JA BizTown™

Initial Report
of
Andre A. Brown, M.D.
Neurology and Neurosurgery

PATIENT: Tony Perry
DATE: 3/5/2015

HISTORY: This eighteen-year-old, right-handed male dates his symptoms from an accident that occurred on March 5, 2015. He states that he was in the Cafe at *JA BizTown* when he slipped on a pickle that was on the floor.

When I first saw him in the emergency room, he had been brought in by the paramedics and was complaining of pain in the back and left hip. He also had hit his head against the floor, but that seemed to be a minor problem. I noted no symptoms of a concussion. He stated that he played high school football and had experienced back problems. He has never had surgery.

ALLERGIES: He is unaware of any allergies to medication.

NEUROLOGICAL EXAMINATION:

MOTOR: The patient has a 0-1 weakness of the anterior tibia on the left. He has -1, 2 extensor hallucis longus and -2 toe extensor weakness on the left. The gastroc is 0, -1 on the left. All other groups are normal. The right lower extremity and uppers are normal.

REFLEXES: The biceps, triceps, and brachiordialsis are normal and symmetric. The quadriceps and gastrocs are normal in the right lower extremity. In the left lower extremity the patient has normal medial hamstring reflex, but external hamstring reflex is absent as is the gastroc.

SENSORY: Sensation to pain, touch, light touch, joint and vibratory sensation is normal and symmetric.

COORDINATION: The patient walks with a gait and tends to favor the left lower extremity. He also pushes off poorly with that foot. He is able to heel walk and lift the metatarsal head off the floor on the left but not as far on the right. The patient does not toe walk as he states the pain is intense.

SENSORIUM: The patient is fully alert and oriented.

SPINE AND EXTREMITIES: The lumbar lordosis is normal. The paraspinal muscles are of normal tone. He has exquisite tenderness in the sciatica notch on the left but not on the right. Trochanters, ischial tuberosity, and sacroiliac joint are all non-tender, however. Straight leg rising on the right is to 30 degrees where there is a crossed straight leg raising pain down the left lower extremity. On the left straight leg rising is to 20 degrees. Flexion of the lumbar spine is limited -3 and accentuates the left leg pain. Extension and right and left lateral bending, however, do not aggravate nor accentuate the pain.

JA BizTown™

GENERAL EXAMINATION:

HEAD: Pharynx. Thyroid normal. Calvarium. No adenopathy. Neck supple.

CHEST: Clear to auscultation and percussion. Good breath sounds.

HEART: Regular sinus rhythm. No murmur.

ABDOMEN: No palpable organs, masses, nor tenderness.

SKIN: Normal.

IMPRESSION: The patient has symptoms of a protruded and extruded disk, likely at L5 but possible at L4 on the left. I would recommend that he proceed with MRI scan of the lumbar spine and in the meantime stay at bed rest. It is not likely that bed rest will be helpful, and I expect he will come to lumber laminectomy. He will be seen again after the MRI scan.

ANDRE A. BROWN, M.D.

JA BizTown™

OPERATIVE REPORT

DATE OF SURGERY: 3/30/2015

SURGEON: James A. Brown, M.D.

PREOPERATIVE DIAGNOSIS: Protruded and extruded L-5 intervertebral disc.

POSTOPERATIVE DIAGNOSIS: Same

OPERATION: Left L-5 laminectomy and discectomy

PROCEDURE: The patient was placed on the operating table after anesthesia had been induced. He was turned gently onto the Wilson frame. The arms, elbows, axillae and all pressure points were carefully padded with sponge rubber and suspended so that there was no pressure upon them.

The back was prepped and draped in the usual manner. Through a small midline incision, the dissection was carried down through the skin and subcutaneous tissue to the fascia. The muscles were reflected subperiosteally over the spinous process of L-5 and the sacrum on the left side. The Taylor retractor was inserted and a partial hemi-laminectomy was carried out after the interspace had been identified and confirmed by x-ray. The yellow ligament was carefully dissected away. The nerve root and interspace were then explored. There was an extruded disc fragment, which had extruded interiorly. This was hooked with a blunt hook and extracted.

There was a hole in the inferior portion of the disc. The annulus was incised and the disc material was removed from the interspace, removing degenerative fragments from there. This was worked medially and laterally until there was no further degenerative disc material present.

Exploration again up and down the canal, in the foramen and out the axilla revealed no further extruded disc fragments. The nerve root was very well visualized and was under no further pressure. The wound was lavaged and meticulously hemostased. The muscles were closed with 0 Vicryl. The subcutaneous tissue was closed with 3/0 plain catgut and the skin with 4/0 nylon. Dressings were applied and the patient was returned to the PAR.

JA BizTown™

Final Report
of
Andre A. Brown, M.D.
Neurology and Neurosurgery

PATIENT: Tony Perry
DATE: 9/6/2015

HISTORY: The patient is an 18-year-old man who injured himself on March 5, 2015, at the Cafe at *JA BizTown* where he slipped and fell. Examination revealed a well-muscled young man who had radicular symptoms with positive straight leg raising and decreased range of motion of the lumbar spine. It was felt that he had a protruded lumbar disk, and he underwent an MRI scan which showed the protruded disk at L5. He underwent a lumbar laminectomy at the JA BizTown Hospital on March 30, 2015. He had a left l5 laminectomy and diskectomy. Postoperatively, the patient has done well but still has some residual pain in the left thigh and experiences difficulty sitting for long periods of time. He has not yet returned to school or work.

NEUROLOGICAL EXAMININATION:

MOTOR: Strength is normal in the major groups of the lower extremities.

SENSORY: Sensation is normal in the lower extremities.

REFLEXES: The quadricepses are normal. The gastric reflex on the right is normal. That on the left is absent. Plantar response in flexor.

COORDINATION: The patient walks with a normal gait with normal heel and toe walking. He has no ataxia or list.

SENSORIUM: The patient is fully alert and oriented.

SPINE AND EXTREMITIES: The lumbar spine range of motion is limited -1 in flexion, extension and right and left lateral bending. The wound from the operation is well healed. The Para spinal muscles are of normal tone. Straight leg rising is to 80 bilaterally.

IMPRESSION: The patient is generally doing well and can return to school or light work. I do not feel that he will be successful at doing heavy work at any time in the future. This includes football, weight lifting or other strenuous physical activity. He should seek employment that does not require frequent bending, lifting, stooping or twisting. He has a permanent partial disability on 15% of the body as a whole.

ANDRE A BROWN, M.D.