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June 13, 2022

Office seen at:
S.P. Physical Therapy
1320 Louis Nine Boulevard
Bronx, NY 10459
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Re: Roa, Oscar
DOB: 08/27/1969
DOA: 05/05/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, right knee, left knee, and left foot pain.

HISTORY OF PRESENT ILLNESS: A 52-year-old right-hand dominant male involved in a motor vehicle accident on 05/05/2022. The patient was a motorcyclist. The patient is an Uber Eats employee on duty, hit the front, flew off the motorcycle, and landed on the back. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient was transported via ambulance to Lincoln Hospital and was treated and released the same day. The patient presents today complaining of left shoulder, right knee, left knee, and left foot pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 1 month with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Plastic surgery face about 20-30 years ago, status post trauma MVA, nose deviated septum about 10 years ago, varicose vein in testicle about 30 years ago.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

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

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for 5 blocks. He can stand with no issues 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: negotiating stairs.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is unable to reach overhead, unable to reach behind the back. Worse with range of motion and improves with physical therapy.

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

Left knee: Left knee pain is 4/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. Worse with range of motion and improves with rest.

Left foot: Left foot pain is 9/10, described as constant, dull, achy pain. The patient has pain with walking and climbing. Worse with range of motion and improves with rest.

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 6 feet, weight is 216 pounds, and BMI is 29.3. The left shoulder reveals no tenderness to palpation. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Negative empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 140/180 degrees, adduction 40/45 degrees, forward flexion 145/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and external rotation 65/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the left upper extremity.

The right knee reveals no tenderness to palpation. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Negative

Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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.

The left knee reveals no tenderness to palpation. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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 left lower extremity.

The left foot ROM intact. Positive flat foot, anterior aspect, tenderness.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 05/12/2022, shows moderate AC joint arthrosis with capsular sprains and a small effusion. Tendinopathy and bursal surface fraying of the supraspinatus and infraspinatus tendons. Tear of the superior and anterior labrum. Multilobulated ganglion cyst extending from the suprascapular notch to the spinoglenoid notch measuring approximately 3.5 cm. MRI of the right knee, done on 05/11/2022, shows superficial involvement of chondral surface erosion of the lateral patellar facet, measuring approximately 6 mm in transverse dimension. Synovial fluid accumulated medially and laterally at the level of the patellofemoral articulation and there is edema in prepatellar subcutaneous tissues. Superior patellar tendinosis/tendinopathy. Strain of the anterior cruciate ligament and there is pericruciate edema. Central type I signal alteration of the posterior horn and body-posterior horn junction of the medial meniscus. Strain of the medial collateral ligament at its femoral attachment site. Edema in the subcutaneous tissues medially and extending anteromedially at the level peripheral to the knee joint margin. Focal chondral surface signal alteration and chondral surface irregularity of the medial tibial plateau approximately 1 cm from its medial weightbearing margin. Thin popliteal cyst tracking superiorly from the joint line measuring up to 3.5 cm. MRI of the left knee, done on 05/11/2022, shows subcortical fracture involving the anterior weightbearing margin of the lateral tibial plateau, without depression, with the fracture measuring approximately 1 cm in greatest dimension. Marrow edema is present associated with the fracture indicating a recent injury. Peripheral tear involving the body-posterior horn junction of the medial meniscus extending focally to the capsular margin inferiorly with adjacent obliquely-oriented component to the tear extending through the red-white zone at the peripheral third of the meniscus. Signal alteration and thinning of the chondral surface at the lateral weightbearing surface of the medial femoral condyle. Strain of the medial collateral ligament at its anterior attachment site on the femur is present. Anterior cruciate ligament inhomogeneity and sprain with pericruciate edema. Popliteal cyst tracking primarily superiorly from the joint line measuring approximately 6 cm. Superficial chondral surface irregularity approximately 4 mm in transverse dimension extending slightly lateral from the midline ridge of the patella within the lateral patellar facet. Paucity of patellofemoral synovial fluid. MRI of the left foot, 05/13/2022, shows subcortical bone marrow edema involving the lateral base of the first metatarsal with erosion of the cortex. Chrondral surface and cortical thinning and underlying subcortical bone marrow edema involving the lateral convexity of the first metatarsal head at the first metatarsophalangeal joint. Subcortical cystic foci benign in appearance base of the anterior

process of the calcaneus. Edema in the sinus tarsi with a ganglion cyst tracking dorsally from the medial aspect of the sinus tarsi measuring up to approximately 1.5 cm. Flat foot appearance. Peroneus brevis tendon which is slightly attenuated at the level of the malleolus and a dedicated ankle MRI would b advised if warranted clinically for the characterization and overall appearance of the integrity of the peroneus brevis. Trace peroneus brevis and posterior tibial as well as flexor hallucis longus tenosynovitis and there is also tibiotalar and posterior subtalar joint fluid. Marrow edema involving the tibial sesamoid compatible with sesamoditis and there is also edema in the plantar subcutaneous tissues at the level of the first metatarsal head. Evidence of intermetarasal bursitis involving the first, second and third interdigital spaces at the metatarsophalangeal joint level.

ASSESSMENT:

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. S43.432A Labral tear, left shoulder.
5. M25.512 Pain, left shoulder.
6. S49.92XA Injury, left shoulder.
7. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
8. M25.412 Joint effusion, left shoulder.
9. S83.241A Medial meniscus tear, right knee.
10. M23.91 Internal derangement, right knee.
11. S83.519A Anterior cruciate ligament tear, right knee.
12. S83.511A Anterior cruciate ligament sprain, right knee.
13. S83.411A Medial collateral ligament sprain, right knee.
14. M22.2X1 Patellofemoral chondral injury, right knee.
15. M25.461 Joint effusion, right knee.
16. S80.911A Injury, right knee.
17. M25.561 Pain, right knee.
18. M65.161 Synovitis, right knee.
19. S83.242A Medial meniscus tear, left knee.
20. M23.92 Internal derangement, left knee.
21. S83.512A Anterior cruciate ligament sprain, left knee.
22. S83.412A Medial collateral ligament sprain, left knee.
23. M22.2X2 Patellofemoral chondral injury, left knee.
24. M25.462 Joint effusion, left knee.
25. S80.912A Injury, left knee.
26. M25.562 Pain, left knee.
27. Subchondral cyst, left knee.
28. Flat foot, left foot.
29. Tenosynovitis, left foot.

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, left knee, and left foot.

4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, right knee, left knee, and left foot 3 days/week.
6. Recommend steroid injections with pain management for left shoulder, right knee, left knee, and left foot. The patient refuses due to side effects.
7. Discussed left shoulder, right knee, left knee, and left foot arthroscopy versus conservative management with the patient. The patient refuses any intervention as the pain does not warrant intervention as per the patient.
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, left knee, and left foot 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, left knee, and left foot 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. Refer to podiatrist.
13. Follow up on a p.r.n. basis.

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