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Diplomate American Board of Orthopaedic Surgery

May 18, 2005

Robert Rathbone, D.C.
3895 SW 185th Ave., Ste 160
Aloha, OR 87006

RE: FRANK
DOB: 02/13/44

Dear Rob:

Thank you for referring Frank regarding his left shoulder. He is age 61 and is right-handed, a foundation administrator. He was mowing his lawn with an electric lawn mower and he felt a sudden very painful pop in the left shoulder. He could not elevate his arm up after that.

PAST MEDICAL HISTORY: Three years ago he had a right rotator cuff repair by Brad Butler, M.D. This went quite well. He had a lot of physical therapy afterwards for at least three months. He had an excellent result.

In college football, he had bilateral shoulder injuries not requiring much in the way of treatment. He has had pain all these years bilaterally. He did have left shoulder physical therapy at the same time as his right because he knew that he had some deterioration. Dr. Butler really did not evaluate his left shoulder at that time.

You ordered an MRI scan performed on 05/10/05 and it demonstrated a complete supraspinatus tear.

He is in generally good health. Illnesses: None serious. Operations: See above. Medications: Oxycodone, APAP, hydrocodone APAP provided by PCP, Dr. Tewfik. Allergies: None. Smoking: None. Alcohol: Minimal, 2 to 4 shots per evening. Addictions: None. Social History: Married. Education Level: College.

PRESENT COMPLAINTS: He has anterior, lateral, and posterior left shoulder pain radiating into the biceps muscle into the left hand radially. These are worsened by lifting, carrying, reaching, grasping, typing, pushing, pulling, throwing, even lying down. Alcohol helps more than the drugs. These pains awaken him and are present all day. He has developed numbness and tingling in both hands, primarily the left and this occurred immediately after the left shoulder injury one-and-one-half-weeks ago. He awakens with either arm asleep, particularly the left.

He cannot actively abduct his left arm.

PHYSICAL EXAM: He cannot actively abduct this left shoulder. There are old right shoulder arthroscopic surgical scars. He cannot actively abduct his left arm more than 25 degrees, which is mostly scapulothoracic. ER strength 4-/5, IR 5/5. Cervical spine is minimally tender. There is trapezius substitution with attempts at elevation. He is 3+ tender over the anterior, lateral, and posterior left shoulder, negative AC joint.

IMAGING STUDIES: I reviewed personally his left shoulder MRI of 05/10/05. There are moderate cystic changes of the greater tuberosity and the biceps tendon is in normal position. The anterior labrum has a tiny physiological cleft. There is a full thickness rotator cuff tear which is somewhat retracted and the cuff is folded. It appears to have been torn from bone. There is mild supraspinatus atrophy and there is a large effusion.

DIAGNOSIS: Acute left full thickness rotator cuff tear with effusion.

DISCUSSION/DISPOSITION: I am referring him to Brooke Benz, M.D., for evaluation of repair and arthroscopy. He will return as needed.

Rob, thank you very much for allowing me to participate in Frank's care. I greatly appreciate your referral.

Very truly yours,

Paul M. Puziss, M.D.

PMP/sd

cc: Brooke Benz, M.D.

Open Advanced MRI

DEC 1 1 2006

Patient Name: Frank

Date of Exam: 12/07/2006

Referred By: Paul Puziss, M.D.

Appt. #: 163857

ENHANCED CT/MR ARTHROGRAM LEFT HIP

CLINICAL CONCERN: Loose body.

TECHNIQUE: The skin was prepped and anesthetized in the usual manner and a 22-gauge needle was advanced under CT guidance to the femoral neck. Buffered Lidocaine was instilled as the needle was advanced. Approximately 18 cc of iodinated contrast with dilute gadolinium and 0.3 mg of Epinephrine was injected, distending the joint capsule. High resolution CT slices were obtained and sent to an independent 3D workstation for reconstruction, review and filming. An MRI was done using fat-suppressed T1 and T2 images in three planes.

FINDINGS: There are small osteophytes on the inferior margin of the femoral head. There is mild to moderate thinning of hyaline cartilage in a roughly 1 cm area of the femoral head superomedially. There is a 1 to 2 mm thick, 4 x 8 mm diameter cartilaginous loose body located directly anterior and slightly inferior to the femoral head, located at an 8 o'clock position as viewed from the side. There is a similar-sized bare area at the bottom of the acetabulum on the other side of the femoral head directly opposite the current location of the loose body. There is mild irregularity of the acetabular hyaline cartilage along the base of the posterior labrum for another few millimeters above the bare area. The hyaline cartilage in the hip is otherwise normal. There are mild irregularities of the base of the labrum next to the posterior-inferior cartilage irregularities but there is no other evidence of a labral abnormality.

IMPRESSION: Several millimeter area of hyaline cartilage irregularities on the posterior-inferior margin of the acetabulum next to the base of the labrum, with a 7 x 8 mm loose body.

CM/dw

Films Read by Christopher Morgan, M.D.

Approved By Christopher Morgan, M.D.

Open Advanced MRI

APR 03 2007

Patient Name: Frank

Date of Exam: 03/29/2007

Referred By: Paul Puziss, M.D.

Appt. #: 170579

Sch. 4-4-07

ENHANCED CT/MR ARTHROGRAM RIGHT HIP

CLINICAL CONCERN: Degenerative changes.

TECHNIQUE: The skin was prepped and anesthetized in the usual manner and a 22-gauge needle was advanced under CT guidance to the femoral neck. Buffered Lidocaine was instilled as the needle was advanced. Approximately 10 to 15 cc of iodinated contrast with dilute gadolinium was injected, distending the joint capsule. High resolution CT slices were obtained and sent to an independent 3D workstation for reconstruction, review and filming. An MRI was done using fat-suppressed T1 and T2 images in three planes.

FINDINGS: There is a 3 cm long strip of abnormal hyaline cartilage along the posterior acetabulum running from about 1 o'clock to 3 o'clock. At the upper end it is a simple fissure in the cartilage located at the base of the labrum but inferiorly it gets wider and the area bare of cartilage is over 7 mm wide at about 2:30. The lower part of this defect tapers down to a fissure and then stops. Just below the margin of the femoral head has osteophytes which protrude out about 3 to 4 mm. The labrum is worn flat and slightly posterolaterally displaced from about 2 o'clock to 3 o'clock.

There is a roughly 10 to 15 mm diameter area of hyaline cartilage thinning on the femoral head at and medial to the center of the weight-bearing portion of the joint, where the cartilage is at least moderately thin and in some areas vanishingly thin.

There is a several millimeter area of moderately high grade cartilage thinning on both sides of the joint anteriorly next to the base of the labrum at about 10 o'clock, which lie close to each other with the leg straight. There are no other articular cartilage or labral abnormalities visible and there are no loose bodies visible. The soft tissues around the hip are normal.

IMPRESSION: There are at least three areas of fairly high grade cartilage thinning and there is degenerative tearing of the posterior-superior labrum.

CM/dw

Films Read by Christopher Morgan, M.D.

Open Advanced MRI

Patient Name: Frank

Date of Exam: 03/29/2007

Referred By: Paul Puziss, M.D.

Appt. #: 170579

Approved By Christopher Morgan, M.D.