UK Sinha Physician, P.C.

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October 18, 2022

Office seen at:
Gurvansh Anand Chiropractic PC
2598 3rd Avenue
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Re: Simmons, Jody
DOB: 09/19/1957
DOA: 05/22/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder and right knee pain.

HISTORY OF PRESENT ILLNESS: A 65-year-old right-hand dominant female involved in a motor vehicle accident on 05/22/2022. The patient was a bus passenger. The bus driver closed the door on right leg from the knee down. The EMS arrived on the scene. The police were not called to the scene of the accident. The patient was transported via ambulance to NewYork-Presbyterian Hospital and was treated and released the same day. The patient presents today complaining of right shoulder and right knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 4.5 months with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Tubal ligation about 40 years of ago.

DRUG ALLERGIES: PERCOCET.

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

SOCIAL HISTORY: The patient vapes. The patient drinks alcohol socially. The patient does not use recreational drugs.

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 9/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is able to reach overhead and able to reach behind the back, but is unable to sleep at night due to pain. Worse with range of motion and improves with rest.

Right knee: Right knee pain is 7.5/10, 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.

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 5 feet 10 inches, weight is 154 pounds, and BMI is 22.1. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, and proximal biceps tendon. 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 105/180 degrees, adduction 30/45 degrees, forward flexion 110/180 degrees, extension 35/60 degrees, internal rotation 45/90 degrees, and external rotation 50/90 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, superior pole of the patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Positive posterior drawer. Range of motion reveals flexion 90/130 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 10/03/2022, shows that tendinosis/tendinopathy remains within the supraspinatus tendon with heterogeneous intrasubstance signal abnormality ventrally approaching the distal insertion. Trace fluid within the glenohumeral joint and long head biceps tendon sheath. Now some thickening of the ventral-inferior glenohumeral joint capsule which, in the proper clinical setting, is consistent with adhesive capsulitis (frozen shoulder). Hypertrophic changes of the AC joint remain, ventrally and laterally downsloping acromion which abuts the bursal surface of the rotator cuff. MRI of the right knee, done on 10/03/2022, shows patellofemoral joint space narrowing with diffuse chondral surface thinning of the medial patellofemoral articular surfaces extending to the midline of the trochlear groove as well as midline ridge of the patella. Paucity of patellofemoral synovial fluid and anterior tibiofemoral synovial fluid. Edema in the prepatellar subcutaneous tissues and distal patellar tendinosis/tendinopathy. Chondral surface erosion involving the lateral femoral condyle involving its posterior and posteromedial weightbearing portion extending superiorly to involve its posterior non-weightbearing portion. Cortical erosion and subcortical reactive bone marrow edema, particularly involving the most medial 1.5 cm of the weightbearing lateral femoral condyle. Focal thinning of the chondral surface of the medial femoral condyle at its central to slightly medial weightbearing portion and thinning of the medial tibiofemoral joint compartment. Thickening and sprain of the medial collateral ligament. Focal peripheral tear involving the body-posterior horn junction of the medial meniscus at its inferior capsule attachment site, located posteromedially. Anterior and posterior cruciate ligament strain.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, 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. Type II acromion, right shoulder.
11. S83.241A Medial meniscus tear, right knee.
12. M23.91 Internal derangement, right knee.
13. S83.511A Anterior cruciate ligament sprain, right knee.
14. S83.411 Medial collateral ligament sprain, right knee.
15. S83.31XA Tear articular cartilage, right knee.
16. M22.2X1 Patellofemoral chondral injury, right knee.
17. M25.461 Joint effusion, right knee.
18. S80.911A Injury, right knee.
19. M25.561 Pain, right knee.
20. M17.11 Osteoarthritis, right knee.

21. M70.41 Prepatellar bursitis, right knee.
22. Posterior collateral ligament sprain, right knee.

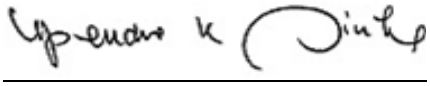
PLAN:

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. The patient needs medical clearance prior to surgery.
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 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.
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 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.
12. All the questions in regard to the procedure were answered.
13. 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.
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



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MS/AEI