TUFTS - NEW ENGLAND MEDICAL CENTER
REHABILITATION MEDICINE CLINIC

PATIENT: Rhodes, Marcia

OFFICE VISIT: July 20, 2004

INDEPENDENT MEDICAL EVALUATION

HISTORY: Ms. Rhodes is a 49-year-old, very pleasant lady who sustained an unfortunate motor vehicle accident which rendered her a complete T12 paraplegic. The accident occurred on January 9, 2002. Her post-injury medical course has been complicated by multiple infections, surgeries, and latest bilateral lower extremity fracture secondary to transferring.

PAST MEDICAL HISTORY: Significant for multiple surgical procedures with traumatic spinal cord injury T12 level rendering her paraplegic; tendinitis, bursitises, bipolar disorder, status post appendectomy, herniorrhaphy, two miscarriages, history of renal stones, ADHD, recent bilateral lower extremity fractures, left patellar fracture and right tib/fib fracture. She has neurogenic bowel and bladder secondary to her spinal cord injury and has an indwelling Foley catheter.

MEDICATIONS: Current medications are Colchicine, Percocet, Wellbutrin XL, Restoril, Nystar, Fosamax, Prozac, Valium, Zyprexa, Cylert, methenamine, Weight Smart tablets, Cultural, Nature's Bounty Coral Calcium Plus, Nature's Bounty vitamin D, Dulcolax suppositories, Colace, Nature's Bounty cranberry, Benefiber.

ALLERGIES: Allergies are to penicillin injectable form and sulfur.

CURRENT STATUS: The patient sustained a motor vehicle accident back in January of 2002 which rendered her a paraplegic. She was a driver, was restrained, and was hit from behind by an 18-wheeler truck. She was rushed to the hospital, and she states that she had no loss of consciousness. She knew that she was not quadriplegic because she could feel her upper body, but not her lower body. Since then, she has had multiple hospitalizations and physical therapy and rehabilitation sessions and surgical procedures and complications of urinary tract infections, wound infections, tendinitis, cholecystectomy, and fractures of her lower extremities secondary to trauma with transferring.

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Currently, she has an indwelling Foley catheter. She ambulates using an electric wheelchair here to the clinic. She wears bilateral lower extremity Aircasts more for protection when she has her transfers and to protect her from any future fracture.

She also has had long-extended periods of pressure ulcer treatments lasting for a good 10 months.

REVIEW OF SYSTEMS: She denies any headaches. She has no visual difficulties except for the need to wear glasses. She has no hearing difficulties, no tinnitus. She has a good sense of smell and taste as well. She has no swallowing difficulties. She denies any dizziness, light-headedness or vertigo. She denies any chest pain, shortness of breath or palpitations.

Gastrointestinal system: She does have indigestion, heartburn. Her bowels are such that she has a bowel movement every day which takes approximately four hours, starting at 8:00 a.m., where she gets out of bed, transfers to a chair, and then to the bathroom where she sits on the toilet for a total of about four hours. She states that she has an initial bowel movement and then three others thereafter, having four evacuations in the four-hour period, and then thereafter has no problem.

Bladder: She has an indwelling Foley catheter secondary to her neurogenic bladder. She has been instructed on how to do intermittent self-catheterization, but, despite the teaching, is physically unable to do that because of her body weight, and she has tried to learn to do it herself, but is unable at this time.

Her menses have been regular except for the past couple of months have been irregular. She denies any hot flashes or pre-menopausal symptoms.

More musculoskeletal issues: She describes a junctional pain which is sharp at the area between, as she refers to it as the equator of her body, where she has sensation, to below where she has no sensation. There is no precipitating movement or position that would initiate this pain. She also complains of back spasms as well, which usually occur later in the day.

Her mood is generally good, but becomes depressed between the hours of 5:00 and 9:00 p.m.

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Her sleep is uninterrupted and is able to sleep after she takes her Restoril.

Her exercise routine: She goes to the Wellness Center twice a week, and she does some free weights as well on her own at home, working on her upper body strength.

FAMILY/SOCIAL HISTORY: She is married with one daughter who is 16 years old. She was an antiques dealer, which entailed going to many different estates and homes and various stores, and there was a lot of traveling involved.

Currently, she is not doing any work and is not sure what vocation she would like to do or what goals are possible for her at this time.

I address whether she has been involved in any vocational assistance, but nothing as of yet.

She does not smoke and will have an occasional alcoholic beverage, and she denies any illicit drug use.

Functionally, she uses a E-Z board for sliding transfers with mod-assist x 1. She requires assistance because she has to wear the Aircast as protection to protect any future fractures.

When she is in bed, she wears Lenards to her lower extremities to prevent any flexion contractures.

PHYSICAL EXAMINATION: On physical examination, she is alert and oriented x 3. She does state that her short-term memory is greatly affected since her accident. When asking her about certain medications, she gave me a list of her medications, but at times is unclear of which medication is for what.

Range of motion of her shoulders is within normal range. Manual muscle testing of her upper extremity is 5/5. Testing her rotator cuff muscles was normal, 5/5, with no weaknesses, no pain elicited. She had good trunk control and sitting balance. I could stress her both with forward, backward and side-to-side balance in the seated position.

Sensation was tested, pinprick sensation, and was found to have a little more sensation intact on the left side versus the right

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side, where I was able to elicit sensation in the area of no sensation halfway in between her umbilicus and inguinal region on the left and about a third of the way down from the umbilical line on the right. I checked her Beaver sign; it was negative. She has abdominal strength and intact motor function in the upper and lower abdominal muscles and also noticed that she had some left hip flexor motor function as well. I was not sure whether this was abdominal muscles contracting and causing the leg to lift because of a left hip flexion contracture. However, I tested her in the side-lying position, and she in fact did have left hip flexion motor function. This was probably more the iliopsoas. I tried to test her quadriceps muscle, but there was nothing elicited there motor-strength wise, and range of motion of her hips and knees on the left side was within normal range and flaccid and at the foot itself. Negative Babinski, no sensation at all there.

I examined her feet and her legs. I removed her Aircasts and socks. She does wear TED stockings, but now just wearing the socks with the Aircasts, and I see no skin breakdown at all and no issues there. On the right lower extremity, there is more resistance to full extension and feel this is more due to the fracture she sustained, the tib/fib fracture on the right, which may have altered the joint range of motion to full extension. Although it is not functional, but I can flex her knee passively to 90 degrees without difficulties.

She has a Foley catheter in place with a bag.

She ambulates using an electric wheelchair at this time.

IMPRESSION: Ms. Rhodes is a very pleasant lady who sustained a very unfortunate accident, rendering her a T12 complete paraplegic patient who has neurogenic bladder, neurogenic bowels. Her bowel routine is every morning, which entails four hours a day. It has been brought up about possibly doing a colostomy on her, and she will be seeing a specialist for this in the next couple of months.

Concerning her bladder, she has the indwelling Foley catheter. She has tried to learn to do self-catheterization, but it is physically difficult for her because of her weight, and she is losing weight that would greatly help her gain more independence.

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Concerning her motor testing, she has good strength in her upper extremities, and the exercising that she is doing is demonstrated in this strength. I encouraged her to continue with this. She has no rotator cuff tendinopathy nor weakness nor injury, and this will only help her with using a manual wheelchair for short distances and also for transfers and self-care.

On examination she did have some left hip flexor motor activation, and physical therapy should work on this with trying to strengthen this area in that it would help her with transfers.

I am glad that she is at a stable condition at this point, no active issues in a sense of infection or fractures. The orthopedic specialist who is managing her lower extremity fractures should advise the need for the continued need and use of the Air-casts on her bilateral lower extremities. This would help with her transferring ability and see no reason why Ms. Rhodes would not be able to perform independent transfers. Her upper extremity strength and trunk control would make this a very attainable goal.

She is also actively losing weight which would only aid in her overall health, functional independence, activities of daily living, transfers and self catheterizations without the need for an indwelling foley catheter which predisposes to repeat infection and possible bladder wall malignancy which should be annually checked.

There is no reason after going through the necessary testing for driving that she would not be able to drive with the proper modifications done to her car.

A manual wheel chair would be appropriate for her for short distances, which in general would help her general conditioning and aerobic performance as well as independence. An electric wheel chair could be used more for long distances.

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When asking her about the accident and how it occurred, she was able to explain the incident and seems to have adjusted well considering her injury, and seems to be making good progress and understanding her limitations and having a fairly good attitude about this, based on my interaction with her.

I would like to make note that there was a legal representative present during the entire evaluation with the patient's permission.

Thank you for allowing me to evaluate this patient.

Joseph A. Hanak, MD

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