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Initial Comprehensive Medical Evaluation

Date: 07/01/2022

RE: Reyes Merino
DOB: 3/8/1967
DOA: 12/24/2017
Location: Cruz Banting Imelda MD PT, North Bronx
Case Type: WC

1st Evaluation

Work Status: Not working-temporarily totally disabled.

HISTORY:
On 07/01/2022, Ms. Reyes Merino, a right-handed 55-year-old female presents for the evaluation of the injuries sustained in a work-related incident which occurred on the date of 12/24/2017. Patient was unit clerk in Bronx Lebanon Hospital when going up the stair she slipped and fell and hurt her right shoulder and bilateral knees. The patient reports no injury to the head and no loss of consciousness. During the accident the patient reports injuries to right shoulder, and bilateral knees.

CHIEF COMPLAINTS:
The patient complains of right shoulder pain that is 4/10, with 10 being the worst, which is sharp, dull and achy in nature. Right shoulder pain is worsened with movement, lifting objects, rotation, walking and overhead activities.

The patient complains of left knee pain that is 7/10, with 10 being the worst, which is sharp, dull and achy in nature. Left knee pain is worsened with walking, climbing stairs and squatting.

The patient complains of right knee pain that is 6/10, with 10 being the worst, which is sharp, dull and achy in nature. Right knee pain is worsened with walking, climbing stairs and squatting.

REVIEW OF SYSTEMS: The patient denies seizures, chest pain, shortness of breath, jaw pain, abdominal pain, fevers, night sweats, diarrhea, blood in urine, bowel/bladder incontinence, double vision, hearing loss, recent weight loss, episodic lightheadedness and rashes.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL / HOSPITALIZATION HISTORY: Noncontributory.

MEDICATIONS: None.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Unknown.

PHYSICAL EXAM:
General: The patient presents in an uncomfortable state.

Neurological Exam: Patient is alert and cooperative and responding appropriately. Cranial nerves II-XII grossly intact.

Deep Tendon Reflexes: Are 2+ and equal.

Sensory Examination: It is intact.

Manual Muscle Strength Testing: Is 5/5 normal.

Right Shoulder Examination: Reveals tenderness upon palpation of the right AC joint, glenohumeral, supraspinatus and scapular region Neer's test is positive, Hawkins test is positive and Yergason's test is positive. ROM is as follows: Abduction is 160 degrees, normal is 180 degrees; flexion is 130 degrees, normal is 180 degrees; external rotation is 90 degrees, normal is 90 degrees and internal rotation is 80 degrees, normal is 90 degrees.

Left Knee Examination: Reveals tenderness along the medial joint line and lateral joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 degrees and extension 4/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

Right Knee Examination: Reveals tenderness along the medial joint line. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 120/130 degrees and extension 4/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity.

GAIT: Normal.

Diagnostic Studies:
3/22/2018 - MRI of the left knee reveals the left knee is in good alignment. Sprain of the anterior cruciate ligament. Mild bone contusion of the intercondylar notch of the distal femur. No cortically based fracture is seen. No medial meniscal tear is seen. No lateral meniscal tear is seen. Hematoma of Hoffa's fat pad. The extensor mechanism and patellofemoral compartment are intact. The posterior cruciate ligament is intact. The collateral ligaments are intact. No muscle strain or muscle hematoma is seen. No popliteal cyst is noted. No osseous or soft tissue mass is seen.

The above diagnostic studies were reviewed.

Diagnoses:
S83.242A Medial meniscus tear, left knee.
S83.282A Lateral meniscus tear, left knee.
M23.92 Internal derangement, left knee.
M25.462 Joint effusion, left knee.
S80.912A Injury, left knee.
M25.562 Pain, left knee.
M65.162 Synovitis, left knee.
M23.91 Internal derangement, right knee.
S80.911A Injury, right knee.
M25.561 Pain, right knee.
M65.161 Synovitis, right knee.

Plan:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and right knee 3 days/week.
6. Though the patient continues to receive conservative therapy, there is no improvement as hoped. Since the patient's injuries are not healing from continued conservative management, the standard of care is surgery. So based upon the imaging results as well as the objective findings along with the patient's subjective complaints, surgery is medically indicated and is the best course of treatment to provide the best outcome. Hence, I am recommending surgery.
7. Discussed left knee arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient wants to think about surgery.
8. It is medically necessary to perform the suggested surgery to properly diagnose the patient's condition and to objectively verify presence and severity of internal derangement and other left knee pathology in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the left knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
11. All the questions in regard to the procedure were answered.
12. **Procedure - intra-articular right shoulder injection under ultrasound guidance:** I have performed an intra-articular steroid injection under ultrasound guidance of the right shoulder today. The patient has been receiving therapy since the accident and had an MRI of the right shoulder as noted above. The ultrasound will aid in assuring that the needle indeed enters the intra-articular space. In an effort to avoid surgery, this injection should

decrease inflammation and pain which will aid the physical therapist in achieving and maintaining the conditioned increase in the range of motion and overall expedite recovery.

13. **Procedure - right shoulder suprascapular nerve block:** Given the persistent right shoulder pain and multiple attempts of conservative care treatment including physical therapy, anti-inflammatories and intra-articular steroid injection with limited relief and persistent pain, a suprascapular nerve block was performed on the patient.
14. Follow up in 4 weeks.

IMPAIRMENT RATING: 75%.

CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.

AFFIRMATION: Being duly licensed to practice medicine in the state of New York, pursuant to the applicable provisions of the Civil Practice Laws and Rules, I hereby affirm under penalty of perjury that the statements contained herein are true and accurate.

Rehan Khan, FNP-BC
RK/AEI

Michael Murray, MD