U.K. Sinha Physician, P.C.

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May 25, 2022

Office seen at:
Bronx County Medical Care PC
4014A Boston Rd
Bronx, NY 10475
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Re: Paniagua, Kirk
DOB: 08/02/1959
DOA: 12/17/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder pain.

HISTORY OF PRESENT ILLNESS: A 62-year-old right-hand dominant male involved in a motor vehicle accident on 12/17/2021. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the driver's front side. The airbags did not deploy. The EMS arrived on the scene. The police were 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 pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 6 months with no relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Asthma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient smokes one-fourth pack of cigarettes per day. The patient does not drink alcohol. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for less than 1 block. He can stand for 15 minutes before he has to sit. He can sit for 10 minutes before needing to change positions secondary to pain. As a direct result of the injuries sustained in this accident, the patient states

that he is unable to do the following activities: play sports, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with medication.

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. The patient has asthma.
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 6 feet 0 inches, weight is 250 pounds, and BMI is 33.9. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, proximal biceps tendon, coracoid, and deltoid. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive 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 130/180 degrees, adduction 30/45 degrees, forward flexion 125/180 degrees, extension 35/60 degrees, internal rotation 55/90 degrees, and external rotation 50/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 04/01/2022, shows high-grade partial tear of the distal supraspinatus tendon. High-grade partial tear of the distal subscapularis tendon. Partial tear of the distal infraspinatus tendon. Fluid in the subacromial/subdeltoid bursa suggestive of underlying rotator cuff tears and/or subacromial/subdeltoid bursitis, in an appropriate clinical setting. Productive hypertrophic changes of the acromioclavicular joint with impingement of rotator cuff. Edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint, consistent with recent trauma. Long head of the bicep tendon sheath is severely distended with fluid, consistent with severe tenosynovitis. Severe osteoarthritic changes with subcortical cystic changes of the humeral head. Several up to the 2.0 cm subcentimeter subcortical cysts in the humeral head under the insertion of the rotator cuff. Large joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting. 2.0 x 1.0 cm high T2

and low T1 signal in the subchondral aspect of the articular surface of the humeral head, consistent with avascular necrosis of the humeral head

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M65.811 Tenosynovitis, right shoulder.
5. M75.51 Bursitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
9. M19.011 Primary osteoarthritis, right shoulder.
10. M25.411 Joint effusion, right shoulder.
11. Subcortical cyst humeral head, right shoulder.

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.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder 3 days/week.
6. Recommend steroid injections with pain management for right shoulder. The patient accepts.
7. Discussed right shoulder 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 right shoulder 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 right shoulder 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. 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.

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Mellita Shakhmurov, PA-C Upendra K. Sinha, MD
MS/AEI