Mitchell S. Grobman, M.D.

DULBERG, PAUL
SS#: 323-76-4001

DOB: 03/19/70
DOV: 05/08/02

CONSULTING PHYSICIAN: Frank Sek, M.D.

REASON FOR EVALUATION: Pain and sensory disturbance since a motor vehicle accident.

HISTORY: This is a 32-year-old right-handed gentleman with no significant past medical history who was involved in a motor vehicle accident on March 1, 2002. He reports that he was stopped to make a turn when another car tried to pass him and then turned back quickly into his lane. The other car's front passenger side impacted on his rear driver's side. The patient states that he had turned all the way towards the left to find the car that was passing him when the impact occurred and his left arm was actually between his seat and the doorframe. He was pushed back into the seat and his seat belt held. His left shoulder may have hit the window. He had no bruises or obvious external injuries and he got out of the car without difficulty, walking fine. The next day was his first symptom and it was spasm in the left side of his neck and into the upper shoulder. Over the following week this increased in intensity and spread into the left proximal arm (near the deltoid insertion), into the left shoulder blade and trapezius region and down the paraspinal muscles into the lumbar spine region. From the lumbar paraspinal region it goes into the buttock and also can spread into a region in the left posterior thigh and the left posterior calf. These regions feel like they are deep inside and burn and reside in a region approximately 3 inches in diameter. These symptoms are worsened by walking. In addition, the left foot tingles on the dorsal surface. He has no complaints regarding the right leg or the right arm. There are no cranial nerve complaints. The rest of the review of systems is per the health questionnaire.

PAST MEDICAL HISTORY: Essentially negative.

MEDICATIONS:
1. Flexeril 10 mg b.i.d.
2. Carisoprodol 350 mg q.i.d.
3. Naproxen 500 mg b.i.d.
4. Talwin alternating with Vicodin.
5. Amitriptyline 50 mg q h.s. for the last week only. He is experiencing some daytime sleepiness.

ALLERGIES: There are no known medication allergies.

FAMILY HISTORY: His parents are alive and healthy in their 60's. No significant neurologic problems in the family were identified.

SOCIAL HISTORY: He is single. He works a printing press but has not been able to do his work due to his injuries. He has smoked one pack of cigarettes per day for the last 11 years and does not drink alcohol or use recreational drugs. He usually exercises regularly.

NEUROLOGIC EXAMINATION:

Mental Status: There are no signs of aphasia, dementia, or other cognitive defects at this time.

Cranial Nerves: Funduscopic examination reveals flat discs bilaterally without significant optic atrophy and without hemorrhage or exudate. Visual fields are intact to confrontational testing both singly and simultaneously. Pupils are round, symmetrical, and reactive to light equally both directly and consensually. There is no anisocoria or afferent pupillary defect. Extraocular movements are full and normal speed. There is no nystagmus. There is no ptosis. Facial sensation is intact to light touch and pin. Muscles of mastication contract symmetrically. Muscles of facial expression, both upper and lower groups, contract normally. The palate elevates in the midline. Trapezii muscles elevate with normal strength. The tongue protrudes in the midline. There is no sensorineural or conductive hearing loss detected.

Motor: With the exception of slight weakness of the flexors of the left toes, the patient can demonstrate normal strength throughout all four extremities. There is no loss of muscle bulk. There is no dysmetria or dysdiadochokinesia. Specifically there is no weakness of finger adductors or the flexors of the distal interphalangeal joints of digits four and five.

Sensory: Vibratory sense is intact throughout. Light touch is intact throughout both legs. Pin is diminished in a region stretching from the anterolateral shin proximally, anterior shin distally and dorsal medial foot on the left. Pin is intact throughout elsewhere.

Reflexes: Deep tendon reflexes are present, normoactive and symmetrical at biceps, triceps, brachioradialis and patellar tendons. The left medial hamstring and Achilles tendon reflexes are slightly diminished compared to the right. Toes are downgoing on plantar stimulation.

Gait: Resting ambulation is normal. Toe walking is intact but he has decreased toe clearance on heel walking on the left compared to the right. His base is normal and tandem is performed without difficulty.

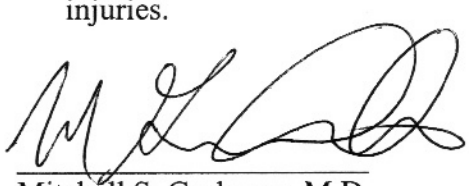
General: The patient is well-developed, well-nourished and well-groomed. Heart is regular rate and rhythm without murmurs. There is no meningismus. There are no carotid bruits and carotid pulsations are normal. Range of motion of the neck is pain limited, especially for lateral bending and lateral rotation bilaterally. There is palpable hypertension in the muscles of the posterior neck just to the left of midline at approximately the C6 level. There is tenderness to palpation at the medial border of the lumbar scapula on the left. Tinel's sign is negative at the right elbow but induces severe tingling with very light pressure at the left ulnar groove. Peripheral pulses are normal. There is no pedal edema. Pulse is 84. Blood pressure is 114/80. Respirations are 12.

STUDIES: I had available for my review both the plain cervical spine x-rays and the CT scan of the cervical spine, which does seem to indicate a small avulsion fracture inferior to the C5 lamina and no other specific abnormalities. I also reviewed the films of an MRI scan of the lumbar spine and found this study to be normal.

IMPRESSIONS:

1. Musculoskeletal pain due to flexion/extension injury.
2. Sensory disturbance in the left arm consistent with ulnar neuropathy. Due to the position of his arm at the time of the accident, it is likely to be directly related to the accident.
3. Sensory disturbance in the left leg consistent with an L5 radiculopathy. There is no acute compressive lesion but this does not exclude a stretch injury to the nerve root. This also would likely be related to the motor vehicle accident.

RECOMMENDATIONS:
1. Stop Carisoprodol.
2. Increase the Flexeril to 10 mg three times a day.
3. Continue amitriptyline.
4. Medrol Dosepak. Long-term and short-term side effects were discussed at length. The patient was instructed not to use Naproxen while taking the Medrol.
5. EMG and nerve conduction study of the left arm and left leg for above possible nerve injuries.



Mitchell S. Grobman, M.D.

MSG/jak

DD: 05/08/02
DT: 05/09/02

CONTINUATION

NAME Dulberg, Paul DATE

ADDRESS

5/8/02 Pt. comes to office to be evaluated for neck & back pain due to an MVA. He has had muscle spasms in the neck & the low back and then resulting in cramping in those areas as well. Pt gets bad muscle spasms pretty much down his entire spine. His ⓛ side is worse than ⓡ side. Pt. is off work. Meds: see ~~chart~~ list NKDA _____ mh.

5/9/02 PC from pt. This Pt is running out as well as his Flexeril and Dr. Silk has told pt that MSG should handle this because it is beyond his expertise. Per MSG. pt. should cont. PT. & refill of Flexeril auth. Script faxed to Centegra in McHenry. _____ mh.

5.20.02 Pt showed ½ Hr late for Emg rescheduled

5/29/02 Office Visit
Pt here for EMG
Pt noting ~~swelling~~ of ⓛ rib cage.
On exam: ⓛ lower ribcage sticks out & ⓛ nipple ~ ¾" higher than ⓡ
R/O muscle spasm vs. rib fracture
Plan - ~~drugs~~ of ribs
Ace split for ⓛ chest area

5/31/02 Per MSG - pt's rib X-Rays were nl. Pt. notified. _____ mh.

6/11/02 PC from pt. wanting another script for PT. Per Mil ok. Faxed script to Centegra. Tom.

CONTINUATION

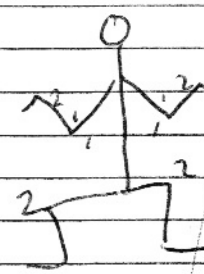
NAME Dulberg, Paul DATE

ADDRESS

7/10/02 Office Visit

Naprox
Amitryptylin 100 - 50 x 2
Cyclobenzaprine + tid
Vicodin - wkly prn

R-ib x-ray (L)



symptoms worse if forgets/skips a dose
Working 4 hrs/day

Using splint on (L) elbow. Getting numbness less frequency essentially only when bends elbow - cranks (c) left hand by habit
No more shooting pain in (L) leg but still (c) muscle pain in low back upper buttocks.
Still (c) muscle spasms in neck, but brief + responds to brief massage
Mentally better also
(L) Shoulder still spasms but can put his arm into a position to block it
O - Sees [illegible] trigger points in (L) trap ~~[illegible]~~ rhomboids
Overall 40-50% better
Exam normal strength in hands
medial 4th digit (L) hand ↓ compared to lateral + all other digits
(+) Tinel's (L) elbow/ulnar groove

Imp: (L) Ulnar neuropathy, less symptomatic. Rb working
↓↓ (L) Lumbar rad.
↓ Musculoskeletal pain
Rec: Continue Plexus
Amitryptiline same dose
Continue PT.
Consider not using splint during day
6 more weeks

[signature]

8/23/02 Office Visit - Mom here also
Spasms in shoulder/neck region gone, but are still ~~[illegible]~~ hurts
Amitryptyline 50 2 qHS Pain shooting from trapezius/collar bone area lateral to elbow into back of hand
Cyclobenzaprine 10 tid + back of thumb, especially when reverses his shoulder, or sitting
Naproxen 500 bid. (L) ~~middle~~ little finger numb, rarely tingles medial 4th ~~[illegible]~~ travel car.
Vicodin <1/week. Dropping things with (L) hand
Using splints at night only - no worse

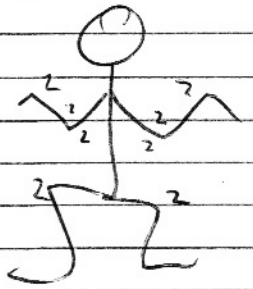
Exam Pressure (R) supraclavicular fossa elicits paresthesia
digits 3+4 of R hand dorsally
Strength normal including hand intrinsics and arms biceps
Tinels positive (L) elbow (-) median (wrist), ulnar wrist, or radial in arm
5th digit ↓ pin by 15%. Still holds (L) shoulder higher
Imp: (R) Some complaints outside of ulnar distribution and pressure in supraclavicular fossa duplicates hand symptoms. R/o brachial plexus or C-sp
Neck spasms improved
[signature] Plan - Same Meds! Continue PT
MR C-spine + (L) Brachial plexus. F/U ~4 weeks

CONTINUATION

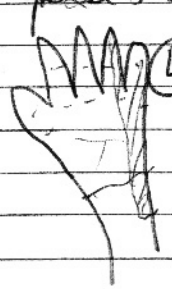
NAME Dulberg, Paul DATE

ADDRESS

9/5/02 PC from pt requesting MRI results. Per msg it shows mild arthritic d's. There is nothing in the nerve bundle in the shoulder. ——— mdm.

9/24/02 Office Visit. Here c mom discussed at length
MRI reviewed. Minor arthritic changes - Likely not the cause of Sympt
Elavil 100 7 qHS One episode of spasmodic pain in (L) trapezius region x 5 hrs.
Flexeril 10 tid Low back tightness w/ when driving
Naprosyn 500 bid Occ shot of pain into (L) pinky Doing therapy tid.
Ø Vicodin No overall Changes
No GI symptoms
Headaches (predicted MUA) non-existent

Scrozzi jerk at (L) elbow → radiating pain into hand
Exam - normal strength throughout. borderline (L) finger abduction
Sensation
Pinprick - both hands Muscle spasm in (L) thumb
Tinels at elbow questionable → numb but not tingly
Imp: Ulnar neuropathy improving (sensory exam).
Muscle spasm pain
Plan: No change in meds
Pt has no chiropractic contraindications to chiropractic/osteopathy - may consider if gets a recommendation
2 months

11/15/02 - Pts mom called to cancel same day. Resched 12/20/02 (ek)

12/20/02 Office Visit - Mom here. Uses left elbow pad at Doing better - Spasms of pain all but gone. Some pain in biceps region
Elavil 100 7 qHS Appetite improving. No other changes in health
Flexeril 10 tid Hx'd (chiropractic manipulation of ribs 7 injection (trigger pts?) in the
Naprosyn 500 bid Some pain in med of hand 3-4x/day 2-30 minutes. "Overlooked current

Exam - Strength intact in forearm biceps
Pin ↓ in ulnar (L) arm splits 4th digit extends proximally
Reflexes normal in arm

Imp: Ulnar neuropathy c sensory/pain deficit but no motor deficit
Musculoskeletal pain improving
Plan Repeat EMG (L) arm only
to eval ulnar neuropathy
Try ↓ Flexeril to 5 mg tid

CONTINUATION

NAME Dulberg, Paul DATE

ADDRESS

12/23/02 Per msg - pt notified that the Emg was slightly better than previous, but still abnl. mdm.

12/23/02 EMG Report mailed to Dr. Sek (ak)

~~02/21/03 sent record copies to: MELINDA LOVE~~
~~AMERICAN NATIONAL CORPORATE CENTRE~~
~~1949 EAST SUNSHINE~~
~~SPRINGFIELD, MO [illegible] 65899-0001~~
JE

error JE

3/4/03 Records sent to American National property
1949 E. Sunshine Springfield MISSOURI - 65899.0001

3/12/03 Office Visit

Flexeril 5mg hs
Naproxen 500 bid
Elavil 100 qHS

EMG results reviewed - Disabled conduction velocity across ulnar groove
Had "overload" (swollen, but no longer pins + needles) of [illegible] & [illegible] moves arm + it goes away.
Neck still hurts, esp with precipitation, but okay without precipitation
Much more energy when stops Elavil, but can't sleep.
Had wisdom teeth pulled
Stopped using splint - fell apart. Tends to sleep on arm ē elbow bent
Exam ⊕ Tinel's Ⓛ elbow
subtle weakness Flexor of Distal phalanx Ⓛ 5th digit
subtle weakness Ⓛ [illegible] ADM, FDI okay
Reflexes = [illegible]
Subtle ↓ pin on 5th digit

Imp: Symptoms improving. Seem more [illegible]
Ulnar neuropathy improving electrophysiologically, still ē some deficit

Recs Another elbow splint/pad to use at night
Continue Naproxen. May occasionally use 3/day
D/c Flexeril over a week
Taper Elavil by 25mg weekly to off if possible

[signature]

CONTINUATION

NAME Dalberg, Paul DATE

ADDRESS

6/6/03 Office Visit

~~Flexeril~~ Elavil Naproxen bid

Lost sleep coming off Flexeril + Elavil, now back to 5 or 6 hours
No loss of pain control with above
Naproxen necessary for pain. Did have heartburn for 2 weeks, now resolved. No blood/black in stool
Test was great. Some pain in neck on bad days (not today)
Less tingling in (L) fingers intermittent + mild pain intermittently
Grip in (L) hand still ~~poor~~ weak. Not worse or better
Wears elbow pad at night
Bothered by weakness enough to switch jobs to graphic design

Trouble c typing incoordinated left finger (L) hand.

Exam - (+) Tinels in (L) ulnar groove c pin cut
(L) ADM 4/5, FDI 4+/5
(L) FDH+5 okay
DTR = in UEs
Pin ↓ 5th digit + ulnar 4th digit medial ~ 60%

Imp: Persistent ulnar neuropathy c sensory + motor deficits
Pt interested in surgery if not better.
Some GI symptoms ? related to Naproxen
Plan - D/c Naproxen
Vioxx 50mg qd x 5 then 25 mg
3 months, Surgery referral
See Dr Sek for heartburn referral
[illegible]

8/19/03 PC to pt to confirm the Naproxen refill. Spoke c pt's mom + she stated the Vioxx was not helping, so pt returned to the Naproxen. Refill auth.
mdm.

9/5/03 Office Visit

Naproxen bid
No other meds

Stopped Vioxx - not working, Back to Naproxen, but taking it with food no GI problem. Needs it for neck pain, not too bad unless weather changes
(L) hand not better. Still c grip weakness. 4th + 5th digits weaker than 2nd + 3rd
Stopped using elbow pad when it fell apart (3 weeks ago)

Pain ~~back~~ when bends elbow

Exam (+) Tinels (L) elbow (ulnar) groove
FDP 5 weak 4/5 FDI 4+ ADM 4 weak. Froment's sign
Opponens + APB 5/5. DTRs N = in UEs
Pin ↓ in 5th + ulnar > median 4th ↓50% dorsal ↓20% palmar

Imp: Continued neck pain
Continued ulnar neuropathy despite 18 months conservative Rx c weakness
Plan - Continue Naproxen. GI bleeding after heartburn → consult Dr Sek.
Consult Dr [illegible] FU 3 months

CONTINUATION

NAME Dulberg, Paul

ADDRESS DATE

5/11/07 Office Visit

Had transposit. ~ surgery. Fixed the shooting pain - mostly

Naproxen 500 bid Strength is much better, No shakyness ~ 5th leg

Still sl numb, more than before surgery

Now neck more bother some than arm

Some unexplained wt loss ~ 30# in 4 weeks despite good appetite

No stomach complaints excessively thirsty, no excessive urination.

Exam: Strength now normal throughout

DTR =

Tinel now pres. anterior to medial epicondyle.

Pin ↓ in ulnar palm up to distal wrist ventrally

+ only distal phalange dorsally

Imp: Good pain + motor response to surgery

Plan Continue physical activity / home exercise program

May continue Naproxen. Careful c stomach

See MD (internist) if unintended wt loss continues

11/10/07 Office Visit

Strength feeling!

Hand Doing very well Typing Continues to improve

No meds by script Repetitive flexion of Ⓛ elbow → hot stinging pain in hand.

Aleve 8-10 pills all at once 3-4x/month. Neck still sore intermittently. Flare up but needs a lot of meds

Stopped Naproxen due to blood in stool & on toilet paper for 5-7 days. Stopped after a week of no Naproxen

Also had heartburn when supine off of Naproxen resolved. Did not see PMD.

O/w healthy.

Exam Strength Completely normal in hands

Tinel anterior to med epicondyle

Pin intact in hand including Ulnar

Imp: Excellent recovery in ulnar nerve sensory + motor

Still c neck pain

Misusing Aleve,

GERD/Ulcer a possibility

Plan - See PMD about Rectal bleeding & Heartburn

No more Aleve > 4/day unless instructed by PMD

F/U prn

CONDELL MEDICAL CENTER
RADIOLOGY DEPARTMENT

RADIOLOGY NUMBER: 484161
PATIENT NAME: DULBERG, PAUL
ATTENDING DR: GROBMAN, MITCHELL
ORDERING DR : GROBMAN, MITCHELL

EXAM DATE: 5/29/02
TRANSCRIBE DATE: 5/29/02
DICTATION DATE: 5/29/02
ACCT. NUMBER: 1403666
ORDER NUMBER: 432435

EXAM DESCRIPTION: RIBS UNILATERAL

RIB SERIES - IMPRESSION: NO FOCAL RIB LESION OR FRACTURE SEEN.

CLINICAL HISTORY: Status post MVA with left sided chest pain.

FINDINGS: Four views of the left ribs series are obtained. No definite focal lesion or fracture is seen. The lungs are clear. There is no suspicious infiltrate or effusion. There is no pneumothorax.

DK/slr

MAY 3 0 2002

tient Name: DULBERG, PAUL
Number: 484161
om Number: RADIOLOGY
B: 3/19/70
te: 5/29/02

ysician: GROBMAN, MITCHELL

ELECTRONICALLY SIGNED BY
KIM M.D., DANIEL

PHYSICIAN

ASSOCIATED NEUROLOGY, S.C.

MITCHELL S. GROBMAN, M.D.
KAREN F. LEVIN, M.D.
MICHAEL I. LEVIN, M.D.

NEUROPHYSIOLOGY REPORT

Name: **Paul Dulberg** Patient ID: 02-0527 Date of Exam: 29 MAY 02
Consulting Doctor: **F. Sek, M. D.**

Motor Nerve Conduction:

Nerve and Stimulation Site	Latency	Amplitude	Segment	Lat. Difference	Distance	Conduction
Median Motor Nerve.L						
Median Wrist	4.0 ms	12.18 mV	Median Wrist-Median Elbow	5.0 ms	280 mm	56 m/s
Median Elbow	9.0 ms	10.65 mV				
Ulnar Motor Nerve.L						
Ulnar Wrist	2.9 ms	11.28 mV	Ulnar Wrist-Ulnar Below Elbow	3.6 ms	230 mm	64 m/s
Ulnar Below Elbow	6.5 ms	9.037 mV	Ulnar Below Elbow-Ulnar Abv Elbow	4.1 ms	110 mm	27 m/s
Ulnar Above Elbow	10.6 ms	8.295 mV	Ulnar Wrist-Ulnar Above Elbow	7.7 ms	340 mm	44 m/s
Ulnar Inching.L						
Site 2 Up	8.3 ms	5.021 mV	Site 2 Up-Site 1 Up	0.2 ms	20 mm	91 m/s
Site 1 Up	8.1 ms	7.723 mV	Site 1 Up-Ulnar Groove	0.5 ms	20 mm	38 m/s
Ulnar Groove	7.6 ms	7.918 mV	Ulnar Groove-Site 1 Down	0.4 ms	20 mm	53 m/s
Site 1 Down	7.2 ms	8.477 mV	Site 1 Down-Site 2 Down	0.2 ms	20 mm	83 m/s
Site 2 Down	6.9 ms	8.261 mV				
Peroneal nerve.L						
Ankle	6.6 ms	3.356 mV	Ankle-Below Fibular Head	5.9 ms	300 mm	51 m/s
Below Fibular Head	12.5 ms	2.594 mV	Below Fibular Head-Knee	2.0 ms	100 mm	50 m/s
Knee	14.5 ms	4.344 mV	Ankle-Knee	7.9 ms	400 mm	51 m/s
Tibial nerve .L						
Ankle	6.6 ms	11.11 mV	Ankle-Pop. fossa	7.8 ms	360 mm	46 m/s
Pop. fossa	14.4 ms	9.258 mV				

F-Waves:

Nerve	Latency
Median Motor Nerve.L	29.2 ms
Ulnar Motor Nerve .L	29.9 ms
Peroneal nerve .L	56.6 ms
Tibial nerve .L	51.3 ms

Sensory Nerve Conduction:

Nerve and Recording Site	Peak Latency	Amplitude	Segment	Onset Latency	Distance	Conduction
Median Sensory Nerve.L						
2nd Digit	3.4 ms	64.01 uV	Median Wrist-2nd Digit	2.7 ms	130 mm	48 m/s
Ulnar Sensory Nerve.L						
5th Digit	3.0 ms	28.96 uV	Ulnar Wrist-5th Digit	2.3 ms	110 mm	48 m/s
Sural nerve.L						
Calf	3.5 ms	13.06 uV	Ankle-Calf	3.1 ms	140 mm	45 m/s

1900 HOLLISTER DRIVE, SUITE 250, LIBERTYVILLE, IL 60048
PHONE (847) 549-0055 • FAX (847) 549-0404

Name: Paul Dulberg .

Needle EMG Examination:

	Spontaneous and/or Volitional Activity				Maximum Volitional Activity		
Muscle	Fibs	+Waves	Fasc's	Poly	Amp	Pattern	Effort
Vastus Lat.L	none	none	none	none	normal	normal	maximal
Tibialis Ant.L	none	none	none	none	normal	normal	maximal
Peroneus Long.L	none	none	none	none	normal	normal	maximal
Gastroc. Med H.L	none	none	none	none	normal	normal	maximal
Dorsal Interossei - Foot.L	none	none	none	none	normal	normal	maximal
Deltoid.L	none	none	none	none	normal	normal	maximal
Triceps.L	none	none	none	none	normal	normal	maximal
Extn. Dig. Com.L	none	none	none	none	normal	normal	maximal
Biceps Brachii.L	none	none	none	none	normal	normal	maximal
Flex. Car. Rad.L	none	none	none	none	normal	normal	maximal
Flex. Car. Uln.L	none	none	none	none	normal	normal	maximal
1st Dorsal Int.L	none	none	none	none	normal	normal	maximal
Abduc. Dig. Mn.L	none	none	none	none	normal	normal	maximal
Abduc. Pol. Br.L	none	none	none	none	normal	normal	maximal
M-Lumb Paraspin.L	none	none	none	*			
L-Lumb Paraspin.L	none	none	none				

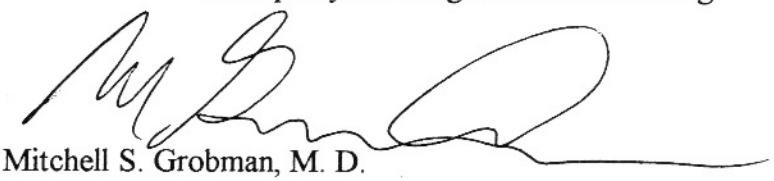
* incomplete relaxation

Impressions: NCV: Motor: Left ulnar response shows marked decrease in conduction velocity across the elbow compared to the forearm segment that further localizes to the segment just proximal to the ulnar groove with short segment stimulation. Left median, peroneal and tibial responses are within normal limits. F-waves: Left median, ulnar, peroneal, and tibial responses are within normal limits. Sensory: Left median, ulnar, and sural response is within normal limits.

EMG: No denervation potentials are seen in tested muscles and muscle regions.

Conclusions:

1) Left ulnar neuropathy at the elbow, proximal to the ulnar groove, without denervation in ulnar enervated muscles. No other focal neuropathies are identified.
2) No electrophysiologic evidence of cervical or lumbar radiculopathy, or diffuse peripheral neuropathy affecting the left arm and leg.



Mitchell S. Grobman, M. D.

03/02/2002 **10400 COMPLETE CERVICAL SPINE**

345562

HISTORY: Neck pain after motor vehicle accident.

Findings: Five views of the cervical spine were obtained. There is a small bony density noted just inferior to the lamina of C5, which is suspicious for an evulsion fracture. There is no dislocation of the cervical vertebrae. The disc spaces and the neural foramina is normal. There is no other bony abnormality of the cervical spine.

IMPRESSION: **A small evulsion fracture adjacent to the lamina of C5. CT scan of the mid and lower cervical spine would be of further help for better evaluation.**

cc: Bernhard Binger, M.D.
Daniel P. Campagna, M.D.
S Mouli, M.D.
Copy Rad
Bernhard Binger, M.D.

Electronically Authenticated
S Mouli, M.D. 03/03/2002 14:05

MR # 000-10-93-81 Acct # 0206001700 DB: 03/19/1970 S Mouli, M.D.
D 03/02/2002 **RADIOLOGY REPORT**
T 03/03/2002 12:58 P jt
470B Daniel P. Campagna, M.D.
Page 1 of 1 **DULBERG, PAUL R**
Rad CopyCopy Rad

THE OPEN MRI
AT CORPORATE WOODS

Open MRI at Corporate Woods
555 Corporate Woods Pkwy
Vernon Hills IL 60061-3111
Phone: (847) 883-0308
Fax: (847) 883-0318

MITCHELL GROBMAN, MD

Patient Name: **DULBERG, PAUL**
MRN Number: **15441**
Phone Number: **(847) 497-4250**
Date of Birth: **03-19-1970/M**
Date of Examination: **08-26-2002**

EXAM: 72141 C SPINE, A

CLINICAL INFORMATION: Left sided neck pain with left arm numbness and muscle spasms.

TECHNIQUE: Sagittal and axial magnetic resonance images through the cervical spine were obtained. The patient's CT scan of the cervical spine (copied films) from Northern Illinois Medical Center dated 3/2/02 is available for comparison.

FINDINGS:
The C2-C3 intervertebral disc appears relatively preserved.

At the C3-C4 and C4-C5 levels, there is minimal encroachment on the ventral canal by tiny central posterior bulging discs without significant central canal or foraminal compromise demonstrated.

At the C5-C6 and C6-C7 levels, there is shallow broad based encroachment on the ventral canal by degenerative bulging discs and minimal marginal spurring. No significant central canal or foraminal stenosis is demonstrated.

The C7-T1 and visualized upper thoracic discs appear relatively preserved.

Bony alignment is anatomic. The spinal cord is normal in size and contour with no altered signal intensity. There is no Chiari malformation. There is no facet arthropathy.

IMPRESSION:

1. Minor discogenic changes, as described, with shallow bulging discs. No significant stenosis or cord compromise is demonstrated.

Harold Friedman, M.D.

8/29/02

Dictated: 08/26/2002 HF/dsv

Electronically Signed: Monday, Aug 26 2002

Thank you for referring PAUL DULBERG to our office.

AUG 2 8 2002

THE OPEN MRI
AT CORPORATE WOODS

Open MRI at Corporate Woods
555 Corporate Woods Pkwy
Vernon Hills IL 60061-3111
Phone: (847) 883-0308
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MITCHELL GROBMAN, MD

Patient Name: **DULBERG, PAUL**
MRN Number: **15441**
Phone Number: **(847) 497-4250**
Date of Birth: **03-19-1970/M**
Date of Examination: **08-26-2002**

EXAM: 70543--LT BRACHIAL PLEXUS W/WO CONTRAST

CLINICAL INFORMATION: MVA 3/1/2002. Hx C4,5 Fx; muscle spasms, numbness lt fingers

TECHNIQUE: Sagittal and coronal magnetic resonance images to the region of the brachial plexus were obtained. Contrast infusion was added.

FINDINGS:
There is no mass lesion present in the supraclavicular space. The lung apex is unremarkable. The neurovascular complex is normal in appearance from the side of the neck through the level of the axilla. There is no adenopathy appreciated. Following contrast administration, no focal areas of abnormal enhancement are demonstrated.

IMPRESSION:

Unremarkable MR examination of the brachial plexus.

Harold Friedman

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ASSOCIATED NEUROLOGY, S.C.

MITCHELL S. GROBMAN, M.D.
KAREN F. LEVIN, M.D.
MICHAEL I. LEVIN, M.D.

NEUROPHYSIOLOGY REPORT

Name: **Paul Dulberg** Patient ID: 02-1221 Date of Exam: 23 DEC 02
Consulting Doctor: **F. Sek, M. D.**

Patient History: Persistent left hand symptoms. Previous study 5/29/02 showed ulnar neuropathy.

Motor Nerve Conduction:

Nerve and Stimulation Site	Latency	Amplitude	Segment	Lat. Difference	Distance	Conduction
Median Motor Nerve.L						
Median Wrist	3.6 ms	10.20 mV	Median Wrist-Median Elbow	4.7 ms	270 mm	57 m/s
Median Elbow	8.3 ms	9.649 mV				
Ulnar Motor Nerve.L						
Ulnar Wrist	2.6 ms	10.39 mV	Ulnar Wrist-Ulnar Below Elbow	3.4 ms	230 mm	68 m/s
Ulnar Below Elbow	6.0 ms	9.928 mV	Ulnar Below Elbow-Ulnar Abv Elbow	2.1 ms	110 mm	52 m/s
Ulnar Above Elbow	8.1 ms	9.703 mV	Ulnar Wrist-Ulnar Above Elbow	5.5 ms	340 mm	62 m/s
Ulnar Inching.L						
Site 2 Up	7.7 ms	9.600 mV	Site 2 Up-Site 1 Up	0.3 ms	20 mm	67 m/s
Site 1 Up	7.4 ms	9.974 mV	Site 1 Up-Ulnar Groove	0.5 ms	20 mm	40 m/s
Ulnar Groove	6.9 ms	10.08 mV	Ulnar Groove-Site 1 Down	0.7 ms	20 mm	29 m/s
Site 1 Down	6.2 ms	9.956 mV	Site 1 Down-Site 2 Down	0.2 ms	20 mm	100 m/s
Site 2 Down	6.0 ms	4.365 mV				

Sensory Nerve Conduction:

Nerve and Recording Site	Peak Latency	Amplitude	Segment	Onset Latency	Distance	Conduction
Median Sensory Nerve.L						
2nd Digit	2.9 ms	41.77 uV	Median Wrist-2nd Digit	2.4 ms	130 mm	54 m/s
Ulnar Sensory Nerve.L						
5th Digit	2.4 ms	19.17 uV	Ulnar Wrist-5th Digit	1.9 ms	110 mm	59 m/s

Needle EMG Examination:

	Spontaneous and/or Volitional Activity				Maximum Volitional Activity		
Muscle	Fibs	+Waves	Fasc's	Poly	Amp	Pattern	Effort
Deltoid.L	none	none	none	none	normal	normal	maximal
Triceps.L	none	none	none	none	normal	normal	maximal
Extn. Dig. Com.L	none	none	none	none	normal	normal	maximal
Biceps Brachii.L	none	none	none	none	normal	normal	maximal
Flex. Car. Rad.L	none	none	none	none	normal	normal	maximal
Flex. Car. Uln.L	none	none	none	none	normal	normal	maximal
1st Dorsal Int.L	none	none	none	none	normal	normal	maximal
Abduc. Dig. Mn.L	none	none	none	none	normal	normal	maximal
Abduc. Pol. Br.L	none	none	none	none	normal	normal	maximal

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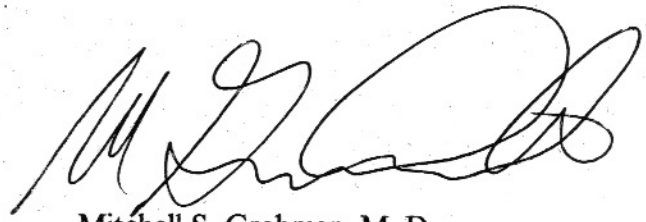
Impressions: NCV: Motor: Left ulnar response has normal amplitude, distal latency, and overall conduction velocity, but relative slowing across the elbow. Additional short segment stimulation study of the left ulnar nerve confirms localized slowing in the segment immediately distal to the ulnar groove. Left median responses are within normal limits. Sensory: Left median and ulnar responses are within normal limits.

EMG: No denervation potentials are seen in tested muscles of the left arm.

Conclusions:

1) Left ulnar neuropathy at the elbow localizing to the 20 mm segment just distal to the ulnar groove, without denervation in ulnar enervated muscles. Compared to the previous study of 5/29/02, there is improved conduction across the elbow.
2) No electrophysiologic evidence of cervical radiculopathy or diffuse peripheral neuropathy affecting the left arm.



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NEUROPHYSIOLOGY REPORT

Name: **Paul Dulberg** Patient ID: 02-0527 Date of Exam: 29 MAY 02
Consulting Doctor: **F. Sek, M. D.**

Motor Nerve Conduction:

Nerve and Stimulation Site	Latency	Amplitude	Segment	Lat. Difference	Distance	Conduction
Median Motor Nerve.L						
Median Wrist	4.0 ms	12.18 mV	Median Wrist-Median Elbow	5.0 ms	280 mm	56 m/s
Median Elbow	9.0 ms	10.65 mV				
Ulnar Motor Nerve.L						
Ulnar Wrist	2.9 ms	11.28 mV	Ulnar Wrist-Ulnar Below Elbow	3.6 ms	230 mm	64 m/s
Ulnar Below Elbow	6.5 ms	9.037 mV	Ulnar Below Elbow-Ulnar Abv Elbow	4.1 ms	110 mm	27 m/s
Ulnar Above Elbow	10.6 ms	8.295 mV	Ulnar Wrist-Ulnar Above Elbow	7.7 ms	340 mm	44 m/s
Ulnar Inching.L						
Site 2 Up	8.3 ms	5.021 mV	Site 2 Up-Site 1 Up	0.2 ms	20 mm	91 m/s
Site 1 Up	8.1 ms	7.723 mV	Site 1 Up-Ulnar Groove	0.5 ms	20 mm	38 m/s
Ulnar Groove	7.6 ms	7.918 mV	Ulnar Groove-Site 1 Down	0.4 ms	20 mm	53 m/s
Site 1 Down	7.2 ms	8.477 mV	Site 1 Down-Site 2 Down	0.2 ms	20 mm	83 m/s
Site 2 Down	6.9 ms	8.261 mV				
Peroneal nerve.L						
Ankle	6.6 ms	3.356 mV	Ankle-Below Fibular Head	5.9 ms	300 mm	51 m/s
Below Fibular Head	12.5 ms	2.594 mV	Below Fibular Head-Knee	2.0 ms	100 mm	50 m/s
Knee	14.5 ms	4.344 mV	Ankle-Knee	7.9 ms	400 mm	51 m/s
Tibial nerve .L						
Ankle	6.6 ms	11.11 mV	Ankle-Pop. fossa	7.8 ms	360 mm	46 m/s
Pop. fossa	14.4 ms	9.258 mV				

F-Waves:

Nerve	Latency
Median Motor Nerve.L	29.2 ms
Ulnar Motor Nerve .L	29.9 ms
Peroneal nerve .L	56.6 ms
Tibial nerve .L	51.3 ms

Sensory Nerve Conduction:

Nerve and Recording Site	Peak Latency	Amplitude	Segment	Onset Latency	Distance	Conduction
Median Sensory Nerve.L						
2nd Digit	3.4 ms	64.01 uV	Median Wrist-2nd Digit	2.7 ms	130 mm	48 m/s
Ulnar Sensory Nerve.L						
5th Digit	3.0 ms	28.96 uV	Ulnar Wrist-5th Digit	2.3 ms	110 mm	48 m/s
Sural nerve.L						
Calf	3.5 ms	13.06 uV	Ankle-Calf	3.1 ms	140 mm	45 m/s

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Name: Paul Dulberg .

Needle EMG Examination:

	Spontaneous and/or Volitional Activity				Maximum Volitional Activity		
Muscle	Fibs	+Waves	Fasc's	Poly	Amp	Pattern	Effort
Vastus Lat.L	none	none	none	none	normal	normal	maximal
Tibialis Ant.L	none	none	none	none	normal	normal	maximal
Peroneus Long.L	none	none	none	none	normal	normal	maximal
Gastroc. Med H.L	none	none	none	none	normal	normal	maximal
Dorsal Interossei - Foot.L	none	none	none	none	normal	normal	maximal
Deltoid.L	none	none	none	none	normal	normal	maximal
Triceps.L	none	none	none	none	normal	normal	maximal
Extn. Dig. Com.L	none	none	none	none	normal	normal	maximal
Biceps Brachii.L	none	none	none	none	normal	normal	maximal
Flex. Car. Rad.L	none	none	none	none	normal	normal	maximal
Flex. Car. Uln.L	none	none	none	none	normal	normal	maximal
1st Dorsal Int.L	none	none	none	none	normal	normal	maximal
Abduc. Dig. Mn.L	none	none	none	none	normal	normal	maximal
Abduc. Pol. Br.L	none	none	none	none	normal	normal	maximal
M-Lumb Paraspin.L	none	none	none	*			
L-Lumb Paraspin.L	none	none	none				

* incomplete relaxation

Impressions: NCV: Motor: Left ulnar response shows marked decrease in conduction velocity across the elbow compared to the forearm segment that further localizes to the segment just proximal to the ulnar groove with short segment stimulation. Left median, peroneal and tibial responses are within normal limits. F-waves: Left median, ulnar, peroneal, and tibial responses are within normal limits. Sensory: Left median, ulnar, and sural response is within normal limits.

EMG: No denervation potentials are seen in tested muscles and muscle regions.

Conclusions:

1) Left ulnar neuropathy at the elbow, proximal to the ulnar groove, without denervation in ulnar enervated muscles. No other focal neuropathies are identified.
2) No electrophysiologic evidence of cervical or lumbar radiculopathy, or diffuse peripheral neuropathy affecting the left arm and leg.

Mitchell S. Grobman, M. D.