



APEX Diagnostics

(BLS Diagnostics, LLC)

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ELECTRODIAGNOSTIC (EDX) REPORT

PI – LEDX – NORMAL / BASELINE

Test Date: 10/13/2021

Patient: [REDACTED] **D.O.B.:** [REDACTED] **EMG Doc:** O. Ajifowobaje, DPT, ECS, RMSK
Gender: Male **Height:** 5' 7" **NCV Tech:** J. Giordano, R.NCS.T.

REASON FOR ELECTRODIAGNOSTIC CONSULTATION AND EXAMINATION:

Patient was referred to this office for a thorough neurological assessment by [REDACTED]. Patient is being seen for an evaluation following a work injury to be assessed due to suffering from cervical and/or upper extremity symptoms. **The goal of this independent examination is to rule in/out radiculopathy, focal neuropathy,** small fiber neuropathy, myopathy and peripheral neuropathy, and make appropriate recommendations for additional diagnostic testing and/or **outside referrals for care** as clinically indicated.

CHIEF COMPLAINT:

Patient is a pleasant 40-year-old right hand dominant Male who presents with 19-day history of worsening lumbar and lower extremity symptoms following a work injury on [REDACTED].

ACCIDENT / INJURY INFORMATION:

Patient was injured at work after a lifting a heavy object on [REDACTED]. when patient was performing a team lift of a heavy object off of a train/platform when he experienced sudden, sharp pain in his lower back, buttock and thigh on the right side. Patient describes symptoms as sharp pain and aching. Patient reports aberrant sensation primarily in the lateral femoral, inguinal, sural, saphenous, superficial peroneal, and plantar sensory nerve distributions on the right. Patient states immediately after the injury he rested, but his symptoms persisted. Patient was seen by his primary physician and a chiropractor where he received lumbar x-rays.

PAST / RELATED MEDICAL HISTORY:

Right knee meniscal repair in 1999. Left rotator cuff repair in 2011. Diabetic. Complains of a 1-year history of dizziness and loss of balance. Patient states he is unable to work due to his current condition. He also states walking and stairs are difficult for him. Please see referring / providing physician's complete H&P for full history details.

ELECTRODIAGNOSTIC FINDINGS:

All nerve conduction studies (as indicated in the following tables) were within normal limits. Left vs. Right side comparison data for the lateral femoral cutaneous sensory nerve indicates abnormal L-R amplitude difference (24.1 %). All remaining left vs. right side differences were within normal limits.

All F Wave latencies were within normal limits. All F Wave left vs. right side latency differences were within normal limits. All H Reflex left vs. right side latency differences were within normal limits.

All examined muscles (as indicated in the following table) showed no evidence of electrical instability.

DIAGNOSTIC IMPRESSION:

- Normal Study: Normal neurological baseline established with no electrophysiological evidence of pre-existing injury/neuropathy (study performed within 3 weeks of patient's injury). (See Clinical Note Section)
- No significant findings regarding radiculopathy (paraspinal or extremity), plexopathy, small fiber neuropathy, proximal neural function or myopathy.
- Based on noted discrepancies, cannot rule-out possible early / mild neuropathy with axonal degeneration as indicated in the Electrodiagnostic Findings above.

CLINICAL NOTE:

Injury affecting the nervous system (peripheral or central) causing symptoms in the extremities will not show those peripheral electrophysiological deficits/effects on nerve conduction studies until 3-weeks (21-days) post-injury, with the exception of a neurotmesis (complete severance of the axon), which generally reveals the deficit sooner than 3-weeks post-trauma (usually immediately). [Md, K. B. (2007). *Electromyography in Clinical Practice: A Case Study Approach* (2nd ed.). Mosby.] A "normal" nerve conduction study within three weeks of a trauma does not necessarily mean there is no damage caused from the trauma. Therefore, this examination performed within the 3-week post-injury window of time factually establishes an objective "normal" baseline, absent of electrophysiological deficit which may have been caused by any pre-existing condition. If patient's symptoms persist or worsen, a study performed at least 6 months in the future would be valuable to compare to the results of this study to establish neurologically-based impairment caused from this patient's trauma.

Absence of abnormal findings on electromyography (EMG) within three weeks of a trauma does not necessarily mean there is no damage caused from the trauma. Most limb muscles show spontaneous activity (fibrillation potentials, positive sharp waves, fasciculations, etc.) within 3 weeks of injury, but 5-6 weeks may be required in the distal portions of the limb. [Weiss Lyn, Silver Julie, Weiss Jay. *Easy EMG*. 2004 pg 145-146.] Therefore, follow-up testing in the future, if symptoms persist or worsen, may prove clinically beneficial to properly diagnose and determine any potential neurologically-based impairment caused from this patient's trauma.

RECOMMENDATIONS:

Follow up with Dr. [REDACTED].

VNG (videonystagmography) to assess for possible balance / vestibular dysfunction.

Conservative care: Chiropractic / Physical Therapy.

Pain management consultation as clinically indicated.

Re-evaluate electrodiagnostically in 6 months or PRN based on patient's clinical progress.

Thank you for this referral and the opportunity to assist with this patient's care. The patient's symptoms and condition are causally related to the injury. These statements are made within a reasonable degree of medical certainty. Recommendations are subject to the clinical data available at the time of this examination. If you have any questions or concerns, please don't hesitate to contact our office.

Professionally,



O. Ajifowobaje, DPT, ECS, RMSK
ABPTS Board Certified in Clinical Electrophysiology



M. Ribeiro, MD
Board Certified Neurologist

Ordered by referring physician with intent to follow up with patient and make appropriate treatment recommendations as necessary. This electrodiagnostic study has been co-signed and performed (including diagnostic interpretation) by a Diplomate of the International and American Boards of Electrodiagnosis / Certified Electromyographer. Autonomic (somatosensory PRN) studies were performed by a Certified (Registered) Nerve Conduction Study Technologist (R.N.C.S.T.) under the supervision of the co-signed Board-Certified Neurologist. Nerve conduction studies and needle EMG have been performed using standardized techniques according to the AANEM, IBE and AAET guidelines. The following electrodiagnostic equipment was used in the examination of this patient: Cadwell Sierra Summit. The following supplies were required for this examination: Ambu concentric needle, 2 ground sticker electrodes, 8 standard sticker electrodes, standard conduction gel, alcohol prep.