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September 29, 2022

Office seen at:
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Re: Zabsonre, Moustapha
DOB: 01/01/1985
DOA: 06/03/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left shoulder, right knee, and left knee pain.

HISTORY OF PRESENT ILLNESS: The patient presents today in followup with continued pain in the left shoulder, right knee, and left knee.

ADL CAPABILITIES: The patient states that he can walk for 5 blocks. He can stand for 20 minutes before he has to sit. He 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 he 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: Left shoulder: Left shoulder pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable 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 rest.

Right knee: Right knee pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, and buckling. Worse with range of motion and improves with rest.

Left knee: Left knee pain is 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, and buckling. Worse with range of motion and improves with rest.

PHYSICAL EXAMINATION: The left shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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 135/180 degrees, adduction 30/45 degrees, forward flexion 140/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and external rotation 55/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The right knee reveals tenderness along the medial joint line, lateral joint line, and superior pole of patella. 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 85/130 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 right lower extremity.

The left knee reveals tenderness along the medial joint line, lateral joint line, and superior pole of patella. 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 85/130 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 left shoulder, done on 07/23/2022, shows trace amount of fluid in the glenohumeral joint. Distal anterolateral supraspinatus tendinosis/tendinopathy. Convex inferior hypertrophic change in the acromioclavicular joint abutting the supraspinatus. Laterally and distally anteriorly down sloping acromion abuts the supraspinatus. Distal anterolateral subscapularis tendinosis/tendinopathy. MRI of the right knee, done on 08/23/2022, shows medial meniscus prominent tear involving the posterior horn with a horizontal tear extending to the inferior meniscal surface near the free margin with the tear extending posteromedially into the body-posterior horn junction and into the body where it extends more obliquely to the inferior meniscal surface at its inner third. The tear extends to the capsular margin posteromedially at the body-posterior horn junction. Strain of the medial collateral ligament. Patellofemoral joint space narrowing with lateral patellar subluxation. Distal quadriceps and diffuse patellar tendinosis/tendinopathy. Reticulation in Hoffa's fat pad more so superiorly and posteriorly. Anterior cruciate ligament diffuse inhomogeneity and sprain and evidence of mucinous degeneration of the anterior cruciate ligament. Trace fluid in the medial gastrocnemius semimembranosus bursa. MRI of the left knee, done on 08/23/2022, shows large lateral meniscal tear involving the posterior horn extending to the superior meniscal surface with horizontal tear which intersects the meniscal surface near the free margin. The tear extends posterolaterally into the body-posterior horn junction where it also extends to the superior articular surface and extends into

the body where a horizontal tear intersects the superior meniscal surface at its inner third and extends through the capsular margin at this region. The tear extends into the body-anterior horn junction with a horizontal tear which is associated with intrameniscal cyst measuring up to 7 mm in size peripherally at the anterior horn-body junction of the lateral meniscus. Lateral tibiofemoral joint space narrowing particularly at its medial weightbearing articular surfaces. Strain of the anterior cruciate ligament with evidence of mucinous degeneration of the ACL. Posterior cruciate ligament more diffuse inhomogeneity and severe sprain with interstitial partial tearing but without rupture and extensive periligamentous edema surrounds the PCL which is diffusely abnormal. Medial meniscus horizontal tear in the posterior horn intersecting the free margin extending to the capsular margin posteromedially at the body-posterior horn junction with a posteromedial tear of the meniscus extending to the superior meniscal surface near the free margin. Thickening and sprain of the medial collateral ligament extending to its femoral attachment site. Slight degree of lateral patellar subluxation and a popliteal cyst tracking superiorly from the joint line measuring up to 3 cm. Distal greater than proximal patellar tendinosis/tendinopathy and distal quadriceps tendinosis/tendinopathy.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.82 Shoulder tendinitis, left shoulder.
3. M75.42 Impingement, left shoulder.
4. M25.512 Pain, left shoulder.
5. S49.92XA Injury, left shoulder.
6. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
7. M25.412 Joint effusion, left shoulder.
8. Type II acromion, left shoulder.
9. S83.241A Medial meniscus tear, right knee.
10. M23.91 Internal derangement, right knee.
11. S83.511A Anterior cruciate ligament sprain, right knee.
12. S83.411 Medial collateral ligament sprain, right knee.
13. S83.31XA Tear articular cartilage, right knee.
14. M25.461 Joint effusion, right knee.
15. S80.911A Injury, right knee.
16. M25.561 Pain, right knee.
17. M65.161 Synovitis, right knee.
18. M76.51 Prepatellar bursitis, right knee.
19. S83.242A Medial meniscus tear, left knee.
20. S83.282A Lateral meniscus tear, left knee.
21. M23.92 Internal derangement, left knee.
22. S83.512A Anterior cruciate ligament sprain, left knee.
23. S83.412A Medial collateral ligament sprain, left knee.
24. S83.32XA Tear articular cartilage, left knee.
25. M25.462 Joint effusion, left knee.
26. S80.912A Injury, left knee.
27. M25.562 Pain, left knee.

28. M65.162 Synovitis, left knee.
29. Posterior cruciate ligament tear, 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 left shoulder, right knee, and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, right knee, and left knee 3 days/week.
6. Recommend steroid injections with pain management for left shoulder, right knee, and left knee. The patient refuses due to side effects.
7. Discussed left shoulder, right knee, and left 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.
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 left shoulder, right knee, and left 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.
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 left shoulder, right knee, and left 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.
11. All the questions in regard to the procedure were answered.
12. The patient verbally consents for the arthroscopy of left knee and the patient will be scheduled for left knee 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.
13. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

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

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

MS/AEI