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October 17, 2022

Office seen at:
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Re: Marks, Juliet
DOB: 03/17/1971
DOA: 01/31/2022

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: 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 5-6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, 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.

Left shoulder: Left shoulder pain is 5/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness, 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.

PHYSICAL EXAMINATION: Postop. The right shoulder reveals tenderness to palpation over supraspinatus tendon region. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative 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 160/180 degrees, adduction 40/45 degrees, forward flexion 170/180 degrees, extension 55/60 degrees, internal rotation 80/90 degrees, and external rotation 80/90

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. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative 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 120/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 75/90 degrees, and external rotation 80/90 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 03/10/2022, shows suggestive shoulder impingement with low-lying acromion on both supraspinatus and infraspinatus tendons, with concomitant tendinosis, and articular surface tear of the posterior infraspinatus. At this level there is also concomitant subjacent subcortical edematous and cystic change of the posterior humeral head which any also suggest concomitant contusion or sequelae of repetitive microtrauma. There is also a broad tear extending from the junction of both infraspinatus and supraspinatus fibers involving both bursa and articular surfaces toward the anterior supraspinatus attachment. Acromioclavicular osteoarthrosis with inflammatory changes of joint capsule and sprain of coracohumeral and coracoacromial ligaments. Subacromial/subdeltoid bursitis. Glenohumeral joint space narrowing with chondral loss, inferomedial osteophytosis. Inferior labial tear 6:00 axis series 6 image 12. Mild subscapularis tendinopathy and sprain of superior glenohumeral ligament. MRI of the left shoulder, done on 03/10/2022, shows shoulder impingement with low-lying acromion predominantly the supraspinatus. Infraspinatus tendinosis with rim rent tear, concomitant subcortical contusion and cystic change of the posterior humeral head series 5 image 5, 6. There is also supraspinatus tendinosis, with broad segment of increased signal with fraying along both superior and inferior margins compatible with an interstitial tear of the supraspinatus at just below the acromioclavicular level and extending distally toward attachment series 5 image 11, 12. Concomitant mild inflammatory changes of the acromioclavicular joint capsule and mild subacromial bursitis. Mild glenohumeral osteophytic changes. Free fluid in the subcoracoid recess and mild subscapularis tendinopathy.

ASSESSMENT:

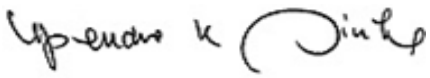
1. M24.811 Internal derangement, right shoulder.
2. M75.41 Impingement, right shoulder.
3. M25.511 Pain, right shoulder.
4. S49.91XA Injury, right shoulder.
5. Arthroscopy on 08/04/2022.
6. S46.012A Partial rotator cuff tear, left shoulder.
7. M24.812 Internal derangement, left shoulder.
8. M75.02 Adhesive Capsulitis, left shoulder.
9. M75.42 Impingement, left shoulder.
10. M25.512 Pain, left shoulder.
11. S49.92XA Injury, 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. Discussed 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 wants to think about surgery.
7. 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 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.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the 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.
10. All the questions in regard to the procedure were answered.
11. Followup in 4 weeks.

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.



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UKS/AEI