Procedure Note

Formatting of this note might be different from the original.

EXAM: MRI LUMBAR SPINE WITHOUT AND WITH CONTRAST

DATE: 3/3/2025 11:02

INDICATION: lower back pain .

COMPARISON: Correlation to abdomen pelvis CT 12/11/2020

TECHNIQUE: Multiplanar, multisequence, precontrast and postcontrast MR imaging of the lumbar spine.
IV contrast: Refer to MRI technologist documentation

FINDINGS:

Numbering: The inferior-most, lumbar-type vertebral body is referred to as L5.

Alignment: Minimal retrolisthesis of L3 over L4. Postsurgical changes of posterior decompression at L5-S1.

Postoperative: L4 and L5 laminectomy.

Bones: T1 hypointense T2 hyperintense signal is noted at L5 vertebral body consistent with bone marrow edema. Otherwise the vertebral body bone marrow shows normal signal. L5 pathologic fracture with approximately 30% height loss without significant retropulsion.

Associated epidural enhancement at L4, L5 and S1 levels. There is paravertebral enhancement at L5.

Conus medullaris: Normal in size and signal. Terminates at L1-L2.

Cauda equina: Nonenlarged.

Individual levels:
L1-L2: Normal.
L2-L3: Normal.
L3-L4: Disc bulge and facet joint hypertrophy results in moderate bilateral neural foraminal narrowing and mild spinal canal stenosis.
L4-L5: Disc bulge and facet joint hypertrophy, with an associated central disc protrusion results in severe right and moderate left neural foraminal narrowing.
L5-S1: Disc bulge, facet joint hypertrophy and endplate spurring resulting in severe bilateral neural foraminal narrowing there is a central disc protrusion. No significant spinal canal stenosis.

Other: Incidental retroperitoneal structures are unremarkable

Postcontrast: Peripheral enhancement of the disc and L5 vertebral body with evidence of diffusion restriction in keeping with osteomyelitis (chronic versus acute on chronic) (series 601/602 image 4). There is also associated abnormal enhancement of the posterior paraspinal and anterior paraspinal muscles (series 901 image 14). No organized/drainable fluid

IMPRESSION:
* Findings concerning for a discitis osteomyelitis at L4-5 and L5-S1, with an associated epidural phlegmon.
* No evidence of fluid collections.
* Fracture of L5 vertebral body causing 20 to 30% height loss without significant retropulsion.

This report was dictated by a Radiology Resident/Fellow/APP: Reema AlRasheed, RES 3/3/2025 14:41

This report was dictated by a Radiology Resident/Fellow/Physician Assistant. I have personally reviewed the images as well as the interpretation and agree with the findings.

Narrative

EXAM: MRI CERVICAL SPINE WITH AND WITHOUT CONTRAST
EXAM: MRI OF THE THORACIC SPINE WITHIN WITHOUT CONTRAST

DATE: 3/4/2025 17:09

INDICATION: osteo workup ,

COMPARISON: None.

TECHNIQUE:
- Multiplanar MR imaging of the cervical spine, with and without contrast.
- Multiplanar MR imaging of the thoracic spine, with and without contrast.

FINDINGS:

CERVICAL SPINE:
The axial postcontrast sequences are limited by motion artifacts.
There is exaggerated cervical lordosis. No significant spinal canal narrowing is present in the interval. No cord compression or focal cord signal abnormality. No abnormal enhancement is identified. Uncovertebral change resulting in moderate bilateral foraminal narrowing at C3-C4, C4-C5 through C6-C7.

THORACIC SPINE:
The axial postcontrast sequences are limited by motion artifacts.
Exaggerated thoracic kyphosis. No cord compression or definite focal cord signal abnormality. No abnormal enhancement. Focal disc protrusion/extrusion at T9-T10 resulting in moderate spinal canal narrowing at this level.

IMPRESSION:
1. No imaging evidence of osteomyelitis in the cervical or thoracic spine. Degenerative changes, as detailed above.

Report finalized by: Arash Kamali, MD 3/4/2025 22:30

Procedure Note

Dr. Arash Kamali, MD - 03/04/2025

Procedure Note

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Authorizing Provider	Result Type	Result Status
Michael Goutnik MD	IMG MRI PROCEDURES	Final Result

MRI CERVICAL SPINE W AND WO IV CONTRAST - Final result (03/04/2025 6:25 PM CST)

Anatomical Region	Laterality	Modality
Spine, C-spine		Magnetic Resonance

Specimen (Source)	Anatomical Location / Laterality	Collection Method / Volume	Collection Time	Received Time

Narrative

03/04/2025 10:30 PM CST
This result has an attachment that is not available.

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No significant spinal canal stenosis.

Other: Incidental retroperitoneal structures are unremarkable

Postcontrast: Peripheral enhancement of the disc and L5 vertebral body with evidence of diffusion restriction in keeping with osteomyelitis (chronic versus acute on chronic) (series 601/602 image 4). There is also associated abnormal enhancement of the posterior paraspinal and anterior paraspinal muscles (series 901 image 14). No organized/drainable fluid

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This report was dictated by a Radiology Resident/Fellow/APP: Reema AlRasheed, RES 3/3/2025 14:41

This report was dictated by a Radiology Resident/Fellow/Physician Assistant. I have personally reviewed the images as well as the interpretation and agree with the findings.

Report finalized by: Andres Rodriguez Gonzalez, MD 3/3/2025 16:49

Procedure Note

Dr. Andres Rodriguez Gonzalez, MD - 03/03/2025

Evaluation and Treatment Note

Patient Name: Steve Kaminczak
MRN: 38345229
Today's Date: 3/4/2025

Preferred Language: English
Assessment & Plan
Assessment:
Patient referred to PT evaluation s/p with worsening back pain radiating to his right hip. Patient endorses falling at his school week ago. Imaging showed L4-L5 and L5-S1 discitis/osteomyelitis with associated epidural phlegmon.

PLOF: Pt lives in an apartment with elevator access. IND with community ambulation, ADL's, working, driving.

CLOF: Pt presents with LSO donned, A/Ox4, hesitant for PT d/t uncontrolled LBP. Pt stands with CGA and takes 10 steps before near LOB 2/2 pain. Pt assisted to bed by PT. Pt provided with RW for t/f training and gait progression. Pt ambulates 150' with SPV, demo's improved balance and endurance with ad and reports decreased LBP when ambulating.

Patient will benefit from skilled therapy services while in house. PT POC to address decreased activity tolerance, sitting/standing balance deficits, gait instability, and fall risk in order to return home at PLOF.

Plan:
Equipment Recommended: Walker- rolling
DC Rec: OP PT to address BLE weakness, falls, LBP, sciatica.

Subjective
"I can't walk very far because of the pain."

Current Problem:
Per EMR:
50-year-old gentleman with past medical history significant for back pain, history of laminectomy many years ago, history of gastric sleeve surgery with complication, SBO s/p gastric bypass, esophageal stricture with J tube placement, h/o TPN via central line, complicated by MRSA bacteremia and osteomyelitis completed daptomycin course, now able to tolerate p.o. intake presented to hospital with worsening back pain that is radiating to his right hip. Patient endorses falling at his school week ago.
Patient otherwise hemodynamically stable. Denies any bowel bladder incontinence or saddle anesthesia. The imaging showed L4-L5 and L5-S1 discitis/osteomyelitis with associated epidural phlegmon. Patient otherwise denies any fever. He completed daptomycin course. Has no central line. Patient still takes clindamycin without any prescription. Patient takes over OxyContin from the street for his pain.
Patient continues to have leakage from the G-tube stoma. Patient is able to tolerate p.o. intake.He only uses G-tube for medications. Patient has complex bariatric surgery history.

Pain:
4/10 LBP at rest, 6/10 LBP with standing/gait.

Skin Screening Assessment:

Vital Signs:
Patient Vitals for the past 24 hrs:
BP MAP (mmHg) Pulse Resp SpO2
03/04/25 1201 -- -- 69 18 94 %
03/04/25 1201 (!) 156/91 (!) 113 -- -- --
03/04/25 0752 -- -- 60 17 97 %
03/04/25 0752 (!) 190/106 (!) 134 -- -- --
03/04/25 0532 145/85 -- 59 19 99 %
03/04/25 0439 -- -- 54 13 100 %
03/04/25 0439 (!) 176/99 (!) 125 -- -- --
03/04/25 0410 144/81 -- 61 -- --
03/04/25 0300 144/81 (!) 104 61 -- 94 %
03/04/25 0145 160/86 (!) 118 56 -- 94 %
03/04/25 0130 (!) 183/81 (!) 116 58 -- 100 %
03/03/25 2300 155/89 (!) 115 71 -- 100 %
03/03/25 2200 (!) 185/96 (!) 132 64 -- 96 %
03/03/25 2100 (!) 161/81 (!) 112 68 -- 95 %
03/03/25 1930 (!) 185/99 (!) 127 62 -- 100 %
03/03/25 1805 (!) 198/117 (!) 148 73 18 97 %
03/03/25 1700 (!) 184/98 (!) 135 58 18 100 %
03/03/25 1500 (!) 148/94 (!) 113 78 18 94 %

Home Living:
Type of Home: Apartment

Patient will tolerate >20 min of therapeutic activity to maximize activity tolerance for I/ADL performance

Start: 03/04/25 Expected End: 03/21/25

Treatment Note: If this is the last documented treatment, then it will signify discharge from acute care prior to discharge from the therapy service and will serve as the discharge summary.

Shannon Sudrla, OT
Electronically signed by Shannon K at 03/04/2025 1:11 PM CST

H&P Notes - documented in this encounter

Dr. Bhrugesh Shah, MD - 03/04/2025 12:43 AM CST
Formatting of this note is different from the original.

Subjective
Chief Complaint
Patient presents with
Back Pain
:

History Of Present Illness
50-year-old gentleman with past medical history significant for back pain, history of laminectomy many years ago, history of gastric sleeve surgery with complication, SBO s/p gastric bypass, esophageal stricture with J tube placement, h/o TPN via central line, complicated by MRSA bacteremia and osteomyelitis completed daptomycin course, now able to tolerate p.o. intake presented to hospital with worsening back pain that is radiating to his right hip. Patient endorses falling at his school week ago.

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Patient continues to have leakage from the G-tube stoma. Patient is able to tolerate p.o. intake.He only uses G-tube for medications. Patient has complex bariatric surgery history.

Past Medical History
HTN
Back pain
H/o MRSA infection
Spinal osteomyelitis

Surgical History
He has no past surgical history on file.

Family History
No family history on file.

Social History
He has no history on file for tobacco use, alcohol use, and drug use.

Allergies
Patient has no known allergies.

Medications
No current outpatient medications

Review of Systems

Objective

Last Recorded Vitals
Blood pressure (!) 185/96, pulse 64, temperature 36.7 °C (98 °F), resp. rate 18, height 1.753 m (5' 9"), weight 74.8 kg (165 lb), SpO2 96%.

Physical Exam:
General Alert awake oriented not in apparent distress
Heart regular rate and rhythm
Lungs clear to auscultation bilaterally

Abdomen soft nontender, G stoma present, peristomal leaking noted covered in gauze
Neuro A and O x 3
Musculoskeletal no midline spinal tenderness noted, right lower extremity straight leg test positive with pain radiating to his right glutes.
Lab Results
Results from last 7 days
Lab Units 03/02/25
2050
WBC 10*3/uL 6.97
HEMOGLOBIN g/dL 13.0
HEMATOCRIT % 40.0
PLATELETS 10*3/uL 348

Results from last 7 days
Lab Units 03/02/25
2050
SODIUM mEq/L 131*
POTASSIUM mEq/L 3.8
CHLORIDE mEq/L 98
CO2 mEq/L 30.2
BUN mg/dL 9
CREATININE mg/dL 0.78
GLUCOSE mg/dL 101*
CALCIUM mg/dL 8.3

Imaging Results
MRI lumbar spine w and wo IV contrast
Result Date: 3/3/2025
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Assessment
Assessment & Plan
Acute midline low back pain with right-sided sciatica
Imaging as discussed above concern for Osteomyelitis/discitis on imaging with phlegmon and L5 compression fracture
No concern for cauda equina at this time
Neurosurgery on board and no acute plan for surgical intervention
Pending entire MRI imaging of spine
CRP mildly elevated
Will monitor off antibiotics for now
PT OT evaluation
PT is duloxetine and Gabapentin
Will resume
MMPR with tylenol tramadol and Oxycodone
Hypertension
Lisinopril
Resume
Closed compression fracture of L5 lumbar vertebra, initial encounter (HCC)
Neurosurgery is on board
Discitis
As above imaging findings concerning for discitis
Blood cultures were drawn