

Dear West,

Re : D.O.B.: 20/05/1955

Address:

Mr Russell originally presented at this practice 6th March 2004 complaining of neck and shoulder pain which resolved within 3 treatments.

The patient represented on 1st February 2006 complaining again of neck and shoulder pain over the levator scapulae, Traps, supraspinatus and deltoid with neuro symptoms into the right extremity in the form of parasthesia in digits 1/2 of the right hand.

Mr Russell described the onset as being 1 week previously for no apparent reason but may have been related to reading in an awkward position in bed. At that time Mr Russell was about to go to America on holiday and was not available for treatment until 11th February .

On attending on the 11th, Mr Russell described a worsening picture with increased pain but sensory signs had almost disappeared.

On examination, I noted

- Reduced range of movement on gross mobility testing the cervical spine by 35 degrees on right rotation and 25 degrees on the left, with sidebending left reduced to 25 degrees.
- Reflexes were P&E, C5,6,7,8, Power was normal, Compression, distraction and VBI were negative, however quadrant testing of the right lower facet joints was positive
- Orthopaedic testing of the shoulder, revealed full range of movement in all vectors with a painful arch between 120 degrees and full range in flexion of the right arm.
- Hawkins & Neers sign for impingement syndrome was negative
- Increased pain pressure thresholds were noted on palpation of all the scapulo-thoracic muscles particularly the rotator cuff group and long head of biceps

I considered rotator cuff and bicipital tendonitis as a working diagnosis and the possibility of foraminal encroachment from likely facet joint osteophytosis as a differential.

Treatment has consisted of soft tissue techniques, scapulo-thoracic and cervical articulation, mobilisation of restricted thoracic spine segments and advice on rehabilitation exercise and hot/cold compresses..

Mr Russells inflammation is fairly severe and as a result we have been seeing him every 4 days. Today he has made me aware of his recent bout of constipation and flare up in his hemorrhoids and rectal bleeding which is likely to be related to his current medication regime.

Mr Russell has made me aware as a result of his slow progress and recent rectal bleeding that he is consulting you for your opinion and medication review. I would suggest that an onward referral for further investigations in the form of a scan might be appropriate to establish the degree of disc degenerative disease and osteophytosis in the cervicle region.

I hope you have found this of use. Please don't hesitate to contact me if you have any further queries. I would welcome the results of any investigations you see fit to undertake to help me in the management of this patient

Yours sincerely

Colm Gregory, Osteopathy

Dear Dr. ?

**RE: Mrs B D.O.B.: 14th February 1953
ADDRESS:**

Mrs B presented at this practice on the 4th August complaining of low back pain, with radiating pain into the extremities along the posterior lateral aspect to the calf on the right and mid thigh on the left, with occasional pain into the right foot.

No weakness was reported, sensory??? bowel/bladder function was reported as normal, however Mrs B did report a couple of recent fall and an altered gait cycle due to knee pain.

At that time she described an episodic history over 15yrs and subsequent discectomy 10yrs ago. This most recent episode has been gradually gaining momentum over the last 3/12.

In terms of differential diagnosis and in light of the patients history I considered disc degenerative disease with likely adaptive remodelling of bone causing foraminal encroachment and possible spinal stenosis. Further questioning on neurogenic claudication was revealed no symptoms.

On examination:

- SLR and XSLR were positive at 40° and 70° respectively
- Flexion was limited to 70° of forward bending with loss of segmental uncoupling (within an increased kyphotic thoracic spine) on side bending from T1 to T10
- Compression and distraction tests of the lumbar spine reproduced lower extremity pain
- Reflexes were absent on the right L2/3/4 but ankle jerk was present
- Hip gross movement was reduced markedly with external/internal rotation being right 40/15, left 40/30
- Babinski was
- Sensory testing
- Power on Lumbar 5 (extensor hallicus longus) was

In light Mrs B's history and her subsequent presentation I would be grateful if you would refer for an MRI scan to ascertain the degree of canal stenosis/ foraminal encroachment

If you have any queries please do not hesitate to contact me on any of the above media and I would be grateful if you would copy in any correspondence. Mrs B is aware of this correspondence and has given her verbal consent for you to communicate with me on this matter.

Yours sincerely

Mr C Gregory, Osteopath

Dear Mr Slater,

RE: Mrs S **D.O.B.:** 17th December 1949
ADDRESS:

Mrs S presented on the 19th December, reporting pain over the lumbro sacral joint, with a point of maximum intensity over the left gluteal.

She reported radiculopathy from the gluteal fold along the posterior lateral aspect to the foot with sensory disturbance over the plantar aspect to digit 5. Increased urination was noted with no bowel dysfunction or intrathecal signs being reported.

The onset was described as 7 weeks prior to consultation for NAR, but does coincide to dancing at a party, with pain coming on in the gluteal region the following day, and leg symptoms appearing 2/7.

Mrs S had consulted her GP on the 5th November, who prescribed **Arthrotec** and **Diazepam**, which was later revised by another GP within the practice. Mrs S advised me that she did not take the Diazepam due to side effects.

On the advice of her GP Mrs S had a number of Physio treatments which were reported as being unhelpful and no diagnosis was offered.

In terms of progression, Mrs Salter reported that she was getting better and had returned to work for a week but had suffered a relapse on the 18th December

On examination

- Weight bearing plantar flexion revealed no weakness or pain
- SLR was positive at 45° with XSLR positive at 70° with increased pain on ankle dorsiflexion
- Doorbell over the left LES reproduced and increased leg pain
- Slump test was positive on the left increased by foot dorsiflexion
- NAD power testing of lower extremity
- Reflexes P&E but needed to be enhanced at L2/3/4 and low S1/ S2 bilaterally Babinski was negative
- Palpation of piriformis revealed an increased pain pressure threshold and increased leg pain
- Sitting lumbar spine compression/distraction tests were negative
- Quadrant test of the facet of L5/S1 was positive for pain on the left
- Gross movement was limited in all vectors, with flexion limited to 45 with radiating pain into the left leg to the foot

My working diagnosis was double crush syndrome at foraminal level and peripherally thru piriformis with likely underlying DDD, facet joint inflammation with possible Disc bulge/ foraminal encroachment causing nerve root hypoxia.

I advised Mrs S on the nature of DDD/disc bulge and agreed to treat conservatively and monitor.

Mrs S responded well to her first treatment with reduced pain levels however, on her most recent appointment (29th December) her benchmarks were deteriorating with

loss of power at extensor hallicus longus and the S1 reflex and increasing pain levels.

In light of the above examinations findings and the emerging clinical picture I contacted the patient's GP and requested this referral. I have signed Mrs S off work until today (2nd January).

I am happy to rehabilitate Mrs S at the appropriate time but feel her current need would be best served by further investigations to ascertain the degree of DDD and nerve root compression.

I would be grateful if you would copy me in any correspondence and please don't hesitate to contact me if you have any queries.