UK Sinha Physician, P.C.

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Office seen at:
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Re: Williams, Cheryl
DOB: 09/22/1972
DOA: 05/02/2022

FOLLOW-UP NOTE

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

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

ADL CAPABILITIES: The patient states that she can walk for 2 blocks. She can stand for 1/2 hour before she has to sit. She can sit for 1 hour 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: garden, play sports, lifting heavy objects, carrying heavy objects, laundry, kneeling, squatting, negotiating stairs, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 5/10, 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 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.

Right knee: Right knee pain is 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.

Left knee: Left knee pain is 8/10, 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.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region, trapezius, and proximal biceps tendon. 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. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 160/180 degrees, adduction 45/45 degrees, forward flexion 150/180 degrees, extension 50/60 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, trapezius, and proximal biceps tendon. 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 160/180 degrees, adduction 40/45 degrees, forward flexion 140/180 degrees, extension 50/60 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 left upper extremity.

The right knee reveals tenderness along the superior pole of patella and inferior pole of the patella. There is swelling and crepitus appreciated. There is no heat, erythema or deformity appreciated. Negative McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 120/130 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 right lower extremity.

The left knee reveals tenderness along the medial 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. Negative Lachman test. Positive patellofemoral grinding test. Negative 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 right shoulder, done on 07/12/2022, shows there is increased bone marrow edema at the proximal right humeral neck and AC joint from trauma sequela. Increased intrasubstance signal at the anterior leading edge and fluid inferiorly representing a partial tear of the supraspinatus tendon, and with no muscle or tendon retraction. Bone marrow edema of the AC joint and hypertrophy contributing to supraspinatus outlet obstruction. Long head biceps tendon is intact with tenosynovitis. MRI of the left shoulder, done

on 07/12/2022, shows increased bone marrow of the proximal left humerus glenoid portion of the scapula and AC joint. There is an intramuscular cyst of the supraspinatus tendon, fluid seen inferiorly and intrasubstance increased signal indicating partial tear at the articular surface with no muscle or tendon retraction of the supraspinatus tendon. AC joint pulmonary edema present with hypertrophy contributing to supraspinatus outlet obstruction. Tenosynovitis of the long head biceps tendon. MRI of the left knee, done on 06/21/2022, shows trace suprapatellar effusion. Multiple small osteochondral defects are seen predominantly at the lateral patellar facet. Differential diagnosis includes foci of osteochondritis dissecans versus osteochondral fracture. Please correlate clinically. Grade I signal posterior horn of the medial meniscus corresponds to mucoid changes.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M65.811 Tenosynovitis, right shoulder.
6. M75.21 Bicipital tendinitis, right shoulder.
7. M25.511 Pain, right shoulder.
8. S49.91XA Injury, right shoulder.
9. M25.411 Joint effusion, right shoulder.
10. S46.012A Partial rotator cuff tear, left shoulder.
11. M24.812 Internal derangement, left shoulder.
12. M75.02 Adhesive Capsulitis, left shoulder.
13. M75.42 Impingement, left shoulder.
14. M65.812 Tenosynovitis, left shoulder.
15. M75.22 Bicipital Tendinitis, left shoulder.
16. M25.512 Pain, left shoulder.
17. S49.92XA Injury, left shoulder.
18. M25.412 Joint effusion, left shoulder.
19. M23.91 Internal derangement, right knee.
20. S80.911A Injury, right knee.
21. M25.561 Pain, right knee.
22. MRI ordered, right knee.
23. S83.242A Medial meniscus tear, left knee.
24. M23.92 Internal derangement, left knee.
25. M94.262 Chondromalacia, left knee.
26. M22.2X2 Patellofemoral chondral injury, left knee.
27. M25.462 Joint effusion, left knee.
28. M12.569 Traumatic arthropathy, left knee.
29. S80.912A Injury, left knee.
30. M25.562 Pain, left knee.
31. M65.162 Synovitis, left knee.
32. M24.10 Chondral lesion, left knee.
33. Cortisone injection given today, 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, left shoulder, right knee, and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, and left knee 3 days/week.
6. Recommend steroid injections with pain management for left knee. The patient accepts
7. Cortisone injection given in the left knee today, 0.25% Marcaine 3 cc and Depo-Medrol 1 cc.
8. The patient is going for MRI of the right knee.
9. Follow up in 2 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.

U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon

UKS/AEI