KDV Medical, P.C.
Tel #: 1-877-SPINE-DR
Fax: (347) 708-8499

October 18, 2022

Re: Nicaj Case 2, Peter
DOB: 07/01/1971
DOA: 05/11/2020
Location: Cruz Banting Imelda MD PT

ORTHOPEDIC RE-EVALUATION

CHIEF COMPLAINT: Right knee, left knee and left elbow pain.

HISTORY OF PRESENT ILLNESS: This is a 51-year-old right-hand dominant male who presents for follow-up evaluation of injuries sustained in a work related incident on 05/11/2020.

Right knee pain is 6/10. The patient complains of weakness. The patient has difficulty raising from a chair and walking up and down stairs. Patient reports clicking.

Left knee pain is 7/10, described as sharp. The patient complains of weakness and clicking.

The patient complains of left elbow pain that is 8/10 with 10 being the worst, which is constant in nature, with weakness. The elbow pain radiates with numbness and tingling to 4th and 5th digits. Patient has pain with lifting, carrying and driving. Patient had steroid injection 6 months ago without adequate relief of pain.

EMG completed with Neuro.

IMPAIRMENT RATING: Patient is currently and temporarily 100% disabled and not working.

PHYSICAL EXAMINATION:
Right Knee: No swelling, heat, erythema or crepitus noted. Reveals tenderness to palpation over medial and lateral joint line, and patella. Range of motion, flexion is 120 degrees, normal is 135 degrees and full extension. Positive McMurray test. Positive patellofemoral grinding test. Left knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the right lower extremity. Muscle strength 4-/5.

Left Knee: No swelling, heat, erythema or crepitus noted. Puncture scars noted. Reveals tenderness to palpation over medial and lateral joint line, and patella. Range of motion, flexion is 120 degrees, normal is 135 degrees and full extension. Left knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity. Muscle strength 4-/5.

Left Elbow: No heat, erythema, swelling noted. There is tenderness upon palpation over the medial and lateral epicondyle. Tinel's positive. Range of motion: extension is 0-150 degrees,

normal is 150 degrees; Flexion is 140 degrees, normal is 150 degrees; Supination is 90 degrees, normal is 90 degrees; Pronation is 90 degrees, normal is 90 degrees. Muscle strength is 4-/5. Pain noted with range of motion of elbow. Numbness and tingling of 4th and 5th digits.

DIAGNOSTIC STUDIES:

Right shoulder MRI, done on 09/13/2018, Low-grade edema deep to the ITB which can be seen in the setting of ITB friction. Focal undersurface tear of the posterior junctional zone of the medial meniscus. • Proximal patellar tendinosis. Suprapatellar effusion with eden1a in the quadriceps fat pad. Prepatellar soft tissue swelling.
Left knee MRI, done on 04/04/2022, Oblique tear of the posterior junctional zone and body of the medial meniscus contacting the free edge/inferior articular surface. No displacement. Mild patellar tendinosis. Small knee effusion.
10/05/2022 - UE NCV/EMG of the Abnormal study most suggestive of peripheral neuropathy involving the left ulnar never at the level of the elbow.
02/09/2021 - MRI of the left elbow: Scarring and sprain of anterior bundle of medial collateral ligament. Insertional tendinosis of biceps and triceps.

FINAL DIAGNOSES:

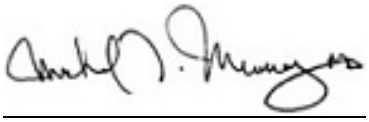
1. Joint effusion, right knee - M25.461
2. Medial Meniscus tear, right knee - S83.241D
3. Pain, right knee - M25.561
4. Joint effusion, left knee - M25.462
5. Medial Meniscus tear, left knee - S83.242D
6. Pain, left knee - M25.562
7. Popliteal cyst, Left knee. – M71.22
8. Internal derangement of the left elbow – M24.829
9. Left elbow, ulnar neuritis - G56.22
10. Pain, left elbow – M25.22

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 bilateral knees and left elbow 3 days/week.
5. Discussed left elbow 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. 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 elbow 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 left elbow 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. All the questions in regard to the procedure were answered.

6. The patient verbally consents for the arthroscopy of left elbow and the patient will be scheduled for left elbow surgery. On the day of the surgery, before the procedure, the surgeon will explain all related questions of the procedure. The patient will sign a written consent and be witnessed by the surgeon.
7. Workers' Compensation Board authorization needed prior to surgery.
8. The patient will follow up 4-6 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 diagnoses rendered are causally related to the injuries the patient incurred on the right knee, left knee, and left elbow on May 23, 2022. These current symptoms were nonexistent prior to the accident. Findings were discussed with the patient.



Nadezhda Bababekova, NP-BC
Michael Murray, MD

NB/AEI