UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF LOUISIANA

LAFAYETTE DIVISION

GARFIELD JOHN JOSEPH LANDRY	*	**CIVIL ACTION NO. 13–0226**
VERSUS	*	**JUDGE DOHERTY**
COMMISSIONER OF SOCIAL SECURITY	*	**MAGISTRATE JUDGE HILL**

REPORT AND RECOMMENDATION

This social security appeal was referred to me for review, Report and Recommendation pursuant to this Court's Standing Order of July 8, 1993. Garfield John Joseph Landry, born April 13, 1959, filed applications for a period of disability, disability insurance benefits and supplemental security income on January 6, 2011, alleging disability since September 11, 2010, due to degenerative disc disease of the lumbar and cervical spines, left shoulder tendonitis and illiteracy.

FINDINGS AND CONCLUSIONS

After a review of the entire administrative record and the briefs filed by the parties, and pursuant to 42 U.S.C. § 405(g), I find that there is substantial evidence in the record to support the Commissioner's decision of non-disability and that the

Commissioner's decision comports with all relevant legal standards. *Anthony v. Sullivan*, 954 F.2d 289, 292 (5th Cir. 1992).

In fulfillment of F.R.Civ.P. 52, I find that the Commissioner's findings and conclusions are supported by substantial evidence, which can be outlined as follows:

(1) Records from Dr. John Cobb dated September 11, 2010 to January 3, 2011. On September 11, 2010, claimant reported shoulder pain after an on-the-job injury. (Tr. 174). He was working at light duty at that time.

On examination, claimant had full range of motion of the cervical spine, positive Spurling's test on the left, depressed DTRs on the left, weakness of the left thumb extensors three out of five, and left hand swelling. (Tr. 176-77). Cervical motor and sensory function and grip strength were normal. (Tr. 177). On left shoulder examination, he had positive impingement and some prominence of the acromioclavicular joint.

Cervical spine x-rays showed spondylosis at C4-5 on the right. C5-6 was worse with formaminal narrowing nearing the uncinate processes, right greater than left.

Dr. Cobb's impression was post-traumatic cervical pain syndrome, sprain/strain cervical spine, possible herniated disc, spondylosis with narrowing,

worse at the C5-6 level, radiculitis in the left upper extremity in the C6 distribution, rotator cuff injury on the left, and impingement tendonitis on the left. He injected the left shoulder and prescribed Percocet. He stated that claimant was unable to work at that time. (Tr. 178).

A cervical spine MRI dated November 8, 2010, showed a small central protrusion which mildly indented the ventral cervical cord with mild canal stenosis at C4-5; mild to moderate canal and moderate to severe bilateral foraminal stenosis at C5-6, and moderate bilateral foraminal stenosis at C6-7. (Tr. 179).

On November 22, 2010, claimant continued to complain of problems on both sides of his neck and back pain. (Tr. 181). On examination, he had some weakness of the extensors of the left thumb. Thoracolumbar x-rays showed mild spondylosis with good alignment.

Dr. Cobb's assessment was disc protrusions at C4-5 and C5-6, some degeneration at the C6-7 level, bursitis of the left shoulder with inflammation and impingement, rotator cuff tear, thoracolumbar pain syndrome and mild spondylosis in the thoracic area. He recommended that claimant continue with physical therapy and injections at C5-6 and C6-7. (Tr. 182). He prescribed Lortab.

A lumbar MRI dated December 22, 2010, showed a central left lateral focal disc herniation, posterior displacement of the left L5 nerve root within the spinal canal and possible compromise of the L4 nerve root within the neural foramina at L4-5, and a right lateral disc herniation with possible compromise of the S1 nerve root at L5-S1. (Tr. 183). An MRI of the thoracic spine was normal. (Tr. 185).

On January 3, 2011, claimant indicated that his shoulder was doing better. (Tr. 186). On examination, he had some nerve symptoms in the left upper extremity. The impression was impingement of the left shoulder with mild rotator cuff strain and radiculitis in the left upper extremity in the C6 distribution, which had improved. Dr. Cobb recommended continued physical therapy for the shoulder.

(2) Consultative Examination by Dr. Andrea Murina dated March 5, 2011. Claimant complained of lower back pain radiating down to the knees, especially on the right side; left rotator cuff tear; cervical radiculitis; tendonitis, hand stiffness and swelling, and headaches three times a week. (Tr. 188).

Claimant had a little trouble dressing himself, and no problem feeding himself. He could stand for 15 minutes at one time and approximately 20 minutes in an eight-hour period. He could walk approximately one block and lift approximately 10 pounds. He did not drive.

On examination, claimant had no difficulty getting on and off the exam table. (Tr. 189). He took off his shoes with his right hand and was able to unbuckle his belt without any difficulty.

On spine/extremities exam, claimant's pulses were +2 and grip strength was 5/5. He was able to oppose finger to thumb and button and pick up a coin. He had no muscle atrophy in the hand.

Claimant was able to walk on his heels, toes, and perform tandem walking without difficulty. (Tr. 190). He was able to squat without difficulty. He had intact sensation to light touch, and had no sensory deficits in the hands or feet. Deep tendon reflexes were +2 in the extremities.

Dr. Murina noted that claimant was obvious in attempts to use his right arm instead of the left, except that he used both when undressing. She observed that although claimant alleged back pain that was severely limiting, he had normal muscle tone, range of motion and muscle strength in the upper extremities. Straight leg raises were negative bilaterally, and gait was normal.

Additionally, Dr. Murina found that claimant had normal range of motion in the shoulder. He had no difficulty in lateral rotation, flexion or extension of the neck. He had no hand swelling and no detectable sensory deficits of the hand.

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