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Initial Comprehensive Medical Evaluation

Date: 07/01/2022

RE: Onelia Sanchez
DOB: 3/23/1941
DOA: 06/25/2021
Location: Cruz Banting Imelda MD PT, North Bronx
Case Type: NF

1st Evaluation

HISTORY:
On 07/01/2022, Ms. Onelia Sanchez, a right-handed 81-year-old female presents for the evaluation of the injuries sustained in a motor vehicle accident which occurred on the date of 06/25/2021. Patient was a passenger on the MTA bus, when the bus started before she could sit, making her fall to the floor of the bus and hurting her right knee and bilateral shoulders. The patient reports injury to the head and no loss of consciousness. During the accident the patient reports injuries to bilateral shoulders and right knee.

CHIEF COMPLAINTS:
The patient complains of left shoulder pain that is 2-3/10, with 10 being the worst, which is dull and achy in nature.

The patient complains of right shoulder pain that is 2-3/10, with 10 being the worst, which is dull and achy in nature.

The patient complains of right knee pain that is 9/10, with 10 being the worst, which is sharp, dull and achy in nature. Right knee pain is worsened with movement, 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: Hypertension.

PAST SURGICAL / HOSPITALIZATION HISTORY: Left Shoulder surgery on 10-11 2021.

MEDICATIONS: None.

ALLERGIES: Seasonal.

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.

Left Shoulder Examination: Reveals tenderness upon palpation of the left AC joint and glenohumeral 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 160 degrees, normal is 180 degrees; external rotation is 80 degrees, normal is 90 degrees and internal rotation is 75 degrees, normal is 90 degrees.

Right Shoulder Examination: Reveals tenderness upon palpation of the right AC joint and glenohumeral region. Neer's test is positive, Hawkins test is positive and Yergason's test is positive. ROM is as follows: Abduction is 180 degrees, normal is 180 degrees; flexion is 180 degrees, normal is 180 degrees; external rotation is 75 degrees, normal is 90 degrees and internal rotation is 75 degrees, normal is 90 degrees.

Right 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 90/130 degrees and extension 0/5 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:
10/5/2021 - MRI of the left shoulder reveals postsurgical changes as described. There is however disruption of the supra and infraspinatus tendons with retraction tendon fibers and approximately 2.2 cm of gap between the proximal and distal tendon intrasubstance tear of the subscapularis and intra-articular biceps tendon. Tear of the superior labrum. Fluid in the subacromial, subdeltoid subcoracoid bursa as well as within the glenohumeral joint. Cystic change within the humeral head and ac joint arthrosis.
9/22/2021 - MRI of the right shoulder reveals complete disruption of the supraspinatus tendons with retraction or tendon fibers. Partial-thickness tearing the subscapularis tendon. Blunting and tearing of the superior labrum. AC joint arthrosis. Fluid in the subacromial, subdeltoid and subcoracoid bursa as well as within the glenohumeral joint.

9/22/2021 - MRI of the right knee reveals diffuse abnormal signal and thickening of the posterior and anterior cruciate ligament consistent with partial tearing sprain of the medial collateral ligament as well as sprain along the fibular collateral ligament and iliotibial bed. Tears within the anterior and posterior horn of the lateral meniscus as well as within the medial meniscus. There is medial subluxation of the posterior horn of the medial meniscus. Osteophytosis as described. Subchondral cystic change in the medial femoral condyle and medial tibial plateau is also noted. A sprain of the medial head of the gastrocnemius muscle. Large joint effusion and popliteal cyst. Fluid surrounding the medial head of the gastrocnemius muscle origin upon the femur consistent with sprain.

The above diagnostic studies were reviewed.

Diagnoses:

1. M25.511 Pain, right shoulder.
2. S49.91XA Injury, right shoulder.
3. M25.512 Pain, left shoulder.
4. S49.92XA Injury, left shoulder.
5. S83.241A Medial meniscus tear, right knee.
6. M23.91 Internal derangement, right knee.
7. S83.411A Medial collateral ligament sprain, right knee.
8. M25.461 Joint effusion, right knee.
9. S80.911A Injury, right knee.
10. M25.561 Pain, right knee.
11. Head contusion.

Plan:

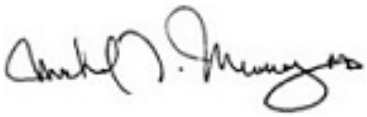
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for bilateral shoulder and right knee 3 days/week.
6. Discussed right 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.
7. 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 right 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.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the right 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.
10. All the questions in regard to the procedure were answered.

11. **Procedure - right knee intra-articular steroid injection:** I have performed a right knee intra-articular steroid injection under ultrasound guidance. The patient has been receiving physical therapy since the accident and had diagnostic studies of the right knee with the findings 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.
12. **Procedure - right knee genicular block:** I have performed a right knee genicular nerve block. The patient has been receiving physical therapy since the accident and had diagnostic studies of the right knee with the findings as noted above. 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. Follow up in 4 weeks.

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