

Narrative Summary

Worker Compensation Burn Injury - 06/15/YYYY

On June 16, YYYY, Mr. XXXX was evaluated by XXXX, M.D. He stated that he burned his right lower leg with hot water and oil June 15, YYYY. He burned palms, lifting self-out. Hot water and oil on the left trouser and in his boot, worse on the right. He remained totally non-compliant with meds, diet, and follow-up. Exam revealed right lateral leg with 2° and 3° burn. He had a large blister in the proximal calf to right ankle (medial aspect without burn). Hot oil and water poured into his boot. Left lower leg erythematous and blister was noted. His diagnosis included burn to right lateral calf, DM type 2 and non-compliance. He was advised to wash with soap and water. He was prescribed Silvadene. He was advised to f/u on June 18, YYYY.

On June 18, YYYY, Mr. XXXX was evaluated by XXXX, M.D., for burns on right leg. Wound looks good. He had no signs of infection. He was advised to continue Silvadene and return for wound care.

On June 22, YYYY, Mr. XXXX was evaluated by XXXX, M.D., and XXXX, MA at Emergency Physicians Medical Center for injury and multiple burn sites in right shin and right calf. He stated that he stepped in burning hydraulic oil while working on June 15, YYYY. He had no facial burns. Has had this burn for several days. He complained of local pain at the site of the burn. He also complained of moderate tenderness pain at the burn site. Noted blisters at site. Cardiac exam revealed musical grade III holosystolic murmur. Best heard along the left sternal border. Skin and soft tissue exam revealed burns over the right shin and right calf. These are primarily predominantly second degree. This burn was an isolated area approximately 30 x 15 cm burn was approximately 3% of total body surface. The affected area was painful, erythematous and had areas within the burn where the blisters are not intact. Based on surface area this was a fairly limited burn. His diagnosis included type 2 diabetes mellitus, hot liquid burn, predominantly second degree burn in right shin and right calf and 3% body area burn partial thickness. Non-adherent dressing was performed. He was prescribed Hydrocodone 5 mg-Acetaminophen 325 mg tablet.

On June 25, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He presented with concerns of an injury to the area of his right calf and lower leg. He had a mixture of partial-thickness burns, superficial and deep. He had tenderness over his leg, it was worse with walking or with contact, better with elevation. Exam revealed a mixture of partial-thickness superficial and deeper partial-thickness burns without obvious full-thickness burns with no signs of infection. His diagnosis included right lower extremity burn wounds. He was recommended debridement and grafting of his right lower extremity wounds and to stay off work.

On June 26, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at Orthopaedic Surgery Center at Gainesville for mixed superficial and deep partial thickness wounds. His pre-op diagnosis and post-op diagnosis included right lower extremity burn wounds superficial and deep partial thickness. He underwent debridement and preparation for skin grafting anterior deep partial thickness wound calf 5x3cm and preparation for skin graft, split-thickness skin graft right anterior calf wound 5x3 cm 15 cm sq, debridement and preparation for skin grafting posterior calf wound right leg 4x4 cm 16 cm sq and split thickness skin graft right posterior calf 4 x 4 cm 16 cm sq. He tolerated the procedure well and was taken to the operating room in stable condition.

On June 30, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He returned four days into the debridement in preparation for skin grafting of his right lower extremity wounds with split-thickness skin grafts to his lower extremity wounds. Upon exam, he had some spotty residual open areas in the wound, and he had a lot of pain associated with his leg. His diagnosis included a right lower leg skin graft. He was recommended physical therapy 1-3 days x/week with Xeroform dressing changes. He was advised to stay off work.

On June 30, YYYY, Mr. XXXX was evaluated by Jamie Primosch, PA-C, XXXX, M.D., and XXXX, M.D., at ABC Medical Center for abdominal pain. He presented with the history of diabetes and an episode of diaphoresis with some light-headedness. He was at his orthopedic doctors today having the bandages on a burn wound changed when he became diaphoretic and lightheaded. He said before this happened, he had severe pain in his right leg. He said that his friend laid him down for a few minutes and the pain went away and he felt much better. Now, back to baseline. His abdominal diagnosis was non-focal. Skin exam revealed erythema and warmth over right lower lateral leg with skin grafts and staple, in place with mild tenderness. His diagnosis included diaphoresis and burn of right leg. He was discharged with previously scheduled Ortho follow-up for wound care.

On June 30, YYYY, A. Varner, M.D., obtained Mr. XXXX's venous doppler ultrasound of right lower extremity at ABC Healthcare for right lower extremity pain. The study revealed no sonographic evidence of right lower extremity DVT.

On June 30, YYYY, Mr. XXXX's EKG was obtained at ABC Medical Center. The study revealed incomplete right bundle branch block, left anterior fascicular block and minimal voltage criteria for LVH, may be normal variants.

On June 30, YYYY, J.J. Stork, M.D., obtained Mr. XXXX's X-ray of chest at ABC Medical Center for diaphoresis. The study was reported to be normal.

On July 01, YYYY, Mr. XXXX was evaluated by XXXX, PT at BCA Institute the Physical Therapy Center for burn of unspecified degree of unspecified site of right lower limb, except ankle and foot, subsequent encounter; stiffness of right foot, not elsewhere classified; pain in right ankle and joints of right foot and muscle weakness (generalized). His pain level was rated as 8/10. He required skilled physical therapy in conjunction with a home exercise program to address the problems and achieve the goals. His overall rehabilitation potential was good. The expected length of this episode of skilled therapy services required to address his condition was estimated to be 8 weeks. He had been educated regarding diagnosis, prognosis, and related pathology. He exhibited good understanding and performance of the therapeutic activity/instruction outlined during this skilled rehabilitation session. He tolerated today's treatment/ therapeutic activity with moderate complaints of pain and difficulty. His clinical findings were consistent with a musculoskeletal pattern or impaired muscle performance, musculoskeletal pattern of impaired joint mobility, motor function, muscle performance, and range of motion associated with localized inflammation, musculoskeletal pattern of impaired joint mobility, motor function, muscle performance, and range of motion associated with bony or soft tissue surgery. It was recommended that he attend rehabilitative therapy for 2 visits a week with an expected duration of 4 weeks.

On July 02, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He was six days into the debridement and grafting of his right lower extremity wounds. Donor site appeared healthy, and it was redressed today. Lower extremity had some minimal residual open wounds. He

continued to complain of a severe burning pain. although his compartments were soft. He holds his ankle in a rigid neutral position with no flexion, extension, eversion or inversion. He was advised to get a nerve conduction and EMG study to the right lower extremity and an MRI to the right calf. He would have an Orthopaedic evaluation this afternoon to exclude any possible occult bony or soft tissue injury. Half of his staples were removed today. He was advised to stay off work.

On July 02, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for right leg pain. He complained of significant pain in the area. He had some numbness in the posterior calf area as well. Upon exam, he walked with a limp off the right leg. Examination of the right leg revealed dressings over his recently skin-grafted wounds. He had tenderness in this area. Examination of the right ankle revealed good range of motion with a little pain with dorsiflexion but really not severe. Examination of the left leg was non-focal. X-ray of the right tibia revealed no fractures or evidence of an acute injury. There was no significant orthopedic injury at this time. He was advised to continue to f/u with Dr. XXXX for treatment of his burns and his recent skin grafts.

On July 14, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He was two weeks and four days into the debridement and grafting of his extensive right lower extremity wounds. He had a residual minimal open area in the posterior region of the calf. He was hesitant to do ankle flexion, extension, eversion, or inversion, but he seems to have that present. He still had sensations of severe pain. X-ray of the right leg revealed no residual or metallic foreign bodies. He was recommended to obtain the nerve conduction and EMG study as well as the MRI. He had a Xeroform dressing change applied today. He was advised to stay off work.

On July 21, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He returned three weeks, four days into the debridement and grafting of his extensive right lower extremity wounds. He continued to complain about some shooting pain, numbness and tingling and decreased range of motion. The donor site was well healed, and the recipient area was completely epithelialized. He would start applying moisturizing lotion to the thigh donor site. The lower extremity wounds were re-dressed. He was reordered to a physical therapy program for range of motion and strengthening. He has not had the MRI or EMG study and he would get those done. He was advised to stay off work.

On July 27, YYYY, Melissa Kwan, M.D., obtained Mr. XXXX's MRI of right calf without contrast at Physicians Imaging for burn injury. The study revealed no abnormality of the posterior tibial neurovascular bundle identified. Circumferential subcutaneous edema of the lower leg which is worst laterally without discrete fluid collection was noted.

On August 04, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He returns for follow-up of the debridement and grafting of his extensive right lower extremity wounds. He continued to be in his postoperative period. His exam showed a well-healed donor site and 100% take of the recipient area. He had complete epithelialization. He has intact extension, flexion, eversion and inversion with persistent light touch hypoesthesia and good capillary refill. He was recommended to obtain nerve conduction and EMG study. He was advised to continue PT and stay off work.

On August 26, YYYY, XXXX, M.D., obtained Mr. XXXX's EMG/nerve conduction study of the bilateral lower extremity for right leg numbness and weakness and left foot numbness. The study revealed right tibial subacute mononeuropathy at level distal to knee with mild denervation noted in

the muscles innervated by the tibial nerve right LE. Superimposed sensory motor demyelinating and axonal polyneuropathy were noted.

On August 26, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at Florida Pain and ABC for burn injury. His pain level was 6/10. Lumbar spine exam revealed lumbar scar. Neurologic exam revealed deep tendon reflexes of 1+ in knees and absent in ankles with reduced sensation in bilateral feet with reduced vibration sense and bilateral feet toes down going. His diagnosis included idiopathic progressive neuropathy, paresthesia of skin and injury of tibial nerve at lower leg level, right leg, initial. He was advised to follow-up with Dr. XXXX for further management.

On September 01, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He returns nine weeks, four days into his right lower extremity debridement and grafting. He had completely healed from this issue. Unfortunately, he has persistent pain in the area of his lower extremity as well as weakness. He has had nerve conduction and EMG study was reviewed. There was superimposed sensory-motor demyelinating and axonal polyneuropathy. He reported continued weakness and the knee "giving out on him." Exam revealed weakness in the toes and some light touch hypoesthesia with a good capillary refill. His diagnosis included right tibial subacute mononeuropathy with associated superimposed sensory and axonal polyneuropathy. He was recommended to get an MRI of the right knee and f/u with Dr. XXXX. He was advised to stay off work.

On September 11, YYYY, XXXX, M.D., obtained Mr. XXXX's MRI of the right calf without contrast at Physicians Imaging for loss of feeling and questionable nerve damage. The study revealed previously described circumferential subcutaneous edema of the lower leg has resolved. No abnormality of the tibia vascular nerve bundle was visualized.

On September 11, YYYY, XXXX, M.D., obtained Mr. XXXX's MRI of the right knee without contrast at Physicians Imaging for pain and fall. The study revealed small joint effusion. No meniscal tear and no bone marrow edema was noted.

From July 09, YYYY, to September 11, YYYY, Mr. XXXX received physical therapy from Christy Yaxley, PT and John Sherman, PTA at BCA Institute for burn injury. In the interim he rated the pain level as 5-8/10. As on September 11, YYYY, he did not return for the treatment.

On November 10, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He returned for evaluation of his right lower extremity dysfunction. He complained that he continues to have difficulty with his knee and tends to fall. His soft tissues have completely healed, and his edema has completely resolved. He had persistent weakness more than pain in the area of his lower extremity. Exam revealed complete soft tissue healing, which was mature. He had some light touch hypoesthesia distally. His diagnosis included right lower extremity weakness with a history of falling. He was recommended nerve conduction and EMG study and FCE to determine his work restrictions. He was advised to stay off work.

On November 24, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He continued to report numbness in the bottom of his foot. He also reported some weakness and a little atrophy. He reported a sensation in the knee of giving out on him. Right knee revealed slight weakness in flexion and extension. His diagnosis included a right tibial burn wound. He had poorly controlled diabetes, and it is critical to his nerve recovery that he gets his diabetes under better

control. He was advised to f/u in one month for follow up with no X-rays necessary at that time. He was advised to return to sedentary work on November 30, YYYY.

On January 12, YYYY, XXXX, M.D., obtained Mr. XXXX's EMG/Nerve Conduction Study of BLE at Spine and Musculoskeletal Institute. The study revealed electrodiagnostic evidence for a diffuse sensorimotor peripheral polyneuropathy.

On January 12, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Orthopedic Associates for pain management and paresthesia of lower extremity. Lower Nerve conduction study and EMG completed, and the results were reviewed.

On January 14, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for right leg pain. He had knee instability, but primarily had weakness due to a tibial mono-neuropathy. Exam revealed decreased ROM of the right knee. His diagnosis included injury of tibial nerve at lower leg level, right leg subsequent encounter – located on the right tibial diaphysis. He was recommended for neurology consultation and PT 2 times per week for 4 weeks.

On January 19, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for right calf pain. His pain had been present for 7 months. He presented with some persistent concern of weakness in his lower extremity. He has an exam which demonstrated a well healed skin graft with soft compartments throughout he was hesitant to perform ankle extension eversion and inversion as well as plantar flexion. But these seem to be intact on observation during clinic visit the patient has good capillary refill with an intact posterior tibial pulsation. He and his family had some questions about compartment syndrome and compartmental releases. He was recommended for functional capacity evaluation and to remain on restricted duty.

On February 11, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He reported leg weakness greater in right leg. He has pain in both legs, 6-8/10, reporting electrical sensation, burning, which impedes sleep. He has had several sensations of legs giving way. He does have a significant history for both neck and back surgery. Neck exam revealed tenderness of neck on palpation and abnormal cervical spine motion. Back exam revealed tenderness on palpation of lumbosacral spine; lumbosacral spine pain elicited by motion. Motor exam revealed muscular atrophy. Sensory exam revealed decreased bilateral LE, R>L; decrease in proprioception; vibration perception decreased after 4 seconds. He had a positive Romberg's sign. He had pitting edema BLE 1+; hair loss on lower legs. Disturbance of gait was noted. He had difficulty with balance. His diagnosis included bilateral post traumatic neuropathic pain of lower extremities after bilateral lower extremity burn injury, RLE>>LLE, after brief submersion, (~30-60sec) into moderately large underground accumulation of extremely hot hydraulic oil, in an adjacent moderate sized dirt hole next to a huge hydraulic pump reservoir tank which had overflowed. Status post skin grafting of right lower extremity, Dr. XXXX, orthopedic Institute plastic surgery; Work comp injury; diabetes mellitus NOS; idiopathic polyneuropathy, bilateral lower extremities, mixed sensory motor peripheral polyneuropathy, complicated by burn injury, with evidence to suggest some asymmetry of legs, right>left; mild ataxia; cervicgia, secondary to multilevel cervical spondylosis, status post multilevel surgical interventions; lumbar spondylosis with stenosis requiring surgical intervention, with L3 through S1 and hyperlipidemia. He was prescribed Topiramate 50 mg and Tramadol 50 mg. He was advised to follow-up in 4 weeks.

On March 04, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for bilateral hand pain x 2 weeks due to fall. Symptoms included numbness, tingling, numbness of the radial three digits, numbness of the ring and small fingers and burning pain. He describes symptoms as intermittent. His symptoms were worse with heavy use and repetitive use. Exam shows excellent stability without ecchymosis and edema. His diagnosis included pain in right hand, pain in left hand. He was advised to refer Dr. XXXX for neck and Dr. XXXX for shoulder. He was advised to continue sedentary work.

On March 05, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. His exam and diagnosis remained the same. He was prescribed Flexeril 10 mg for neck and back pain. He was advised to continue Topamax 100 mg for neuropathic leg pain after burn injury and discontinue Ultram due to nausea. He was advised to return to the clinic with X-ray results.

On April 06, YYYY, Mr. XXXX was evaluated by Steven Smith, PT at H2 Health for Burns bilateral lower extremities. Functional Capacity Evaluation was performed. He attempted all tasks as directed in either a standard or a modified manner. He performed with full effort without complaints of pain. He demonstrated consistent movement patterns with distraction testing related to his diagnosis and the results of this evaluation can be considered to be an accurate representation of the client's functional abilities. His resting heart rate was 68 bpm. Any recorded heart rate response during functional testing that was less than 25% greater than the resting heart rate, or 85 bpm, would indicate low effort. Any recorded heart rate response that was greater than 50% over the resting heart rate, or 102 bpm, would indicate full effort. He demonstrated right leg weakness / atrophy as compared to his left side. Noted with compensatory squatting attempts, however, he was able to complete eccentric lowering (descending) using right leg and showed preference to knee on left knee which typically would require right leg push to stand. However, he attempted bilateral kneeling and was unable to complete the attempt without assistance. He demonstrated limited ability to perform squatting and kneeling. He demonstrated poor balance / proprioception which may increase risk of falls with dynamic activities (i.e., walking, climbing especially on compliant or uneven surfaces. He demonstrated the ability to perform work at the Light physical demand level.

On May 04, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He presented today plateaued in the area of his lower extremity from his debridement and grafting of his lower extremity injuries with persistent weakness and numbness in the area of the lower extremity from his Worker's Compensation injury examination showed no asymmetry or obvious atrophy in the area of the -lower extremities. He does have extension flexion eversion and inversion although they are limited with intact light touch sensation with some hypoesthesia in diffuse areas but a good capillary refill. His nerve conductions showed electrodiagnostic evidence of a diffuse sensorimotor polyneuropathy, no evidence of focal neuropathy. His FCF showed he could be sedentary with a 10-pound restriction, and we will place him at MMI. His whole-body impairment was rated as 5%. No further medical or surgical interventions were planned. He was advised to follow-up in 3-6 months.

On May 21, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He reported taking his Topamax therapy nightly, and tolerated well, and believes his sugar control had improved. He reported being very independent and not wishing to discuss medical issues and very suspect of medical help. His exam and diagnosis remained the same. He was offered Topamax 100 mg q.h.s. for neuropathic pain, with additional benefits for sugar control and potential anorexic effects which may assist his low back

and neck pain issues as well as diabetic control. He was also prescribed Tramadol 50 mg and was advised to follow-up in 4-6 weeks.

On June 29, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He presented for severe burn related work injury to bilateral lower extremities, which has likely been associated with nerve damage but complicated by poorly controlled DM and both significant neck and back disease requiring surgical intervention. He continued with progressive RLE weakness, numbness, and atrophy. He reports PMD told him atrophy will worsen. He continued with poor balance, several near falls, and falls, but not using an assistive device. He had a remote fall with recommendations for X-ray studies, which he never completed to offer assistance regarding neck and back pain. He had chronic neck and back condition and history of surgery. His exam and diagnosis remained the same. He was advised to continue Topamax 100 mg and Tramadol 50 mg. He was recommended to repeat PT evaluation and treatment for progressive LE weakness secondary to deconditioning, and progressive RLE weakness and falls. Reemphasized need to maximize DM control, and role of using cane or other device to prevent falls. He was advised to follow-up in 4-6 weeks.

On July 02, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for third degree burn injury and bilateral leg weakness. He was recommended PT 2 times per week x 4 weeks.

On July 29, YYYY, Mr. XXXX was evaluated by John Palmer, PT at H2 Health for other symptoms and signs involving the musculoskeletal system. He was 13 months post bilateral leg burns with right foot drop which he needs a foot drop prevention AFO or ankle – foot Orthosis with to decrease the right LE gait disturbance and decrease his fall frequency. He would need an order from Dr. Borkoski for the right AFO for foot weakness. His right leg responded with blisters when he stands and walks for activity, exercise and developed cellulitis which puts him at risk of more advanced infection. He was concerned he would lose his leg to amputation eventually. No point more PT would help his overall condition and may even put him at further risk for systemic infection. He is oppositional to doing PT again as well. His rehab potential was good. His discharge prognosis was good. The plans and goals have been developed and discussed.

On August 10, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He reported ongoing atrophy of his right thigh and leg, as well as intermittent blistering of feet when wearing socks. He demonstrated 2 macular erythematous resolving blisters on left foot but reported getting on right foot as well. He reported a symmetric pain in his right foot and leg greater than left. His pain level was 9-10/10. He uses Topamax 50 mg in the morning and Tramadol p.r.n. although limited by nausea. He walked cautiously due to the right foot pain and had a partial foot drop with some occasional tripping when not lifting leg high. He was seen by physical therapy whose only recommendation was for ankle foot orthosis. His exam and diagnosis remained the same. He was advised to continue Topamax 50mg bid for neuropathic leg pain and Continue Tramadol 50 mg. He was advised to follow-up in 4-6 weeks.

On September 02, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for right leg pain. He had persistent complaints of no sensation or function of his right lower extremity with healed scar conditions which were asymptomatic. His diagnosis included unspecified open wound, right lower leg, subsequent encounter - located on the right pretibial region. His duty status would remain per FCE sedentary light duty demand work 10-pound restriction. He was advised on

wound care and home exercise programs. He was referred to Dr. Borkoski for right lower leg NCS and EMG.

On September 27, YYYY, XXXX, M.D., obtained Mr. XXXX's EMG/Nerve Conduction Study of BLE at ABC Medical Center. The study revealed evidence for a RLE mixed sensorimotor axonal peripheral polyneuropathy. He had decreased left compound motor action potential amplitudes, but normal velocities and normal LLE sensory studies. Electrodiagnostic study showed asymmetric RLE>>>LLE polyneuropathy. Clinical correlation was advised.

On September 27, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He had a small ulcer at the base of his left foot and continues with chronic neuropathic changes in both feet with greatest burn in right foot but occurring in both feet at time of accident. He was very unsteady on foot, using a 4 wheeled walker with disc brakes, although can independently ambulate. He had generalized weakness and numbness in both lower extremities and felt extremely unsteady ambulating. He was seen by Dr. XXXX performed skin grafts of his right leg which has healed well. His exam and diagnosis remained the same. He was advised to continue Topamax 50mg bid for neuropathic leg pain and discontinue Tramadol due to tolerability issues. He was prescribed Hydrocodone 5/325 mg. He was advised to return to the clinic in 3-4 weeks to address results of electrodiagnostic and clarify maximum medical improvement and permanent impairment rating.

On September 30, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for a right tibial burn wound. He had knee instability, but primarily had weakness due to a tibial mono-neuropathy. Left foot wound at the dorsal base of big toe for about 1 week. Left ankle ROM was decreased. His diagnosis included an open wound of the right lower leg and an abrasion of the right lower leg. He was recommended for wound care and MRI of bilateral lower extremity. He was referred to Dr. XXXX for pain management follow-up and neurological issues. Compliance with treatment recommendations was emphasized.

On October 07, YYYY, Darren Buono, M.D., obtained Mr. XXXX's MRI of right and left tibia-fibula without contrast at Titan MRI for pain after work injury and burns to lower extremities. The study revealed non-specific subcutaneous edema bilaterally more pronounced on the left than the right, no fluid collections or abscess and no muscle strain.

On October 18, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for right lower extremity pain, neuropathy and recent burn injury. He has a small ulcer at the base of his left foot and continues with chronic neuropathic changes in both feet with greatest burn in right foot but occurring in both feet at time of accident. He was very unsteady on foot, using a 4 wheeled walker with disc brakes, although can independently ambulate is quite unsteady. He had generalized weakness and numbness in both lower extremities and feels extremely unsteady ambulating. He has had physical therapy and does not feel can perform any of his typical work requirements performing diesel mechanic duties and working with heavy machinery. His diagnosis included neuropathic pain of both legs, burn injury, idiopathic polyneuropathy and h/o skin graft. He was advised to continue Topamax 50 mg bid for neuropathic leg pain and discontinue Tramadol due to tolerability issues. He was prescribed Hydrocodone 10/325 mg. He was provided right AFO for partial foot drop but discontinued because of ulceration. His whole person impairment was 21%.

On October 19, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for neuropathic pain of both legs, burn injury and idiopathic polyneuropathy. He was prescribed Hydrocodone 10 mg-Acetaminophen 325 mg and Topiramate 50 mg.

On October 26, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute for f/u abrasion of right lower leg. He complained of dysfunctional right lower extremity with atrophy. Examination showed intact distal pulsations, good capillary refill healed soft tissue envelope with complaints of lack of extension and flexion. He needs continued neurological or psychiatric evaluation. Dr. XXXX was apparently leaving the area, he was ordered a psychiatry or neurology evaluation today. He was advised abrasion care and f/u in 4 to 6 weeks.

On October 28, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at BCA Institute. He needs to continue to follow either a neurologist that he had seen in the past or a new neurologist. A physiatrist is not needed if a neurologist is obtained. He believed the left foot was related to his work comp injury, and it should be addressed by his primary care physician.

On November 10, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at ABC Medical Center for neuropathic pain of both legs. His care was transferred to Pain Management.

On November 15, YYYY, Mr. XXXX was evaluated by XXXX, M.D. His diagnosis included diabetic foot ulcer of left foot, diabetic peripheral neuropathy, DM type 2 – no control, increased BP and non-compliance. He was advised to go to the ER for further evaluation and wound care. He was prescribed Gabapentin 300 mg and Zofran 4 mg ODT.

From November 19, YYYY, to December 02, YYYY, Mr. XXXX was hospitalized at Shands at the University of Florida for cellulitis of left lower extremity. He c/o left leg pain and reported he was burned in June YYYY. He c/o burning pain in L foot. He had redness in left foot. Unable to palpate pulse at this time. He presented with past medical history diabetes mellitus type 2 uncontrolled insulin dependent (last hemoglobin A1c 14), prior burns bilateral lower extremities due to work accident, chronic right lower extremity atrophy, difficulty ambulating (reported impairment rating by neurologist and previously followed by an orthopedist). He presented at the insistence of his PCP for worsening left lower extremity swelling, pain, redness and reported loss of pulse. He has had worsening pain in both feet. This has been progressive; he described it as sharp like walking on "tacks." He does note an area at the base of his left toe on the plantar surface. He associated this with prior burn exposure. His active problems included cellulitis, PAD (peripheral artery disease), complex regional pain syndrome of the left lower limb and poorly controlled type 2 diabetes mellitus. He received physical therapy, occupational therapy and diabetes education. He was discharged in stable condition with medications and instructions for follow-up. He was aware of his Dx and refers to understanding all instructions and recommendations given.

From December 06, YYYY, to December 23, YYYY, Mr. XXXX was treated by XXXX, M.D., for chronic pain in left leg. His diagnosis included peripheral neuropathy – bilateral > on left, intractable pain, regional pain syndrome – left and DM type II. He was prescribed Fentanyl 12 mg, Lortab 10/325 mg and Lantus.

On December 27, YYYY, Mr. XXXX was evaluated by XXXX, M.D., and Lyuda Lundeen, APRN at XXXX Pain Management for leg pain. He presented for consultation at request of Workmen's Comp. He reported having an ulcer on the bottom of the left foot. He reported pain from

the midfoot to the toes. He reported burning, sharp, tearing and severe pain. His pain level was 10/10. DIRE score was 20 (may be a good candidate for long-term opioid analgesia). Lower extremity exam revealed subjective decreased sensation throughout the right lower extremity. Global weakness of the right lower extremity was noted. He was ambulated in a wheelchair. His diagnosis included pain in the limb and long-term opioid therapy. He was prescribed Nucynta ER 50 mg twice daily. He was instructed to take off the Fentanyl patch tonight and start Nucynta tomorrow. He was specifically instructed not to use Fentanyl patch or Hydrocodone with Nucynta. He was recommended for the Urine Drug Screen.

On January 13, YYYY, Mr. XXXX was evaluated by XXXX, M.D., and Lyuda Lundeen, APRN at XXXX Pain Management for leg pain. He returned for a 2-week follow-up visit for medication refills and reassessment of pain. He was seen for reassessment for worsening the patient in both feet. He reported his pain as 10/10. He was insistent that he needs stronger pain medication or let him take Hydrocodone along with Nucynta. About 4 to 5 days ago, he started having visual disturbances with black spots in his visual field in both eyes. Upon exam, he ambulated with a rolling walker. Right lower extremity has decreased sensation. He had global weakness to the right lower extremity which was mild. His diagnosis remained the same and was advised to continue medication.

From January 17, YYYY, to January 21, YYYY, Mr. XXXX was hospitalized at Shands at the University of Florida. His diagnosis included uncontrolled type 2 diabetes mellitus with hyperglycemia; complex regional pain syndrome of left lower limb; diabetic ulcer of foot associated with diabetes mellitus due to underlying condition, limited to breakdown of skin and PAD (peripheral artery disease). He presented with a past medical/surgical history significant for T2DM, chronic regional pain syndrome of feet, PAD. He presented for evaluation of a worsening diabetic foot ulcer. He was recently admitted for lower extremity cellulitis in the setting of poorly controlled diabetes. He was treated with Ceftriaxone and Vancomycin with improvement before being discharged on a few days of Bactrim. He was readmitted on January 17, YYYY, with purulent discharge from the ulcer. Started on IV Vancomycin and Zosyn, transitioned to Vancomycin, Cefepime and Flagyl due to AKI. MRI of the foot was negative for OM. He was evaluated by vascular surgery and was scheduled for outpatient angiogram on Wednesday January 26, YYYY. TTE for DOE evaluation showed mild AS but normal EF with no wall motion abnormalities. He was discharged home in stable condition.

On January 25, YYYY, Mr. XXXX was evaluated by XXXX, APRN and XXXX, M.D., at XXXX Pain Management for leg pain. He returned for follow-up and reassessment of medication changes. At his last visit, he was advised to increase his Gabapentin to 900 mg 3 times a day and increase Nucynta to 100 mg twice a day. He reported that he did not know he had an ulcer there. It became infected and he was placed on IV antibiotics. DIRE score was 17 (may be a good candidate for long-term opioid analgesia). His pain level was 6/10. He ambulated with a rolling walker. Exam revealed a healing diabetic ulcer to the plantar aspect of the left foot along the metatarsal pad. Right lower extremity had decreased sensation on the exam. There was global weakness to the right lower extremity which was mild. His diagnosis included chronic foot pain, peripheral neuropathy of feet and long-term opioid therapy. He was instructed to continue Nucynta 100 mg twice a day. He was also advised to increase Gabapentin to 900 mg 3 times a day.

On February 18, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at XXXX Pain Management for leg pain. He returned with ongoing severe foot pain bilaterally. His pain was mostly from the midfoot to the distal foot. He had intermittent numbness. He reported weakness in his feet. He also reported a lot of stiffness at the feet. His pain worsened with ambulation, but he seems to have

the most trouble at night when trying to sleep. He reported that last night he only slept 1 hour. His wife stated that they are both miserable because of his chronic pain and poor quality of life. He has backed off on the Gabapentin to 600 mg 3 times per day. His pain level was 7/10. He was assessed to have bilateral post traumatic neuropathic pain of lower extremities after bilateral lower extremity burn injury, right greater than left, after brief submersion into a moderately large underground accumulation of extremely hot hydraulic oil. Cardiovascular exam revealed +pedal edema L>R. Skin exam revealed chronic erythema of the feet L>R. Musculoskeletal exam revealed antalgic gait and required walker. His diagnosis remained the same. He was prescribed senna 8.6 mg, Amitriptyline 25 mg, Gabapentin 600 mg and Oxycodone-Acetaminophen 7.5-325 mg.

From March 09, YYYY, to March 21, YYYY, Mr. XXXX was hospitalized at Shands at the University of Florida for osteomyelitis of the left foot. He had a past medical history of burn injury and diabetes mellitus. He presented to the ED with an ischemic/ infected left 2nd toe. ABI was falsely elevated with moderate digital ischemia in the left foot. He was admitted to medicine for uncontrolled DM and IV ABx. He underwent left 2nd toe open amputation on March 09, YYYY. On POD #1, the wound bed appeared ischemic and therefore underwent LLE angiogram on March 16, 22 which demonstrated occluded peroneal and AT. PT was diffusely diseased with an occlusion at the ankle which was treated with balloon angioplasty and underwent L TMA (closed). PT/OT evaluated and recommended discharge to rehab due to history of multiple falls at home (he stated this was from CRPS and neuropathy in both his legs). He declined rehab as worker's comp didn't cover and he did not qualify for Shands Charity Care. He was discharged home with home PT/OT and wound care to apply dry gauze to incisions, kerlix, and ACE. ID recommended discontinuing IV antibiotics and keeping eye on surgical margins / pathology during clinic follow-up, and notifying them if, they are positive. He was discharged on 7 days of Clindamycin and Aspirin.

On March 23, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at XXXX Pain Management for leg pain. His pain was rated as 8/10. He returned with significant improvement of his pain following the change of his regimen to Percocet 7.5 mg 4/day. He and his wife were very thankful for the improved pain control and quality of life. He had all of his toes amputated at the left foot and had an ongoing wound that may require additional surgery/amputation. He was advised to continue the medication and was advised to follow-up in 1 month for reassessment.

On April 05, YYYY, Martin Back, M.D., obtained Mr. XXXX's Lower Extremity Arterial Doppler study at Shands at the University of Florida for routine surveillance following arterial angioplasty, left transmetatarsal amputation. Right side revealed the resting ankle/brachial index on the right lower extremity was falsely elevated due to vessel incompressibility. There was mild arterial insufficiency in the right lower extremity suggested by Doppler waveform analysis. Moderate digital ischemia was noted on the right foot. Left side revealed the resting ankle/brachial index on the left lower extremity was falsely elevated due to vessel incompressibility. There was mild arterial insufficiency in the left lower extremity suggested by Doppler waveform analysis.

On April 18, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at XXXX Pain Management for leg pain. His pain was rated as 4/10. He returned with ongoing struggles with lower extremity pain. He would be admitted to UF for additional left foot amputation. To help him sleep at night, his Amitriptyline was increased to 50 mg. Discussed instructions and possible side effects. He was advised to continue the medications and follow-up in 1 month for reassessment.

From April 22, YYYY, to April 25, YYYY, Mr. XXXX was hospitalized at Shands at the University of Florida for non-healing left TMA. He had a past medical history of burn injury and diabetes mellitus. He received 72 hrs of IV Vancomycin and Cefepime with improvement of TMA appearance and sutures were removed. Endocrine consulted for management of DM. He was discharged home with wound care and was advised to apply Santyl to the wound daily, cover with dry gauze, secure with Kerlix and ACE wrap. His 70/30 was refilled per endocrine's recommendations and would follow closely with his PCP for glucose control. He was discharged in good condition with home care.

On May 18, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at XXXX Pain Management for leg pain. His pain was rated as 6/10. He reported ongoing struggles with bilateral lower extremity pain. He described burning pain in both feet. He had phantom pain in his left toes. After his last visit here, he went to UF and needed some sort of procedure to try to control the infection of the left foot, but this was not successful. He would again go this Friday and would have an MRI of the right foot. He had been told he may need to do a left above ankle amputation. His right toes turned purple and may need amputation at the right foot. Increased dosage of Amitriptyline provided minor benefit. Exam revealed diminished hearing. Feet was in orthotics. He had a slow, antalgic gait and required a walker. His diagnosis remained the same. He was advised to continue the medications and follow-up in 1 month for reassessment.

On June 15, YYYY, Cooper Dean, M.D., obtained Mr. XXXX's X-ray of left foot at Shands at the University of Florida for other osteomyelitis of the left foot. The study revealed postsurgical changes related to first through fifth transmetatarsal amputation with surgical defect along the distal aspect of the operative site. Bandage overlies the foot and operative site. Vascular calcifications were demonstrated diffusely. If there is clinical concern fracture infectious process, advised to consider MRI of the left remnant forefoot for further evaluation.

On June 16, YYYY, Mr. XXXX was evaluated by Lyuda Lundeen, APRN at XXXX Pain Management for leg pain. His pain was rated as 7/10. Musculoskeletal exam revealed antalgic gait and he was wearing orthotics on both feet. He returned for medication recheck. He reported ongoing struggles with bilateral lower extremity pain. He may need amputation above the left ankle. He reported appreciable pain relief with Percocet, Gabapentin. Percocet and Gabapentin 600 mg was refilled. He understood the risks of his medications. He was advised to follow-up in 1 month.

On July 20, YYYY, Mr. XXXX was evaluated by XXXX, M.D., at XXXX Pain Management for leg pain. His pain was rated as 6/10. Exam revealed diminished hearing, moist mucous membranes. Cardiovascular exam revealed diffuse edema of the left foot. Skin exam revealed diffuse erythema of the left foot with distal foot wound s/p amputation of all toes with visible pus and appears to be dehiscing minimal erythema of the right foot with no signs of infection. He had antalgic, slow and shuffling with foot pain.

On August 31, YYYY, Mr. XXXX was evaluated by XXXX, M.D., and XXXX, M.D., a Shands at the University of Florida. He presented with a slowly healing wound after transmetatarsal amputation. He underwent a tibial angioplasty. He has diabetes and peripheral vascular disease. His pre-operative and post-operative diagnosis included left lower extremity critical limb ischemia, slowly healing wound. He underwent right common femoral access with fluoroscopic and ultrasound guidance; selective catheterization of left common femoral artery; left lower extremity angiogram; direct, retrograde puncture of left dorsalis pedis artery; retrograde cannulation of left anterior tibial

artery; selective catheterization of left posterior tibial artery; balloon angioplasty, left posterior tibial artery; selective catheterization of left plantar artery and balloon angioplasty, left plantar artery.

On September 22, YYYY, Mr. XXXX was evaluated by XXXX, M.D. His diagnosis included DM type II, hot oil burn to legs, regional pain syndrome – legs secondary to oil burn, diabetic foot ulcer – resolved, amputation toes left foot and non-compliance. He was recommended diabetic eye exam and was advised to f/u in 1 month.

On September 29, YYYY, Mr. XXXX was evaluated by XXXX, M.D. He had hot oil burns on his legs on June 15, YYYY. As a result of the oil burns, he experienced intractable pain in his legs, multiple skin grafts, hospital admissions and amputation of the toes on his left foot. The above problems are 70% due to the oil burns and 30% due to Type 2 Diabetes Mellitus.

On October 07, YYYY, XXXX, M.D., obtained Mr. XXXX's Lower Extremity Arterial Doppler study at Shands at the University of Florida for routine surveillance following arterial angioplasty. Right side revealed the resting ankle/brachial index on the right lower extremity was falsely elevated. There was mild-moderate arterial insufficiency in the right lower extremity suggested by Doppler waveform analysis. Moderate digital ischemia noted on the right foot. Monophasic waveforms obtained in the right posterior tibial artery and dorsalis pedis artery. Left side revealed the resting ankle/brachial index on the left lower extremity was falsely elevated. There was mild arterial insufficiency in the left lower extremity suggested by Doppler waveform analysis. Left transmetatarsal amputation. Biphasic waveforms obtained in the posterior tibial artery and dorsalis pedis artery.

On April 07, YYYY, XXXX, M.D., obtained Mr. XXXX's Lower Extremity Arterial Doppler study at Shands at the University of Florida for pain in the right lower extremity for an unknown duration. Right side revealed the resting ankle/brachial index on the right lower extremity was falsely elevated. There was moderate arterial insufficiency in the right lower extremity suggested by Doppler waveform analysis. Severe digital ischemia noted on the right foot. Left side revealed mild arterial occlusive disease in the left lower extremity. There was a previous left lower extremity amputation.
