

UK Sinha Physician, P.C.

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July 20, 2022

Office seen at:
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Phone# (718) 346-6580

Re: Heredia, Martha
DOB: 03/01/1977
DOA: 04/18/2022

FOLLOW-UP NOTE

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

HISTORY OF PRESENT ILLNESS: The patient presents today in followup with continued pain in the right shoulder and left shoulder. The patient is status post left shoulder arthroscopy.

ADL CAPABILITIES: As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: driving, lifting heavy objects, carrying, 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.

Left shoulder: Left shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient is unable to reach overhead and able to reach behind the back. Worse with range of motion and improves with physical therapy. Status post arthroscopy.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 120/180 degrees, adduction 30/45 degrees, forward flexion

125/180 degrees, extension 40/60 degrees, internal rotation 55/90 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 left shoulder is nontender. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 165/180 degrees, adduction 40/45 degrees, forward flexion 170/180 degrees, extension 55/60 degrees, internal rotation 75/90 degrees, and external rotation 80/90 degrees. Internal rotation to the mid back. The patient has no motor or sensory deficit of the left upper extremity. Status post arthroscopy.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 06/04/2022, shows high-grade partial tear of the distal supraspinatus tendon. Partial tear of the distal infraspinatus tendon. Edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint consistent with recent trauma. Fluid in the subacromial/subdeltoid bursa suggestive of underlying cuff tears and/or subacromial/subdeltoid bursitis, in an appropriate clinical setting. Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting. MRI of the left shoulder, done on 06/04/2022, shows partial tear of the distal supraspinatus tendon. Partial tear of the distal subscapularis tendon. Low-lying acromion with impingement of rotator cuff, in an appropriate clinical setting. Edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint consistent with recent trauma. Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting.

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. M75.41 Impingement, right shoulder.
5. M65.811 Tenosynovitis, right shoulder.
6. M75.51 Bursitis, right shoulder.
7. M25.511 Pain, right shoulder.
8. S49.91XA Injury, right shoulder.
9. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
10. M25.411 Joint effusion, right shoulder.
11. M25.512 Pain, left shoulder.
12. Status post arthroscopy, left 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 and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.

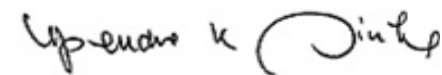
6. Recommend steroid injections with pain management for right shoulder. The patient refuses due to side effects.
7. Discussed right shoulder arthroscopy versus conservative management with the patient. The patient states that due to continual pain and lack of relief with physical therapy and the inability to perform day-to-day activities due to pain, the patient 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 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. 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.
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

MS/AEI



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Board Certified Orthopedic Surgeon