor Vehicle Accident, May 17,2003 (ICD-E829.9)
11) Dx of Head Trauma, Closed (ICD-959.01)
12) Dx of Back Pain (ICD-724.5)
13) Dx of Neck Pain (ICD-723.1)

Neuropsychological Evaluation, September 18 & 19, 2008:
"With regard to effects from a head injury suggested by Dr. Andrews, this writer does not agree, as there is not a documented head injury significant enough to result in cognitive decline and focal cognitive deficits from 5/17/03 accident."

SEE DISCUSSION NOTE OF DONALD DIETZE, MD (ATTACHED)

- This facility saw her in 2003, no neck/back/memory/breast issues
- First of these complaints was in 2005
- No treatment for these complaints for 4 years
- Cognition is intact
- Spine issues are degenerative
- Knee issues are degenerative

06/15/2009 NORTH Institute Donald Dietze, MD

Weight: 240

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 54 year old female here today to follow up on her neck and low back pain.

IMPRESSION & RECOMMENDATIONS:

Problem# 1: BACK PAIN (ICD-724.5)
Her updated medication list for this problem includes:
Lortab 10 10-500 Mg Tabs (Hydrocodone-acetaminophen) 1 tab orally every 4-6 hours as needed for severe intractable pain.

Problem# 2: NECK PAIN (ICD-723.1)
Her updated medication list for this problem includes:
Lortab 10 10-500 Mg Tabs (Hydrocodone-acetaminophen) ..... 1 tab orally every 4-6 hours as needed for severe intractable pain.

Problem# 3: HEAD TRAUMA, CLOSED (ICD-959.01)

(No notes)

07/06/2009 NORTH Institute Donald Dietze, MD

Weight: 238

HISTORY OF PRESENT ILLNESS:
Amelia Barnett is a 54 year old female here today to follow up on her neck and low back pain. She presents with cervical and lumbar

MRI films.
Label 1:
Cervical MRI (6/30/09)- multilevel degenerative changes.
- C6-7 mild broad-based R side predominant disc bulge
-Central T1-2 disc protrusion.
- C5-6 Face! arthrosis
- No acute bony abnormality noted

Label 2:
Lumbar MRI (6/30/09)- multilevel degenerative changes
- L5-S1 significantly decreased disc ht with mild midline posterior disc bulge and facet hypertrophy with osteophytes; no significant stenosis.
- L4-5 grade 1 spondylolisthesis with mild posterior bulge and facet hypertrophy causing significant central stenosis
- L3-4 mild post disc bulge with facet hypertrophy causing significant stenosis.

The unresolved extruded disc herniation at the level of the L4-5 spondylolisthesis will more likely than not require surgical intervention- there is no expectation of spontaneous improvement. Once surgery is entertained, the L3-4 and L5-S1 level diseases would need to be addressed. Surgery recommended would be a L4-5 R. discectomy and TLIF, L5-S1 AxiaLIF and L3-4 Laminectomy with partial facetectomy augmented with L3-4 posterior hybrid dynamic spinal stabilization (DSS System). This is a fairly large complicated surgery and I would demand lumbar facet neurotomy/rhizotomy at B. L4, L5 & S1 +/-trial of ESI before surgery considered.

Dr. Dietze tries to make the case for some trauma, in addition to the degenerative changes. Keep in mind; this is a woman who rode horses for a significant portion of her life.

07/15/2009 NORTH Institute Richard Texada, MD

Weight: 238

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 54 year old w/f following up for bilateral knee pain. She is interested in getting synvisc injections, but rather than get the standard 3, she request 6. R=L

Physical Exam
Ms. Barnett is a 54-year-old woman who comes in for bilateral knee pain. She has had this for a very long period of time, and she blames a lot of this on a motor vehicle accident that she had some years ago. She has tried Synvisc with no relief and Cortisone injections with no relief.

PHYSICAL EXAMINATION: Exam today shows small to moderate effusions bilaterally, -5 degrees full extension, and 90 degrees of flexion. No varus or valgus instability. There is a good bit of diffuse medial and lateral joint line tenderness.

X-RAYS: X-rays show significant arthritic disease.

IMPRESSION/PLAN: I told Ms. Barnett as we have in the past that at some point she is going to need total knee arthroplasty. Actually today she is very interested in proceeding. She wants to get both knees done at one time. She says both knees are so bad that she does not know if she could recover from one with the other as bad as it was. We discussed the unique risks associated with

simultaneous bilateral procedure. We also went over the usual risks and benefits of the procedure, the procedure itself, and the postoperative course which will obviously be more difficulty because of her bilateral procedure. She understands and wishes to proceed. We will set this up at her convenience.
Problem# 1: DEGENERATIVE JOINT DISEASE, KNEES, BILATERAL (ICD-715.96)
Her updated medication list for this problem includes:
Lortab 10 10-500 Mg Tabs (Hydrocodone-acetaminophen) 1 po q 6 h pm

Problem# 2: KNEE PAIN (ICD-719.46)
Her updated medication list for this problem includes:
Lortab 10 10-500 Mg Tabs (Hydrocodone-acetaminophen) 1 po q 6 h prn

10/14/2009 NORTH Institute Richard Texada, MD
(91 days)

Weight: 229

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 54 year old w/ffollowing up for bilateral knee pain. She was scheduled for knee surgery, but cancelled it due to her work situation. She states that she has fallen twice since her last appointment, and has an increase in knee pain as a result.
CC remains B knee pain - equal in intensity. Wants to proceed with B TKA. She has gotten cleared by cardiology, however, her work will not allow her to take off to recuperate from the surgery.

Problem# 1: DEGENERATIVE JOINT DISEASE, KNEES, BilATERAL (ICD-715.96)
Assessment: Unchanged

1) B knee lA injection with 2cc lidocaine and 2cc marcaine - sterile technique
2) Medication management
3) F/U prn

We will be happy to proceed with TKA when Ms. Barnett is ready.
Her updated medication list for this problem includes:
Lortab 1010-500 Mg Tabs (Hydrocodone-acetaminophen) ..... 1 po q6h prn

01/18/2010 NORTH Institute Richard Texada, MD
(96 days)

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 54 year old w/f following up for bilateral knee pain. She request injections.
CC remains B knee pain -equal in intensity.
Not yet ready to proceed with TKA at this time
Dx with significant B knee DJD

Problem# 1: DEGENERATIVE JOINT DISEASE, KNEES, BILATERAL (ICD-715.96)
Assessment: Unchanged

05/12/2010 NORTH Institute Richard Texada, MD
(114 days)

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 54 year old w/f following up for bilateral knee pain. She request injections, she also would like a refill of celebrex.

Physical Exam
Ms. Barnett is a 54-year-old woman who comes in to follow-up on her bilateral knee pain. She has had injections in the past that do work and she requests another today.

PHYSICAL EXAMINATION: Her exam today is fairly similar to that that it has been in the past.

IMPRESSION/PLAN: I gave her bilateral injections today. She asked for a refill on her Celebrex. I will see her back here as needed.

06/19/2010 Advanced Neurodiagnostic Morteza Shamsnia, MD

Ms. Barnett is a 55-year-old white female with a history of traumatic brain injury, depression, and anxiety disorder. The patient was previously followed in this clinic by Dr. Kevin Jackson, but was lost to follow up in 2009.

The patient reports not having seen a psychiatrist in this past year and has been off of medications since January of 2009.

In that accident, the patient states that she hit her head several times on the window and hit her neck on a handle on the dashboard. After the accident, the patient did receive lacerations to her face and her consciousness was waxing and waning immediately after the accident. The patient, however, left the emergency room AMA on the day of the accident. The patient reports that she has problems with her memory since the accident. She forgets what she states in the middle of a conversation. The patient states that when she was working she had to use multiple notes each day to perform routine parts of her job. She also reports that she was easily distracted at work. Since the patient stopped working earlier this year, she notes no problems at home with regards to her memory. The patient's additional stressors include approximately 100 pound weight gain since the accident, chronic pain bilaterally in her knees

She did attempt to go to college, but found that she was unable to concentrate and was unable to complete even one year of college

With regards to developmental and learning disorders, there is some question whether the patient had problems with reading comprehension.

The patient reports not working from the year 2003 to 2006 because of difficulty concentrating. She did work in an answering service from June of 2006 to February of 2010. She states that with great help she was able to function at this job, however, the business closed in February of 2010. The patient is currently unemployed and the patient lives alone

Her inattention and her affective symptoms may have been present prior to this accident, however, she never required medications prior to her traumatic brain injury and clearly her symptoms have worsened since the accident. Her neuropsychological testing reveals a pattern which was consistent with this traumatic brain injury.

With unremarkable MRI studies, he still calls this a traumatic brain injury. Based on what?

Now she hits her head "several" times and her neck hits the dash. How is that possible with a deployed airbag?

Her memory problems seem to abate as soon as she no longer has to go to work.

She apparently has a longstanding history of "not being able to concentrate" and doing poorly with intellectual tasks

There doesn't seem to be any motivation to work.

Her symptoms pre-date the accident

He never explains upon what he bases his diagnosis of "Traumatic Brain Injury"

08/21/2010 Advanced Neurodiagnostic Angela Traylor, MD

Neuropsychiatry Progress Note

> **Results of an MRI of the brain without contrast revealed periventricular[5] white matter disease, slightly more prominent in the sub-insular areas, which were nonspecific, likely representing mild microvascular disease[6]**
>
> **IMPRESSION**
> **Traumatic brain injury, cognitive disorder secondary to traumatic brain injury and mood disorder secondary to general medical condition. The patient's depression is poorly controlled at this time. There does appear to have been some improvement with Cymbalta. However, the patient does continue to be somewhat labile and irritable. . She also has poor' pain control with her current medications.**

MRI Report of 12/14/06 shows: **Unremarkable gray/white** matter differentiation is recorded on appropriate pulse sequences submitted.

[5] In fact, the most common cause of periventricular white matter changes is normal aging that is not associated with a disease process. http://www.medfriendly.com/periventricularwhitematter.html

[6] Cerebromicrovascular disease associated with hypertension and other cardiovascular risk factors, including age, is linked with regional hypoperfusion and brain volume loss , as well as with neuronal degeneration and cognitive decline in elderly people http://www.medscape.org/viewarticle/731130_6

She has a history of hypertension, which can cause microvascualr disease. That **disease in turn can cause cognitive difficulties.** If she suffers any brain issues, likely they are organic and not traumatic.

Again, this doctor doesn't explain the Dx of TBI and her own remarks above appear to attribute any changes to being unremarkable and likely caused by age/hypertension.

12/11/2010 Advanced Neurodiagnostic Angela Traylor, MD

842 DAYS SINCE LAST MEDICAL RECORD

Neuropsychiatry Progress Note

IMPRESSION
Traumatic brain injury, cognitive disorder secondary to traumatic brain injury, and mood disorder secondary to a general medical condition. The patient is progressing well with managing her behaviors that had been reinforcing her depressive symptoms. It is encouraging that she is seeking job training and distancing herself from her children's behavior. The patient does request a medication to help with her concentration and had a side effect of sedation with Concerta.

Again, this doctor doesn't explain the Dx of TBI and her own remarks on 08/21/10 appear to attribute any changes to being unremarkable and likely caused by age/hypertension.

08/08/2011 NORTH Institute Richard Texada, MD
(453 days since this facility)
(240 since last medical record)

HISTORY OF PRESENT ILLNESS:
Ms. Barnett is a 56 year old w/f following up for bilateral knee pain. No new trauma. She also c/o pain in bilateral ankles and hips. She has an appointment with Dr. Espinoza, a rheumatologist, on August 23, 2011. She asked that a "referral" be sent to the physician.

Problems Added:
1) Dx of Pain in Joint, Multiple Sites (ICD-719.49)
2) Dx of Ankle Pain (ICD-719.47
1) Rheumatology referral to Dr. Espinoza
2) Celeb rex 1 OOmg qd with food

3) PT 2-3x a wk for 4-6wks
4) B knee lA injections 2cc lidocaine and 2cc depo medrol

No record for Espinoza, MD

03/03/2012 Advanced Neurodiagnostic Angela Traylor, MD

448 DAYS SINCE LAST MEDICAL RECORD

Neuropsychiatry Progress Note

The patient has not been taking any antidepressant. She is taking Armour Thyroid and hydrocodone p.r.n.

The patient does complain of some difficulty finding words. She feels as though she knows what she wants to says and then she has to "force it out"

She has not complained of bilateral knee pain and low back pain,

IMPRESSION
TBI, mood disorder secondary to her general medical condition, and cognitive disorder secondary to her general medical condition. The patient has not been compliant in the past with various medications. She is interested in restarting an antidepressant that could be helpful for pain.

Again, this doctor doesn't explain the Dx of TBI

06/02/2012 Advanced Neurodiagnostic Angela Traylor, MD

91 DAYS SINCE LAST MEDICAL RECORD

Neuropsychiatry Progress Note

The patient has been active in our absence. She has obtained a PCP, a rheumatologist and is following up with an endocrinologist. Her rheumatologist is working her up for possible fibromyalgia and for rheumatoid arthritis[7].

[7] Also known to cause microvascualr disase