

UK Sinha Physician, P.C.

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September 09, 2022

Office seen at:

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Re: Brito, Madelyn
DOB: 12/06/1975
DOA: 04/29/2022

FOLLOW-UP NOTE

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

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

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She 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 she 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 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has weakness, popping, and clicking. 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, medication, physical therapy, and ice.

Left knee: Left knee pain is 6-7/10, 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. 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. There is no swelling, heat, 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 120/180 degrees, adduction 40/45 degrees, forward flexion 100/180 degrees, extension 40/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 degrees. The patient has no motor or sensory deficit of the right upper extremity.

The left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity 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 3/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 07/06/2022, shows articular surface partial tear for a length of about 10 mm at the attachment of the supraspinatus tendon. AC joint arthrosis. Mild fluid in subacromial-subdeltoid bursa compatible with bursitis. MRI of the left knee, done on 08/01/2022, shows iliotibial band syndrome. Partial lateral collateral ligament and labral capsular tearing. Partial ACL tear. Tear of the posterior horn of the medial meniscus. Erosive disease. 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. M75.41 Impingement, right shoulder.
5. M75.51 Bursitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
9. M25.411 Joint effusion, right shoulder.
10. S83.242A Medial meniscus tear, left knee.
11. M23.92 Internal derangement, left knee.
12. S83.519A Anterior cruciate ligament tear, left knee.
13. M25.462 Joint effusion, left knee.
14. S80.912A Injury, left knee.
15. M25.562 Pain, left knee.
16. Lateral collateral ligament tear, left knee.
17. Iliotibial band syndrome, left 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 left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left knee 3 days/week.

6. Recommend steroid injections with pain management for right shoulder and left knee. The patient refuses due to side effects.
7. Discussed right shoulder and left 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. The patient needs medical clearance prior to surgery. The patient must take care of ongoing vertigo.
9. 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 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.
10. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
11. All the benefits and risks of the right shoulder and left 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.
12. All the questions in regard to the procedure were answered.
13. The patient verbally consents for the arthroscopy of right shoulder and left knee and the patient will be scheduled for right shoulder and left knee surgery after medical condition taken care off. 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.
14. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.

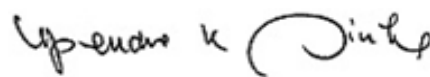
CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the 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