

KDV Medical P.C.

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Date: 08/23/2022

RE: Onelia Sanchez

DOB: 3/23/1941

DOA: 06/25/2021

Location: Cruz Banting Imelda MD PT

ORTHOPEDIC RE-EVALUATION

CHIEF COMPLAINT: Right knee pain.

HISTORY:

This is a right-handed 81-year-old female who presents for follow-up evaluation of the injuries sustained in a motor vehicle accident which occurred on the date of 06/25/2021. Patient had right knee intraarticular injection on 07/01/22 with 3-4 weeks relief.

CHIEF COMPLAINTS:

The patient complains of right knee pain that is 8/10, which is constant in nature with weakness. Patient is having difficulty rising from chair and pain is worsened with climbing stairs. Patient reports clicking and buckling with range of motion.

PHYSICAL EXAM:

General: The patient is awake, alert, and oriented.

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

Diagnostic Studies:

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 band. 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:

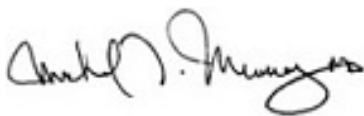
1. S83.241D Medial meniscus tear, right knee.
2. S83.281D Lateral meniscus tear, right knee.
3. S83.519D Anterior cruciate ligament tear, right knee.

4. S83.411D Medial collateral ligament sprain, right knee.
5. M25.461 Joint effusion, right knee.
6. M25.561 Pain, right knee.

Plan:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Continue anti-inflammatory and muscle relaxant medications p.r.n.
4. Continue physical therapy for right knee 3 days/week.
5. 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 would like to proceed with surgery.
6. 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. Discussed the length of the arthroscopy and the postoperative instructions. 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.
7. Patient needs medical clearance for the above surgery.
8. All the questions in regard to the procedure were answered.
9. 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 right knee on 06/25/21. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.



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Michael Murray, MD

NB/AEI