

UK Sinha Physician, P.C.

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September 13, 2022

Office seen at:
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Re: Reid, Michelle
DOB: 11/04/1970
DOA: 06/08/2022

FOLLOW-UP NOTE

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

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

ADL CAPABILITIES: The patient states that she can walk for 2 blocks. She can stand for 5 minutes before she has to sit. She can sit for 30 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: kneeling, 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 has weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Right knee: Right knee pain is 7-8/10, described as intermittent, 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, buckling, and intermittent locking.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per

goniometer, abduction 110/180 degrees, adduction 40/45 degrees, forward flexion 105/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The right knee reveals tenderness along the medial joint line and lateral joint line. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. 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.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 08/15/2022, shows arthrosis of the AC joint with impingement. Myotendinous supraspinatus strain/interstitial tear with associated tenosynovitis/bursitis as discussed in the body of the report. The visualized portions of the labrum appear intact. MRI of the right knee, done on 06/29/2022, shows increased T2 signal on the proton density sequence adjacent to the ACL indicating sprain. No definite tears. Horizontal tear extending to the inferior articular surface at the posterior horn of the medial meniscus. Oblique tear extending to the inferior articular surface in the posterior horn of the lateral meniscus. Patella cartilage erosion. Increased signal seen at the quadriceps insertion at the patella indicating tendinopathy. There is edema adjacent to the patella representing paratenonitis.

ASSESSMENT:

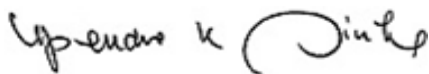
1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M75.51 Bursitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M25.411 Joint effusion, right shoulder.
9. S83.241A Medial meniscus tear, right knee.
10. M23.200 Lateral meniscus derangement, right knee.
11. M23.91 Internal derangement, right knee.
12. S83.511A Anterior cruciate ligament sprain, right knee.
13. S83.31XA Tear articular cartilage, right knee.
14. M22.2X1 Patellofemoral chondral injury, right knee.
15. M25.461 Joint effusion, right knee.
16. M12.569 Traumatic arthropathy, right knee.
17. S80.911A Injury, right knee.
18. M25.561 Pain, right knee.
19. M65.161 Synovitis, right knee.
20. M24.661 Adhesions, right 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 right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and right knee 3 days/week.
6. 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 would like to proceed with surgery.
7. 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.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. 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.
10. All the questions in regard to the procedure were answered.
11. The patient verbally consents for the arthroscopy of right shoulder and the patient will be scheduled for right shoulder 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.
12. 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.



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Board Certified Orthopedic Surgeon

UKS/AEI