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August 22, 2022

Office seen at:
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Re: Derby, Issa
DOB: 11/06/1961
DOA: 04/12/2022

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.

ADL CAPABILITIES: The patient states that she can walk for 1 block. She can stand for 5 minutes before she has to sit. She can sit for 10 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: play sports, lifting heavy objects, childcare, carrying heavy objects, reaching overhead, kneeling, squatting, negotiating stairs, and jogging.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has 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. Worse with range of motion and improves with rest, medication, and physical therapy.

Left shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient is able to reach overhead, able to reach behind the back. Worse with range of motion and improves with rest.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region, proximal biceps tendon, and deltoid. 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. 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 95/180 degrees, adduction 35/45 degrees, forward flexion 100/180 degrees, extension 45/60 degrees, internal rotation 50/90 degrees, and external rotation 65/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. There is crepitus appreciated. There is no heat, swelling, erythema and 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 45/45 degrees, forward flexion 140/180 degrees, extension 45/60 degrees, internal rotation 45/90 degrees, and external rotation 45/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 05/04/2022, shows focal nonretracted interstitial tear at the attachment of the supraspinatus. Type II SLAP tear. Mild fluid in subacromial-subdeltoid bursa compatible with bursitis or may be seen with full thickness rotator cuff tear. MRI of the left shoulder, done on 06/20/2022, shows cuff tendinosis, tendinitis and tendinopathy. Impingement. Chondromalacia with erosions and/or osteochondral defects. Synovitis. Hypoplastic labrum and biceps tendon. Please see body of report.

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. M43.431A SLAP tear.
5. M75.51 Bursitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. M25.411 Joint effusion, right shoulder.
8. M24.812 Internal derangement, left shoulder.
9. M75.82 Shoulder tendinitis, left shoulder.
10. M75.42 Impingement, left shoulder.
11. M65.812 Tenosynovitis, left shoulder.
12. M25.512 Pain, left shoulder.
13. S49.92XA Injury, left shoulder.
14. M94.212 Chondromal, glen/HH, left shoulder.
15. M19.012 Primary osteoarthritis, left shoulder.
16. M25.412 Joint effusion, 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 and left shoulder. The patient refuses due to side effects.
7. Discussed right shoulder and left 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 and left 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 and left 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 left 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

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

MS/AEI