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September 29, 2022

Office seen at:
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Re: Simon, Peterson
DOB: 02/24/1996
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 he can walk for 1/2 block. He can stand for 5 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: Right shoulder: Right shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is unable to reach overhead or behind the back and unable to sleep at night due to pain. Worse with range of motion and improves with rest, physical therapy.

Right knee: Right knee pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking, buckling. Worse with range of motion and improves with rest, physical therapy.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region. There is no swelling, heat, erythema, or deformity appreciated. There is crepitus 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 125/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 45/60 degrees, internal rotation 45/90 degrees, and external rotation 60/90 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, lateral 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 80/130 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.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 07/26/2022, shows partial-thickness articular surface tear of the distal infraspinatus tendon superimposed on infraspinatus and supraspinatus tendinitis. Associated subdeltoid/subacromial bursitis. Tear of the superior glenoid labrum anterior to posterior (SLAP tear). Moderate acromioclavicular joint disease. MRI of the right knee, done on 09/12/2022, shows alta position to patella with diffuse patellar tendinosis/tendinopathy. Distal quadriceps tendinosis/tendinopathy. Paucity of patellofemoral synovial fluid accumulating primarily medially and laterally at the level of the patellofemoral articulation. Prepatellar subcutaneous edema. Obliquely oriented tear involving the posterior horn and body-posterior horn junction of lateral meniscus extending to inferior meniscal surface at its middle third and broad undersurface thinning of the posterior horn of the lateral meniscus. Medial meniscus prominent truncation, erosion, and tear of its body with considerable loss of meniscal substance with most of its torn remnant extruded outside the confines of the medial tibiofemoral joint compartment with superimposed obliquely oriented tearing involving the body and body-posterior horn junction of the medial meniscus. Radial tearing extending to the body-posterior horn junction of the medial meniscus. Thickening and sprain of the medial collateral ligament. Medial tibiofemoral joint space narrowing with thinning of the chondral surface toward the medial aspect of medial tibial plateau. Subcortical reactive change at the posterosuperior non-weightbearing lateral femoral condyle at its posterosuperior capsule attachment site.

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. M75.51 Bursitis, right shoulder.
5. M25.511 Pain, right shoulder.
6. S49.91XA Injury, right shoulder.
7. M25.411 Joint effusion, right shoulder.
8. S83.241A Medial meniscus tear, right knee.
9. M23.200 Lateral meniscus derangement, right knee.
10. M23.91 Internal derangement, right knee.

11. S83.411 Medial collateral ligament sprain, right knee.
12. M25.461 Joint effusion, right knee.
13. S80.911A Injury, right knee.
14. M25.561 Pain, right knee.
15. M76.51 Prepatellar bursitis, right knee.

PLAN:

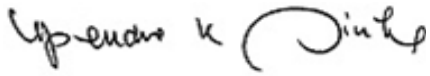
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder and right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and right knee 3 days/week.
6. Recommend steroid injections with pain management for right shoulder and right knee. The patient refuses due to side effects.
7. Discussed right shoulder and right 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 right shoulder and right 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 right shoulder and right 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 right knee and the patient will be scheduled for right 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



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MS/AEI