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Office seen at:
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Re: Jorge, Victor
DOB: 01/03/1979
DOA: 05/11/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left shoulder and left elbow pain.

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

PAST ACCIDENTS: MVA in 2012 – closed, back only.

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, reaching overhead, laundry, and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 9/10, 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 elbow: Left elbow pain is 7-8/10, described as constant, dull, achy pain. Denies weakness, numbness, tingling. The patient has pain with lifting, carrying, and driving. Worse with range of motion and improves with medication.

PHYSICAL EXAMINATION: The left 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 90/180 degrees, adduction 35/45 degrees, forward flexion 95/180 degrees, extension 40/60 degrees, internal rotation 45/90 degrees, and external rotation 40/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left elbow reveals muscle strength is 4/5. Negative Tinel sign. Range of motion reveals flexion 140/150 degrees, extension -15/150 degrees, supination 80/90 degrees, pronation 80/90 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 06/30/2022, shows severe AC joint arthrosis. Interstitial tear for a length of 2 cm at the attachment of the supraspinatus tendon. Type II SLAP tear at superior aspect of labrum. MRI of the left elbow, done on 08/06/2022, shows linear interstitial tearing of the triceps tendon at the level of its insertion. Hyperintense signal at the origin of the common flexor tendon compatible with partial tear.

ASSESSMENT:

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. S43.432A Labral tear, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M25.512 Pain, left shoulder.
6. S49.92XA Injury, left shoulder.
7. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
8. M25.412 Joint effusion, left shoulder.
9. Tear of the triceps tendon, left elbow.
10. Partial tear of the common flexor tendon, left elbow.

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 shoulder and left elbow.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and left elbow 3 days/week.
6. Recommend steroid injections with pain management for left shoulder and left elbow. The patient refuses due to side effects.
7. Discussed left shoulder and left elbow 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 left shoulder and left elbow 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 left shoulder and left elbow 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 left shoulder and left elbow and the patient will be scheduled for left 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.
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