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November 07, 2022

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Re: Hedge, Noel
DOB: 02/24/1965
DOA: 08/06/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left knee pain.

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

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 5 minutes before he has to sit. He 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 he is unable to do the following activities: carrying heavy objects, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: 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, and buckling.

PHYSICAL EXAMINATION: The left knee reveals tenderness along the medial joint line and superior pole of patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 degrees and extension 0/5 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 left knee, done on 10/07/2022, shows an intrasubstance signal in the body and posterior horn of medial meniscus, which may represent an intrasubstance tear. Myxoid degeneration in the anterior horn of medial meniscus and in both horns of lateral

meniscus. Sprain of the anterior cruciate ligament. Buckling of the posterior cruciate ligament. Grade I injury of medial collateral ligament. Mild fluid in relation to the medial collateral ligament, suggestive of medial collateral ligament bursitis. Quadriceps and patellar tendinosis. Mild synovial effusion. Mild changes of osteoarthritis in the knee joint. The patellar cartilage is irregular and reveals hyperintense signal with erosions of the underlying bone. This can be due to injury or can represent chondromalacia patellae (grade III). Subtle, altered marrow signal intensity involving the distal femur and proximal tibia. This can represent mild degenerative marrow edema. Diffuse subcutaneous edema around the knee joint. A few prominent varicosities surrounding the knee joint.

ASSESSMENT:

1. S83.242A Medial meniscus tear, left knee.
2. M23.92 Internal derangement, left knee.
3. M94.262 Chondromalacia, left knee.
4. M25.462 Joint effusion, left knee.
5. M12.569 Traumatic arthropathy, left knee.
6. S80.912A Injury, left knee.
7. M25.562 Pain, left knee.
8. M65.162 Synovitis, left knee.
9. M24.662 Adhesions, left knee.

PLAN:

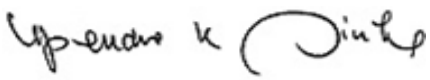
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left knee 3 days/week.
6. Discussed 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.
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 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.
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 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.
10. All the questions in regard to the procedure were answered.
11. The patient verbally consents for the arthroscopy of left knee and the patient will be scheduled for left 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.

12. 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.



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