

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

November 04, 2022

Office seen at:

Liberty Rhea Ranada Ebarle PT PC
14 Bruckner Blvd
Bronx, NY 10454
Phone# (718) 402-5200

Re: Jones, Miranda
DOB: 06/26/1977
DOA: 08/04/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and left knee pain.

HISTORY OF PRESENT ILLNESS: A 45-year-old right-hand dominant female involved in a motor vehicle accident on 08/04/2021. The patient was a rear seat passenger and was wearing a seatbelt. The vehicle was struck on the rear end. The airbags did not deploy. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder and left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 14 months with good relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory. There is a previous history of motor vehicle accident in 2015.

PAST SURGICAL HISTORY: Positive for spinal surgery in 2020 and 2011.

DRUG ALLERGIES: PENICILLIN.

MEDICATIONS: The patient is taking pain medications p.r.n.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She can sit for 5 minutes before needing to change positions secondary to pain. As a direct result of the injuries sustained in this accident, the patient states

that she is unable to do the following activities: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is able to reach overhead but unable to behind the back. Worse with range of motion and improves with rest, physical therapy.

Left knee: Left knee pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has no difficulty rising from a chair or going up and down stairs. The patient also notes buckling. Worse with range of motion and improves with rest, physical therapy.

REVIEW OF SYSTEMS: Temperature taken at the time of exam was 98.6 degrees Fahrenheit.

General: No fever, chills, night sweats, weight gain, or weight loss.

HEENT: No double vision, eye pain, eye redness, decreased hearing, earache, ear ringing, nosebleeds, sore throat or hoarseness.

Endocrine: No cold intolerance, appetite changes or hair changes.

Skin: Clear, no rashes or lesions.

Neuro: No headaches, dizziness, vertigo or tremor.

Respiratory: No wheezing, coughing, shortness of breath or difficulty breathing.

Cardiovascular: No chest pain, murmurs, irregular heart rate or hypertension.

GI: No nausea, vomiting, diarrhea, constipation, jaundice or changes in bowel habits.

GU: No blood in urine, painful urination, loss of bladder control or urinary retention.

Hematology: No active bleeding, bruising, anemia or blood clotting disorders.

Psychiatric: No anxiety, change in sleep pattern, depression or suicidal thoughts.

PHYSICAL EXAMINATION: The patient's height is 5 feet 2 inches, weight is 215 pounds, and BMI is 39.3. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint. There is no swelling, heat, erythema, or deformity appreciated. There is crepitus appreciated. Negative drop arm test. Negative cross-over test. Positive empty can test. Negative Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 125/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 45/60 degrees, internal rotation 50/90 degrees, and external rotation 65/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The left knee reveals tenderness along the medial joint line, superior pole of patella, inferior pole of the patella. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus 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 4/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 02/16/2022, shows partial tear of the distal supraspinatus tendon. Edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint, consistent with recent trauma. Fluid in the subacromial/subdeltoid bursa suggestive of underlying rotator cuff tears and/or subacromial/subdeltoid bursitis, in an appropriate clinical setting. MRI of the left knee, done on 03/03/2022, shows oblique tear in the posterior horn of the medial meniscus. Several subcentimeter erosive/osteochondral lesions with underlying bone marrow edema on the patellar articular surface and 6.0 mm erosive / osteochondral lesion on the anterior articular surface of the lateral femoral condyle. ACL appears thickened and heterogeneous suggestive of a sprain, in an appropriate clinical setting. Mild-to-moderate osteoarthritic changes, most prominent in the patellofemoral compartment.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M75.51 Bursitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M25.411 Joint effusion, right shoulder.
9. S83.242A Medial meniscus tear, left knee.
10. M23.92 Internal derangement, left knee.
11. S83.512A Anterior cruciate ligament sprain, left knee.
12. M22.2X2 Patellofemoral chondral injury, left knee.
13. M25.462 Joint effusion, left knee.
14. S80.912A Injury, left knee.
15. M25.562 Pain, left knee.
16. M93.262 Osteochondral lesion, left knee.
17. M17.12 Osteoarthritis, left 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 left knee 3 days/week.
6. Recommend steroid injections with pain management for right shoulder and left knee. The patient refuses due to side effects.
7. Discussed right shoulder and left knee arthroscopies versus conservative management with the patient. The patient refused any surgical intervention at this time.
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 right shoulder and left knee pathologies in quantitative and qualitative terms and achieve better prognosis. This surgery is crucial to provide most specific and maximally effective treatment to this patient.

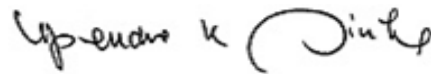
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the right shoulder and left knee arthroscopies have been discussed with the patient. The 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. Follow up as needed.

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.



Mellita Shakhmurov, PA-C
MS/AEI



U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon