

UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

August 01, 2022

Office seen at:
Graham Wellness Medical P.C.
150 Graham Avenue Suite A
Brooklyn NY 11206
Phone# (718) 218-6616

Re: Gibson, Erika
DOB: 02/08/1976
DOA: 05/01/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 46-year-old right-hand dominant female involved in a motor vehicle accident on 05/01/2022. The patient was a pedestrian who had an impact on the left side of her body. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient was transported via car to NewYork-Presbyterian Brooklyn Methodist Hospital and was treated and released the same day. The patient presents today complaining of left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 months with little relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Hypertension. The patient has no history of any prior trauma.

PAST SURGICAL HISTORY: Bilateral bunion surgery in 2012 with screws.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking enalapril 10 mg and pain medications p.r.n.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol occasionally. 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: carrying heavy objects, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 8.5/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking, popping, and intermittent locking. Worse with range of motion and improves with rest and ice.

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 or irregular heart rate. The patient has 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 2 inches, weight is 150 pounds, and BMI is 27.4. The left knee reveals tenderness along the medial joint line, superior pole of patella. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus appreciated. Negative McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 80/130 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 left lower extremity.

DIAGNOSTIC TESTING: MRI of the left knee, done on 06/23/2022, shows posterior medial meniscocapsular junction sprain. Edema within the anterior pre-femoral fat likely representing a soft tissue contusion. Linear interstitial tearing of the distal quadriceps tendon superimposed on tendinitis.

ASSESSMENT:

1. M23.92 Internal derangement, left knee.
2. S80.912A Injury, left knee.
3. M25.562 Pain, left knee.
4. Distal quadriceps tendon tear, left knee.
5. Medial meniscocapsular junction sprain, left knee.
6. Tendinitis, left knee.

PLAN:

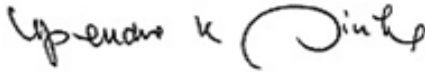
1. Imaging studies and clinical examinations were reviewed with the patient.

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. Recommend steroid injections with pain management for left knee. The patient refuses due to side effects.
7. 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.
8. 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.
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. 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.
11. All the questions in regard to the procedure were answered.
12. 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.
13. 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
MS/AEI



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