MMP-048

New Jersey Department of Health
Medicinal Marijuana Program
PO 360
Trenton, NJ 08625-0360

MEDICINAL MARIJUANA PETITION
(N.J.A.C. 8:64-5.1 et seq.)

INSTRUCTIONS
This petition form is to be used only for requesting approval of an additional medical condition or treatment thereof as a "debilitating medical condition" pursuant to the New Jersey Compassionate Use Medical Marijuana Act, N.J.S.A. 24:6I-3. Only one condition or treatment may be identified per petition form. For additional conditions or treatments, a separate petition form must be submitted.

NOTE: This Petition form tracks the requirements of N.J.A.C. 8:64-5.3. Note that if a petition does not contain all information required by N.J.A.C. 8:64-5.3, the Department will deny the petition and return it to petitioner without further review. For that reason the Department strongly encourages use of the Petition form.

*This completed petition **must** be postmarked **August 1 through August 31, 2016** and sent by **certified mail** to:*

New Jersey Department of Health
Office of Commissioner - Medicinal Marijuana Program
Attention: Michele Stark
369 South Warren Street
Trenton, NJ 08608

Please complete each section of this petition. If there are any supportive documents attached to this petition, you should reference those documents in the text of the petition. If you need additional space for any item, please use a separate piece of paper, number the item accordingly, and attach it to the petition.

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1. **Petitioner Information**

Name:
Street Address:
City, State, Zip:
Telephone Number:
Email Address:

2. **Identify the medical condition or treatment thereof proposed. Please be specific. Do not submit broad categories (such as "mental illness").**

cauda equina syndrome

3. **Do you wish to address the Medical Marijuana Review Panel regarding your petition?**

☐ Yes, in Person
☐ Yes, by Telephone
☑ No

4. **Do you request that your personally identifiable information or health information remain confidential?**

☒ Yes
☑ No

If you answer "Yes" to Question 4, your name, address, phone number, and email, as well as any medical or health information specific to you, will be redacted from the petition before forwarding to the panel for review.

RECEIVED
SEP 6 2016
OFFICE OF THE CHIEF OF STAFF

5. **Describe the extent to which the condition is generally accepted by the medical community and other experts as a valid, existing medical condition.**

My diagnosis has been confirmed by (medical tests,) & it is has been validated (MRI's, xrays) by my drs.

6. **If one or more treatments of the condition, rather than the condition itself, are alleged to be the cause of the patient's suffering, describe the extent to which the treatments causing suffering are generally accepted by the medical community and other experts as valid treatments for the condition.**

A treatment of my condition is opiates to control the pain. The opiates are minimally effective & cause extreme drowsiness & lethargy, which has left me mostly bedridden. Opiates have led to imbalance & falls.

7. **Describe the extent to which the condition itself and/or the treatments thereof cause severe suffering, such as severe and/or chronic pain, severe nausea and/or vomiting or otherwise severely impair the patient's ability to carry on activities of daily living.**

My condition & treatment have triggered much anxiety & depression. I have severe & debilitating pain all the time. Fecal & urinary incontinence severely limits my activities, also the result of my canda equina. Severe constipation & diarrhea, which has led to numerous hospitalization

8. **Describe the availability of conventional medical therapies other than those that cause suffering to alleviate suffering caused by the condition and/or the treatment thereof.**

~~We~~ I have no alternative treatments for this condition that does not have serious side effects.

9. **Describe the extent to which evidence that is generally accepted among the medical community and other experts supports a finding that the use of marijuana alleviates suffering caused by the condition and/or the treatment thereof.** ***[Note:** You may attach articles published in peer-reviewed scientific journals reporting the results of research on the effects of marijuana on the medical condition or treatment of the condition and supporting why the medical condition should be added to the list of debilitating medical conditions.]*

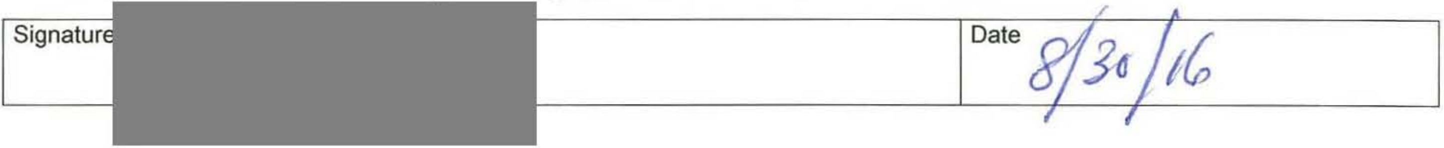
I am not aware of research regarding canda equina specifically, but marajuana has been shown to be effective in pain tolerance & digestive problems.

MEDICINAL MARIJUANA PETITION
(Continued)

10. **Attach letters of support from physicians or other licensed health care professionals knowledgeable about the condition. List below the number of letters attached and identify the authors.**

1. Lucille Bar-David, LCSW
2. Andrew Ankamah, MD + Jason Poco, PA-C
3. Orvil Ayala, MD
4. Antonios Mammis, MD
5. RWJ Radiology
6. St. Peter's University Medical Center
7. Robert Wood Johnson Radiology.
8. Article: The Washington Post.

I certify, under penalty of perjury, that I am 18 years of age or older; that the information provided in this petition is true and accurate to the best of my knowledge; and that the attached documents are authentic.

Signature 	Date 8/30/16

(1.)

Lucille Bar-David,LCSW
1303 Route 27
Somerset, New Jersey 08773

August 30, 2016

RE: [redacted]
Born [redacted]

To Whom it May Concern:

[redacted] is a patient under my care for over 5 years now. I am a Licensed Clinical Social Worker, providing psychotherapy services. He was referred to me by his PCP, with whom I periodically review [redacted] case. After much suffering and hospitalizations, [redacted] was diagnosed with Cauda Equina Syndrome on [redacted], 2015.

In recent years, [redacted] has become increasingly isolated with his incontinence and pain. He is largely bedridden, anxious, depressed, less able to cope with family conflicts, more and more afraid of winding up in a nursing home. [redacted] lives with his parents. His father has dementia and his 80 year old mother is no longer able to take care of them on her own. He has some help from aides, but still finds it very difficult to manage his own life. His pain is being treated with morphine, oxycodone, neuronton, and meloxicam. He still suffers a lot of pain and many side effects, particularly on his digestive system. [redacted] has a syndrome in response to the opiates,overflow constipation, which requires him to be hospitalized. He has been hospitalized five times in this past year.

If medical marijuana would provide some relief to this man and allow him to reduce the opiates that are currently prescribed for his medical condition, please carefully assess if it might be appropriate for him.

Sincerely,
Lucille Bar-David, LCSW
LUCILLE BAR-DAVID, LCSW

2.

PATIENT		FACILITY	ENCOUNTER	
		ANDREW ANKAMAH Practice	NOTE TYPE	SOAP Note
DOB		T (732) 249-9400	SEEN BY	Jason Poco MS, PA-C
AGE	53 yrs	F (732) 249-9500	DATE	/2016
SEX	Male	New Jersey Sports & Spine Med	AGE AT DOS	53 yrs
PRN		1553 State Hwy. 27, Suite 3100	Electronically signed by ANDREW K	
		Somerset, NJ 08873	ANKAMAH M.D. at /2016 03:47 pm	

Chief complaint

Reason for Visit: Chronic low back pain, cauda equina syndrome, Pain management

Referring Physician: Dr. Irving Kaufman, MD PROGRESS REPORT

Subjective

HPI: is a 53 yrs old male with PMH noted for morbid obesity, chronic low back pain who presents with the above chief complaints. He has completed physical therapy, multiple radiofrequency ablations, facet blocks, and epidural injections with minimal relief of his chronic low back pain. He was hospitalized again a few weeks ago for GI issues. He states Dr. Kaufman and Dr. Spierer have recommended him to move to a NH but he prefers to try a live-in aid first. He presents for medication refill.

Current Bowel Regimen:
Lactulose 15mL 9am and 5pm, MOM 30mg 6am and 6pm, Miralax 17gm at 9pm.

PMH: Morbid obesity, cauda equina syndrome, neurogenic bladder, chronic low back pain, HTN, asthma, Hypercholesterolemia.

PAST SURGICAL HISTORY: Status post IVC filter, sleeve gastrectomy, duodenal switch, revision of duodenal switch, sacral nerve stimulator.

SOCIAL HISTORY: Denies smoking and alcohol use. Lives with parents.

FAMILY HISTORY: Noncontributory.

ALLERGIES: Penicillin, bacitracin, neomycin, neosporin.

FUNCTIONAL HISTORY: Modified independent with quad cane and manual wheelchair.

ROS: 10 Reviews of systems are negative except as stated above.

Objective

PHYSICAL EXAMINATION:

GENERAL: NAD. At the time of my physical examination he appeared his stated age of 53 yrs old. He presents in a manual wheelchair.

Right Shoulder: Negative bruising, swelling, or erythema. Range of motion: 100% of normal. Examination of his right shoulder did not reveal any atrophy compared to his asymptomatic left side. No point tenderness at supraspinatus tendon insertion. Negative point tenderness of acromioclavicular (AC) joint.

Special tests/Maneuvers of Right shoulder:
Negative: Neer's, Hawkins, Speed, Empty can, Drop arm impingement tests, and Obrien's.
Negative: Sulcus sign.
Negative: Apprehension test (test for RIGHT/LEFT glenohumeral instability).

Low Back (Lumbar spine): Range of motion is 80% of normal. Palpation showed no spasms and positive point tenderness in lumbar spinous processes and paraspinals. Sitting and supine straight leg raises (Lasegues sign) were positive bilaterally.

Neurologic Examination: He was awake and oriented times three, to person place and time. His tongue was in midline. Facial expression was symmetric. Speech was coherent with no evidence of aphasia.

Bilateral Lower Extremities: 5-/5 bilateral lower extremity muscle strength. Reflexes at his bilateral patellar 2/4 and bilateral ankles were 2/4. Light touch sensation was intact in all dermatomes of bilateral lower extremities.

RADIOGRAPHIC/DIAGNOSTIC STUDIES:

MRI OF LUMBAR SPINE obtained on /14 showed:
FINDINGS: Comparison is made to lumbar spine MRI from /12.
There is a mild remote compression fracture of L2 again seen without significant change. There is no evidence of retropulsion of bone.
There is 7 mm of anterolisthesis of L5 on S1 which is unchanged. There is moderate loss of disc height at this level which is unchanged. There are mild diskogenic endplate changes at L4-5 and moderate diskogenic endplate changes at L4-5 again seen. Previously seen abnormal signal throughout the paraspinal musculature has resolved.
The conus terminates at the L1-2 level and is normal in signal. There is no evidence of abnormal enhancement within the thecal sac.
At T12-L1 there is no significant abnormality.
At L1-2 there is mild bilateral facet hypertrophy without disc bulge or protrusion. There is no significant central canal or neural foraminal narrowing. These findings are unchanged.
At L2-3 there is a minimal disc bulge and tiny central disc protrusion with annular tear. There is mild bilateral facet hypertrophy. There is minimal central canal narrowing but no significant neural foraminal narrowing. These findings are unchanged.
At L3-4 there is a mild disc bulge and mild to moderate bilateral facet hypertrophy with minimal central canal and minimal bilateral neural foraminal narrowing. These findings are unchanged.
At L4-5 there is a mild disc bulge and small central disc protrusion again seen. There is severe left and moderate right facet hypertrophy. There is mild central canal narrowing and bilateral mild to moderate left neural foraminal narrowing. These findings are unchanged.
At L5-S1 there is uncovering of the intervertebral disc, unchanged. There is a tiny central disc protrusion with annular tear, unchanged. There is severe bilateral facet hypertrophy again seen. Fluid in the left facet joint is unchanged. However there is new fluid in the right facet joint. There is moderate to severe central canal narrowing and lateral recess stenosis bilaterally. There is severe bilateral neural foraminal narrowing. These findings are unchanged.
IMPRESSION:
1. Unchanged mild remote L2 compression fracture.
2. Unchanged 7 mm of anterolisthesis of L5 on S1. Moderate to severe central canal narrowing and severe bilateral neural foraminal narrowing at this level are unchanged. There is new fluid within the right facet joint at this level.
3. Stable degenerative changes elsewhere throughout the lumbar region.

Assessment

is a 53 yrs old male who presents with cauda equina syndrome and chronic low back pain. He was recently hospitalized again at RWJ for GI issues.

Diagnoses attached to this encounter:

Cauda equina syndrome [ICD-10: G83.4], [ICD-9: 344.61], [SNOMED: 192970008]

Low back pain [ICD-10: M54.5], [ICD-9: 724.2], [SNOMED: 279039007]

Myalgia [ICD-10: M79.1], [ICD-9: 729.1], [SNOMED: 68962001]

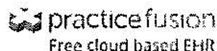
Neuralgia and neuritis, unspecified [ICD-10: M79.2], [ICD-9: 729.2], [SNOMED: 16269008], [SNOMED: 84299009]

Spondylosis without myelopathy or radiculopathy, lumbosacral region [ICD-10: M47.817], [ICD-9: 721.3], [SNOMED: 68859000]

Lumbar spinal stenosis [ICD-10: M48.06], [ICD-9: 724.02], [SNOMED: 18347007]

Plan

1. Continue Gabapentin.
2. Continue Oxycodone. Refilled today.
3. Continue Morphine sulfate extended release.
4. He has read and signed a pain management contract. He agrees to the terms of the contract and understands that any breach of contract will result in permanent discharge from NJSS.
5. He has read and signed a pain medication consent form which states the potential risks of taking pain medication.
6. Follow up: 4 weeks for medication refill.
7. Continue Meloxicam.
8. Continue Prilosec as per Dr. Kaufman.
9. Hold Outpatient Physical Therapy 2-3x/week x 4 weeks at a facility that accepts his insurance due to him on VNA PT s/p recent hospitalization.
10. Will call Dr. Kaufman's office for latest LFT blood work.

The above treatment plan was explained to the patient including risks and benefits. He agrees to the above treatment plan. I will update you with his progress. Thank you for the opportunity to participate in the care of .

Signature: Jason Poro, PA-C.

Signature: Andrew K. Ankamah, M.D.
Board Certified in Physical Medicine and Rehabilitation.

New Jersey Sports & Spine Medicine, P.C.
1553 State Highway 27
Suite 3100
Somerset, NJ 08873
Ph: 732-249-9400.
Fax: 732-249-9500.
www.njsportspinemed.com

Medications attached to this encounter:

Gabapentin 800 MG Oral Tablet Take 1 tablet (800 mg) by mouth 4 times per day (start date: /2016) prescription: not prescribed this visit

OxyCODONE HCl 15 MG Oral Tablet Take one tablet (15 mg) by mouth every 8 hours as needed (start date: /2016)

prescription: qty 90 of 15 MG Take one tablet (15 mg) by mouth every 8 hours as needed (NO refills)

Morphine Sulfate ER 15 MG Oral Tablet Extended Release Take 1 tablet (15 mg) by mouth every 12 hours (start date: /2016)

prescription: qty 60 of 15 MG Take 1 tablet (15 mg) by mouth every 12 hours (NO refills)

Meloxicam 15 MG Oral Tablet Take 1 tablet (15 mg) by mouth daily as needed (start date /2016) prescription: not prescribed this visit

practice fusion
Free cloud based EHR

PATIENT

DOB
AGE 53 yrs
SEX Male
PRN

FACILITY
ANDREW ANKAMAH Practice
T (732) 249-9400
F (732) 249-9500
New Jersey Sports & Spine Med
1553 State Hwy 27, Suite 3100
Somerset, NJ 08873

ENCOUNTER
NOTE TYPE SOAP Note
SEEN BY Jason Poco MS, PA-C
DATE /2016
AGE AT DOS 53 yrs
Electronically signed by ANDREW K ANKAMAH M.D. at /2016 03:17 pm

Chief complaint

Reason for Visit: Chronic low back pain, cauda equina syndrome, Pain management

Referring Physician: Dr. Irving Kaufman, MD PROGRESS REPORT

Subjective

HPI: is a 53 yrs old male with PMH noted for morbid obesity, chronic low back pain who presents with the above chief complaints. He has completed physical therapy, multiple radiofrequency ablations, facet blocks, and epidural injections with minimal relief of his chronic low back pain. He states he was hospitalized at RWJUH recently for overflow incontinence and completed about 2 weeks of SAR at Golden Living. He states he was recently hospitalized and resumed VNA PT at home. He reports he slid out of his wheelchair this am in the bathroom and hit his right shoulder on the wall. He denies any pain today. He reports he may be gluten intolerant. He presents for medication refill.

Current Bowel Regimen:
Lactulose 15mL 9am and 5pm, MOM 30mg 6am and 6pm, Miralax 17gm at 9pm.

PMH: Morbid obesity, cauda equina syndrome, neurogenic bladder, chronic low back pain, HTN, asthma, Hypercholesterolemia.

PAST SURGICAL HISTORY: Status post IVC filter, sleeve gastrectomy, duodenal switch, revision of duodenal switch, sacral nerve stimulator.

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FAMILY HISTORY: Noncontributory.

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Lumbar spinal stenosis [ICD-10: M48.06], [ICD-9: 724.02], [SNOMED: 18347007]

Plan

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The above treatment plan was explained to the patient including risks and benefits. He agrees to the above treatment plan. I will update you with his progress. Thank you for the opportunity to participate in the care of .

Signature: Jason Poco, PA-C.

Signature: Andrew K. Ankamah, M.D.
Board Certified in Physical Medicine and Rehabilitation.

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Ph: 732-249-9400.
Fax: 732-249-9500.

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prescription: qty 120 of 800 MG Take 1 tablet (800 mg) by mouth 4 times per day (3 refills)

OxyCODONE HCl 15 MG Oral Tablet Take one tablet (15 mg) by mouth every 8 hours as needed (start date: /2016) prescription: not prescribed this visit

Morphine Sulfate ER 15 MG Oral Tablet Extended Release Take 1 tablet (15 mg) by mouth every 12 hours (start date /2016) prescription: not prescribed this visit

Meloxicam 15 MG Oral Tablet Take 1 tablet (15 mg) by mouth daily as needed (start date: /2016) prescription: not prescribed this visit

Special tests/Maneuvers of Right shoulder:
Negative: Neer's, Hawkins, Speed, Empty can, Drop arm impingement tests, and Obrien's.
Negative: Sulcus sign.
Negative: Apprehension test (test for RIGHT/LEFT glenohumeral instability).

Low Back (Lumbar spine): Range of motion is 80% of normal. Palpation showed no spasms and positive point tenderness in lumbar spinous processes and paraspinals. Sitting and supine straight leg raises (Lasegues sign) were positive bilaterally.

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Bilateral Lower Extremities: 5-/5 bilateral lower extremity muscle strength. Reflexes at his bilateral patellar 2/4 and bilateral ankles were 2/4. Light touch sensation was intact in all dermatomes of bilateral lower extremities.

RADIOGRAPHIC/DIAGNOSTIC STUDIES:

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There is 7 mm of anterolisthesis of L5 on S1 which is unchanged. There is moderate loss of disc height at this level which is unchanged. There are mild diskogenic endplate changes at L4-5 and moderate diskogenic endplate changes at L4-5 again seen.
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At L3-4 there is a mild disc bulge and mild to moderate bilateral facet hypertrophy with minimal central canal and minimal bilateral neural foraminal narrowing. These findings are unchanged.
At L4-5 there is a mild disc bulge and small central disc protrusion again seen. There is severe left and moderate right facet hypertrophy. There is mild central canal narrowing and bilateral mild to moderate left neural foraminal narrowing. These findings are unchanged.
At L5-S1 there is uncovering of the intervertebral disc, unchanged. There is a tiny central disc protrusion with annular tear, unchanged. There is severe bilateral facet hypertrophy again seen. Fluid in the left facet joint is unchanged. However there is new fluid in the right facet joint. There is moderate to severe central canal narrowing and lateral recess stenosis bilaterally. There is severe bilateral neural foraminal narrowing. These findings are unchanged.
IMPRESSION:
1. Unchanged mild remote L2 compression fracture.
2. Unchanged 7 mm of anterolisthesis of L5 on S1. Moderate to severe central canal narrowing and severe bilateral neural foraminal narrowing at this level are unchanged. There is new fluid within the right facet joint at this level.
3. Stable degenerative changes elsewhere throughout the lumbar region.

Assessment

is a 53 yrs old male who presents with cauda equina syndrome and chronic low back pain. He was recently hospitalized at RWJ due to overflow incontinence and completed 2 weeks of SAR recently.

Diagnoses attached to this encounter:

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Health Records

3.

- Home
- Health Records
  - Lab test results
  - Diagnoses
  - Medications
  - Immunizations
  - Allergies
  - Procedures
  - Care plans
  - Past visits
  - Vitals
  - Social history
- Appointments
- Messages
- Providers
- Profile
- Account settings
- Log out

Help (https://patientfusion.uservoic /knowledgebase/)

Terms (/terms)

Privacy (/privacy)

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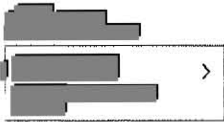
Diagnoses

Name	Start Date	End Date	Provider
Hip pain	2015		Orvil Ayala
Ankle pain	2015		Orvil Ayala
Ankle joint - painful on mo vement	, 2015		Orvil Ayala
Peripheral nerve disease	, 2015		Orvil Ayala
Myofascial pain	2015		Orvil Ayala
Low back pain	, 2015		Orvil Ayala
Shoulder joint pain	, 2015		Orvil Ayala
Knee pain	2015		Orvil Ayala
Foot pain	, 2015		Orvil Ayala
Lumbosacral spondylosis	2015		Orvil Ayala
Lumbosacral spondylosis with myelopathy			Orvil Ayala
Anemia			Orvil Ayala
Bronchitis			Orvil Ayala
Headache			Orvil Ayala
Hypertensive disorder			Orvil Ayala
Kidney disease			Orvil Ayala
Cauda equina syndrome			Orvil Ayala
Incontinence of feces			Orvil Ayala
Urinary incontinence			Orvil Ayala
Unspecified inflammatory and toxic neuropathies			Orvil Ayala
Osteoarthrosis, unspecifie d whether generalized or l ocalized, involving unspeci fied site			Orvil Ayala

≡ Health Records

Care Plans

Description	Encounter Date	Provider
1. Driving: Patient instructed regarding side effects and the need to avoid driving until they know how the medication changes affect them. 2. Weight Loss: Patient counseled on the importance of weight loss to help with overall health and pain control. Patient instructed to attempt weight loss. 3. Treatment Agreement: *pending UDS results.4. New patient visit, urine drug screen per office policy. *Random urine drug screen per office policy. 5. Discussed with the patient regarding the etiology of their pain. Informed them that they would likely benefit from:*Referral to Physical Therapy*Opioid rotation*Adding adjunct analgesics*Interventional Therapies (caudal ESI; LESI; Prialt trial; SCS--DVD given to patient)*Surgical intervention 6. Referral to Physical Therapy (RX give)*eval/tx; aquatic therapy; core; stretching; massage; TENS.7. Start Tizanidine 4 mg BID PRN muscle spasms/pain (2 weeks supply)8. Increase Gabapentin to 800 mg for neuropathic pain (2 week supply).*TID x 7days, then QID.9. Patient is to return to clinic for a follow up visit in 2 weeks.	2015	Dr Orvil Ayala M.D.
1. Patient instructed regarding side effects and the need to avoid driving until they know how the medication changes affect them. 2. Patient counseled on the importance of weight loss to help with overall health and pain control. Patient instructed to attempt weight loss. 3. Treatment Agreement: will pursue on next visit.4. Random urine drug screen per office policy. 5. Discussed with the patient regarding the etiology of their pain. Informed them that they would likely benefit from:*Physical Therapy (has yet to participate)*Opioid rotation*Adding adjunct analgesics*Interventional Therapies (caudal ESI; LESI; Prialt trial; SCS--DVD given to patient)*Surgical intervention 6.Encouraged patient to initiate Physical Therapy.7. Increase Tizanidine to 4 mg TID PRN muscle spasms/pain (4 weeks supply)8. Continue Gabapentin 800 mg QID for neuropathic pain (2 week supply).9. Increase Topamax to 100 mg TID for neuropathic pain.10. Oxycodone 15 mg BID PRN pain.*Long-term side effects of opioids including but not limited to opioid induced hormonal suppression, hyperalgesia, possible opioid induced altered immune system, and elevated risk of myocardial infarction. *Long-term use of opioid medications discussed with patient for pain control. Proper use and potential life threatening side effects of over use discussed with patient. Patient states understanding of their use and risks. 11. Start Butrans 10 mcg patch q7 days for pain.12. Patient is to return to clinic for a follow up visit in 4 weeks.	2015	Dr Orvil Ayala M.D.
1. Patient instructed regarding side effects and the need to avoid driving until they know how the medication changes affect them. 2. Patient counseled on the importance of weight loss to help with overall health and pain control. Patient instructed to attempt weight loss. 3. Treatment Agreement: will pursue on next visit.4. Random urine drug screen per office policy. *performed today5. Discussed with the patient regarding the etiology of their pain. Informed them that they would likely benefit from:*Physical Therapy*Opioid rotation*Adding adjunct analgesics*Interventional Therapies (caudal ESI; LESI; Prialt trial; SCS--DVD given to patient)*Surgical intervention 6.Encouraged patient to initiate Physical Therapy.7. Continue Tizanidine to 4 mg TID PRN muscle spasms/pain (4 weeks supply)8. Continue Gabapentin 800 mg QID for neuropathic pain (4 week supply).9. Continue Topamax to 100 mg TID for neuropathic pain (4 week supply).10. Continue Oxycodone 15 mg BID PRN pain (4 week supply).*Long-term side effects of opioids including but not limited to opioid induced hormonal suppression, hyperalgesia, possible opioid induced altered immune system, and elevated risk of myocardial infarction. *Long-term use of opioid medications discussed with patient for pain control. Proper use and potential life threatening side effects of over use discussed with patient. Patient states understanding of their use and risks. 11. Start Morphine ER 15 mg BID for pain.12. Left Ankle Injection:Discussed with the patient regarding the etiology of their pain. Informed them that they would likely benefit from a Left ankle injection (talofibular joint). The procedure was described in detail and the risks, benefits and alternatives were discussed with the patient (including but not limited to: bleeding, infection, nerve damage, worsening of pain, CSF leak, inability to perform injection, paralysis, seizures, and death) who agreed to proceed. *tolerated procedure well.*Pre-procedure pain: 9*Post-procedure pain: 313. Referral for left ankle X-ray.14. Caudal Epidural Steroid Injection:Discussed with the patient regarding the etiology of their pain. Informed them that they would likely benefit from a Caudal ESI. The procedure was described in detail and the risks, benefits and alternatives were discussed with the patient (including but not limited to: bleeding, infection, nerve damage,	2015	Dr Orvil Ayala M.D.



worsening of pain, CSF leak, inability to perform injection, paralysis, seizures, and death) who agreed to proceed. *will schedule
15. Patient is to return to clinic for a follow up visit in 4 weeks.

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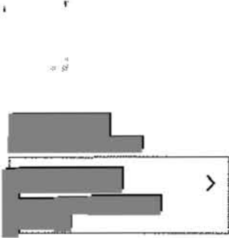

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New Jersey Medical School

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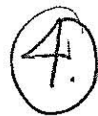

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Administration
Aaron F. Hajart, MS, ATC
Senior Director of Administration
Ashlee Capano, ATC
Clinical Coordinator

[redacted] 2015

Irving H. Kaufman, M.D.
Family Practice
1303 Route 27
Somerset, NJ 08873

Re: [redacted]
DOB: [redacted]

Dear Dr. Kaufman:

I had the pleasure of meeting with your patient [redacted] in the office today. As you know, [redacted] is a 51-year-old man with morbid obesity and chronic lumbago and sciatica with left leg being worse than the right and with bilateral burning dysesthetic buttock pain. His pain ranges from 3-10/10 on the visual analogue scale and was burning, sharp, shooting and squeezing. He states that progressively since 1990s, he has developed burning dysesthetic saddle anesthesia and paresthesias in bilateral feet, weakness in lower extremities and ultimately bowel and bladder symptomatology with incontinence of urine and stool and sexual dysfunction. At this time, he has a urostomy and a colostomy and sacral nerve stimulator, which is not providing any relief and he has had a course of physical therapy, multiple radiofrequency ablations, facet blocks, and epidural steroid injections without relief and so he presents today for discussion of surgical management of his chronic cauda equina syndrome.

PMH/PSH: Extensive with hypertension, asthma, morbid obesity, hypercholesterolemia, bronchitis, GI reflux, renal insufficiency, bowel and bladder dysfunction, sexual dysfunction, vena cava filter placement, sleeve gastrectomy, duodenal switch, revision of the duodenal switch, and sacral nerve stimulator.

MED: He is currently taking tamsulosin 0.4 mg, docusate, modafinil, sennosides calcium, Amitiza, vitamin B12, fluticasone, alendronate, Reguloid, Nucynta, diazepam, indapamide, gabapentin, aspirin, omeprazole, ketoconazole shampoo, pravastatin, milk of magnesium, Abilify, escitalopram, vitamins, finasteride, and Furacin ointment, acetaminophen, folic acid, OsCal, lactobacillus, bupropion, Centrum, topiramate, ferrous gluconate tablets and fleets enemas, and oxycodone 30 mg.

ALL: He has allergies to penicillin, bacitracin, neomycin and neosporin as well as grass, trees, pollen, mold and peanuts.

SH: He is left-handed. He is single, he has no children. He lives with his parents. He does not smoke, drink or use illicit drugs. He is permanently disabled.

FH: Significant for spinal stenosis.

ROS: Signed and is in the chart.

PE: On examination, he is morbidly obese, pleasant, cooperative. 2+ reflexes throughout. Diminished sensation in the left L4 dermatome. His gait is steady. Tandem is positive with ataxia. Romberg is positive. His power is 5/5 in all motor groups in the lower extremities with the exception of the left iliopsoas, which is 5-5, right iliopsoas 4+/5, hamstrings left 4/5, right 4+/5, left plantarflexion is 4+/5, right plantarflexion is 5-/5.

FILMS: Review of MRI of the lumbar spine demonstrates an enormous L5-S1 disc herniation with complete obliteration of thecal sac as well as tricompartmental stenosis secondary to facet hypertrophy and ligamentum flavum hypertrophy. Flexion-extension x-rays of the lumbar spine demonstrate a grade II spondylolisthesis with dynamic subluxation across L5-S1.

IMP/PLAN: [redacted] is a 51-year-old man with chronic cauda equina syndrome characterized by lumbago, sciatica, bowel and bladder dysfunction, sexual dysfunction and saddle anesthesia. He has spinal instability across L5-S1 and his thecal sac and nerve roots are completely obliterated by an L5-S1 disc herniation. It is medically necessary for him to undergo lumbar laminectomy at L5-S1, discectomy at L5-S1 and fusion across L5-S1. I have described the risks, benefits and alternatives of spinal fusion with the patient and his mother and they have demonstrated understanding of these with the risks including, but not being limited to bleeding, infection, neurologic decline, comma, paralysis and death. Prior to consideration of any surgery, the patient must undergo clearance by cardiologist as he does have intermittent dyspnea and he is morbidly obese and hypertensive. Assuming he is medically cleared for surgery, we will proceed for surgery in February.

I thank you for the courtesy of this referral. If there are any questions or concerns, do not hesitate to contact me directly.

Sincerely yours,

Antonios Mammis, M.D.
Assistant Professor, Neurological Surgery
Rutgers New Jersey Medical School
Director, Functional and Restorative Neurosurgery
Director, Center for Neuromodulation
Surgical Director, Center for Headache, Orofacial, and Neuropathic Pain

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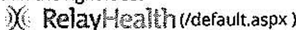
St Peters Univ Hospital - Radiology
NJ

Patient Information

Order Details

MRI LUMBAR W W/O

DATE OF EXAM: 2014
MRI 0087 - MRI LUMBAR W W/O:
ACCESSION#
RESULT:
EXAM: MRI LUMBAR W W/O
CLINICAL INDICATION: 724. Low back pain
TECHNIQUE: A noncontrast and contrast enhanced MRI of the lumbar spine was performed.
FINDINGS: Comparison is made to lumbar spine MRI from 12.
There is a mild remote compression fracture of L2 again seen without significant change. There is no evidence of retropulsion of bone.
There is 7 mm of anterolisthesis of L5 on S1 which is unchanged. There is moderate loss of disc height at this level which is unchanged. There are mild diskogenic endplate changes at L4-5 and moderate diskogenic endplate changes at L4-5 again seen.
Previously seen abnormal signal throughout the paraspinal musculature has resolved.
The conus terminates at the L1-2 level and is normal in signal. There is no evidence of abnormal enhancement within the thecal sac.
At T12-L1 there is no significant abnormality.
At L1-2 there is mild bilateral facet hypertrophy without disc bulge or protrusion. There is no significant central canal or neural foraminal narrowing. These findings are unchanged.
At L2-3 there is a minimal disc bulge and tiny central disc protrusion with annular tear. There is mild bilateral facet hypertrophy. There is minimal central canal narrowing but no significant neural foraminal narrowing. These findings are unchanged.
At L3-4 there is a mild disc bulge and mild to moderate bilateral facet hypertrophy with minimal central canal and minimal bilateral neural foraminal narrowing. These findings are unchanged.
At L4-5 there is a mild disc bulge and small central disc protrusion again seen. There is severe left and moderate right facet hypertrophy. There is mild central canal narrowing and bilateral mild to moderate left neural foraminal narrowing. These findings are unchanged.
At L5-S1 there is uncovering of the intervertebral disc, unchanged. There is a tiny central disc protrusion with annular tear, unchanged. There is severe bilateral facet hypertrophy again seen. Fluid in the left facet joint is unchanged. However there is new fluid in the right facet joint. There is moderate to severe central canal narrowing and lateral recess stenosis bilaterally. There is severe bilateral neural foraminal narrowing. These findings are unchanged.
IMPRESSION:
Unchanged mild remote L2 compression fracture.
Unchanged 7 mm of anterolisthesis of L5 on S1. Moderate to severe central canal narrowing and severe bilateral neural foraminal narrowing at this level are unchanged. There is new fluid within the right facet joint at this level.
Stable degenerative changes elsewhere throughout the lumbar region.
: BASAK, SANDIP M.D. On: 2014 3:42P



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AS NOTED ABOVE.
This document has been electronically signed.
Radiologist: BASAK, SANDIP M.D. On: [redacted] 2014 3:41P
Transcriptionist: RDWARE
Transcribe Date/Time: [redacted] 2014 3:41P

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Robert Wood Johnson RAD

Patient Information

Order Details

DX Knee 3 Views Left

Report

LEFT KNEE X-RAYS
CLINICAL INDICATION:
Left knee: S86.009A - Injury Knee
COMPARISON: None.
TECHNIQUE: 3 views of the left knee were obtained.
FINDINGS:
Bones/Joint Spaces: There is osteopenia present. There is medial compartment and patellofemoral joint space narrowing.
No acute fracture or dislocation is seen.
Effusion: There is no suprapatellar effusion.
Soft tissues/Other: Within normal limits.
IMPRESSION:
Left knee: Osteopenia with degenerative joint space narrowing. No acute fracture or dislocation.
Comments:
*** Final Report ***
Dictated by: Fitzpatrick, Maurice MD /2016 3:31 pm
Approved by: Fitzpatrick, Maurice MD /2016 3:31 pm
Transcribed by: Digital, Voice /2016 3:31 pm

Provider Comments: This result has been automatically released to your health record at the direction of your pr

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SAINT PETER'S UNIVERSITY HOSPITAL

254 Easton Avenue,
New Brunswick, NJ 08901

Patient Name:		**Sex:**	M
DOB:		**Pt. Class:**	O
Acct No:		**Order No:**	
Med Rec No:		**Pt NS/Room:**	MAM /
Ordering Dr:	IRVING KAUFMAN M.D. (000113)	**Referring Dr.:**	IRVING KAUFMAN M.D. (000113)

PERMANENT MEDICAL RECORD DO NOT DESTROY

DATE OF EXAM: 2013
USM 0013 - BONE DENSITY DEXA AXIAL:

RESULT:
EXAM: BONE DENSITY DEXA AXIAL

CLINICAL INDICATION: DEXA SCAN

Bone densitometry was performed on the GE Lunar Prodigy Advance DXA System. The bone mineral density status of this patient is based on the lowest lumbar spine, femoral neck, or total hip T- or Z- Score. T-score (comparison with young adults) is used for post-menopausal women and men 50 years and over according to World Health Organization criteria. Z-score (comparison with age-matched controls) is used for pre-menopausal women and men less than 50 years.

IMPRESSION:
This patient is in the osteoporotic category.

A more detailed DEXA report/images has been mailed to the referring physician. Should additional copies be required, please contact the Women's Imaging Center at (732) 745-6686.

I HAVE INTERPRETED THIS/THESE EXAMINATION(S) AND AGREE WITH THE FINDINGS AS NOTED ABOVE
Dictated By: GREENBERG, CAROLINE M.D. On: 2013 4:25P

This document has been electronically signed.
Radiologist: GREENBERG, CAROLINE M.D. On 2013 4:21P

Transcriptionist: RDWARE
Transcribe Date/Time: 2013 4:21P

SAINT PETER'S UNIVERSITY HOSPITAL
A MEMBER OF SAINT PETER'S HEALTHCARE SYSTEM
254 Easton Avenue
New Brunswick, NJ 08901
732-745-8600 • www.saintpetershcs.com

NAME: [redacted]
DOB: [redacted]
PHONE #: [redacted]
DATE: [redacted] 2013
LOCATION: 732-745-6686

IRVING KAUFMAN M.D. No. [redacted]

Bone Densitometry was performed on the GE Lunar Prodigy Advance DXA System (analysis version: 12.30).

PATIENT BIOGRAPHICAL:

Gender: Male Height: 73.0 in. Weight: 285.0 lbs. Age: 50.4 years

CLINICAL INDICATION:

DATA SUMMARY:

AP Spine L1-L4:	BMD = 1.080 g/cm²	T-score = -1.2	Z-score = -1.7
Left Femoral Neck:	BMD = 0.874 g/cm²	T-score = -1.5	Z-score = -1.4
Left Femoral Total:	BMD = 0.805 g/cm²	T-score = -2.1	Z-score = -2.2
Right Femoral Neck:	BMD = 0.896 g/cm²	T-score = -1.3	Z-score = -1.2
Right Femoral Total:	BMD = 0.723 g/cm²	T-score = -2.6	Z-score = -2.7

TREND SUMMARY:	% change from most recent	%change from baseline
AP Spine L1-L4:	N/A	baseline
Left Femoral Neck:	N/A	baseline
Left Femoral Total:	N/A	baseline
Right Femoral Neck:	N/A	baseline
Right Femoral Total:	N/A	baseline

SEE ATTACHED SHEET FOR COMPLETE TRENDING DATA (IF PRIORS ARE AVAILABLE).

ESTIMATED 10 YEAR FRACTURE RISK (AVAILABLE FOR PATIENTS 50-86 YEARS OLD):

Site	Your Patient's Risk	Age Matched Controls at 50.4 years*
Hip	1.1%	<1.0%
Any Site	4.6%	4.0%

Fracture risk estimates are based only on age and BMD (Kanis 2002, Lancet 359:1929-36.).
Overall fracture risk depends on many additional factors that should be considered before making diagnostic and therapeutic recommendations.

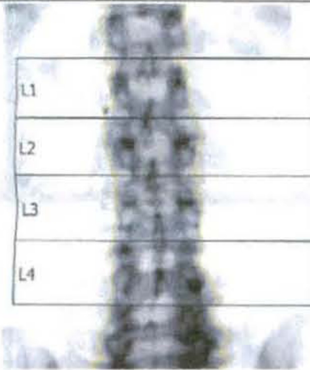
IMPRESSION:

Your patient is in the OSTEOPOROTIC category.
The BMD status of your patient is based on the lowest Lumbar Spine, Femoral Neck or Total Hip T-Score.*
In your patient this lowest value is at the Total Right Femur with a T-score of -2.6.
*Bone density status of postmenopausal women and men 50 years and over uses WHO criteria (T-score).

SAINT PETER'S UNIVERSITY HOSPITAL

254 Easton Ave.
New Brunswick, NJ 08901

Patient:		**Facility ID:**	2880479
Birth Date:	50.4 years	**Referring Physician:**	IRVING KAUFMAN M.D.
Height / Weight:	73.0 in. 285.0 lbs.	**Measured:**	/2013 3:38:36 PM (12.30)
Sex / Ethnic:	Male White	**Analyzed:**	/2013 3:42:50 PM (12.30)



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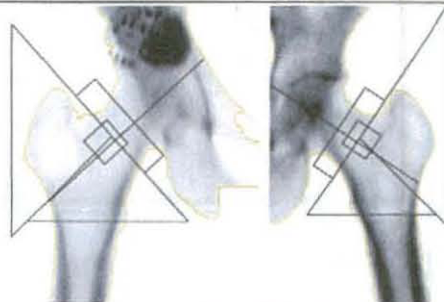

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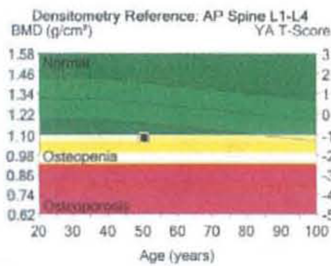
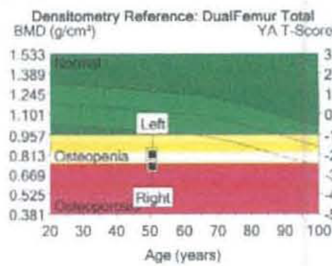




Region	BMD [1] (g/cm²)	Young-Adult [2,7] (%)	T-Score	Age-Matched [3] (%)	Z-Score	WHO Classification [11]
AP Spine L1-L4	1.080	89	-1.2	84	-1.7	Osteopenia
DualFemur Total						
Left	0.805	73	-2.1	72	-2.2	Osteopenia
Right	0.723	66	-2.6	65	-2.7	Osteoporosis
Mean	0.764	69	-2.3	68	-2.5	Osteopenia
Difference	0.081	7	0.6	7	0.6	-

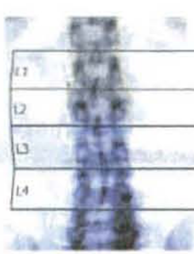
1 - Statistically 68% of repeat scans fall within 1SD (± 0.010 g/cm² for AP Spine L1-L4); (± 0.010 g/cm² for DualFemur Total)
2 - USA (Combined NHANES (ages 20-30) / Lunar (ages 20-40)) AP Spine Reference Population (v112); USA (Combined NHANES (ages 20-30) / Lunar (ages 20-40)) Femur Reference Population (v112)
3 - AP Spine Matched for Age, Weight (males 25-100 kg), Ethnic; DualFemur Matched for Age, Weight (males 25-100 kg), Ethnic
7 - DualFemur Total T-Score difference is 0.6. Asymmetry is Mild.
11 World Health Organization - Definition of Osteoporosis and Osteopenia for Caucasian Women: Normal = T-Score at or above -1.0 SD; Osteopenia = T-Score between -1.0 and -2.5 SD; Osteoporosis = T-Score at or below -2.5 SD; (WHO definitions only apply when a young healthy Caucasian Women reference database is used to determine T-Scores.)

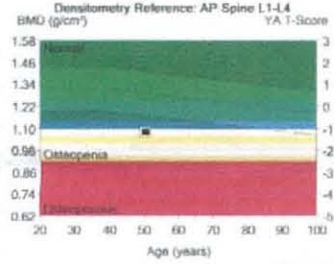
Printed: 2013 3:45:15 PM (12.30); Filename: AP Spine; 25.6:%Fat=36.9%; Scan Mode: Thick 83.0 µGy; Right Femur; 22.7:%Fat=34.2%; Neck Angle (deg)= 48; Scan Mode: Standard 37.0 µGy; Left Femur; 23.7:%Fat=39.9%; Neck Angle (deg)= 56; Scan Mode: Standard 37.0 µGy

SAINT PETER'S UNIVERSITY HOSPITAL

254 Easton Ave.
New Brunswick, NJ 08901

Patient:		**Facility ID:**	2880479		
Birth Date:	50.4 years	**Referring Physician:**	IRVING KAUFMAN M.D.		
Height / Weight:	73.0 in. 285.0 lbs.	**Measured:**	/2013	3:38:36 PM	(12.30)
Sex / Ethnic:	Male White	**Analyzed:**	/2013	3:42:50 PM	(12.30)

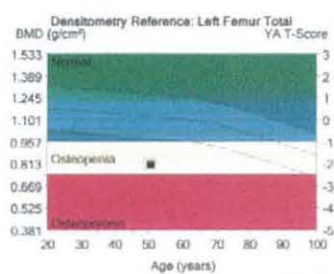




Region	BMD (g/cm²)	Young-Adult (%)	Young-Adult T-Score	Age-Matched (%)	Age-Matched Z-Score
L1	0.990	85	-1.4	81	-2.0
L2	1.102	89	-1.1	84	-1.7
L3	1.026	83	-1.8	79	-2.3
L4	1.180	95	-0.5	90	-1.0
L1-L4	1.080	89	-1.2	84	-1.7

Matched for Age, Weight (males 25-100 kg), Ethnic
USA (Combined NHANES (ages 20-30) / Lunar (ages 20-40)) AP Spine Reference Population (v112)
Statistically 68% of repeat scans fall within 1SD (± 0.010 g/cm² for AP Spine L1-L4)

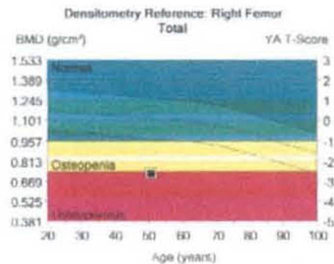
Image not for diagnosis



Region	BMD (g/cm²)	Young-Adult (%)	Young-Adult T-Score	Age-Matched (%)	Age-Matched Z-Score
Neck	0.874	82	-1.5	83	-1.4
Total	0.805	73	-2.1	72	-2.2

Matched for Age, Weight (males 25-100 kg), Ethnic
USA (Combined NHANES (ages 20-30) / Lunar (ages 20-40)) Femur Reference Population (v112)
Statistically 68% of repeat scans fall within 1SD (± 0.012 g/cm² for Left Femur Total)

Image not for diagnosis



Region	BMD (g/cm²)	Young-Adult (%)	Young-Adult T-Score	Age-Matched (%)	Age-Matched Z-Score
Neck	0.896	84	-1.3	85	-1.2
Total	0.723	66	-2.6	65	-2.7

Matched for Age, Weight (males 25-100 kg), Ethnic
USA (Combined NHANES (ages 20-30) / Lunar (ages 20-40)) Femur Reference Population (v112)
Statistically 68% of repeat scans fall within 1SD (± 0.012 g/cm² for Right Femur Total)

Image not for diagnosis

RelayHealth - Health Records

https://app.relayhealth.com/PatientPortal/HealthRecords#!/

5/10/16

5/9/16 Fecal impaction

Access the rest of your health information by clicking 'Health Records' in the top menu.

8

In the 17 states with a medical-marijuana law in place by 2013, prescriptions for painkillers and other classes of drugs fell sharply. In medical-marijuana states, the average doctor prescribed 265 fewer doses of antidepressants each year, 486 fewer doses of seizure medication, 541 fewer anti-nausea doses, and 562 fewer doses of anti-anxiety medication—and 1,826 fewer doses of painkillers in a given year.
The Washington Post