UK Sinha Physician, P.C.

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

September 30, 2022

Re: Pouponneau, Fabiola
DOB: 07/24/1982
DOA: 06/08/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and left knee pain.

HISTORY OF PRESENT ILLNESS: A 40-year-old right-hand dominant female involved in a motor vehicle accident on 06/08/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the front driver side. The airbags deployed. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Downstate Medical Center and was treated and released the same day. The patient presents today complaining of left shoulder and 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, only stopped for 2 days after date of accident.

PAST MEDICAL HISTORY: Noncontributory. There is a previous history of MVA on 07/17/2021 which is open (other sites).

PAST SURGICAL HISTORY: C-section x2 in 2004 and in 2012.

DRUG ALLERGIES: OVER-THE-COUNTER.

MEDICATIONS: The patient is not taking any medication at this time.

SOCIAL HISTORY: The patient is a nonsmoker. The patient does not drink alcohol. 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: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with medication and physical therapy.

Left knee: Left knee pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes popping, buckling, and intermittent locking. Worse with range of motion and improves with rest, medication, and physical therapy.

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, irregular heart rate or 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 4 inches, weight is 160 pounds, and BMI is 27.5. The left shoulder reveals tenderness to palpation over supraspinatus tendon region and trapezius. 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 140/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 70/90 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 left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema, crepitus 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 left shoulder, done on 09/11/2022, shows supraspinatus tendon becomes bulbous at its anterior leading edge and distally representing tendinosis/tendinopathy. Slightly low lying position to the anterior acromion with

acromioclavicular joint hypertrophic changes and capsular bulging, accompanied by laterally down sloping type II acromion that abuts the underlying supraspinatus. Paucity of fluid at the subscapularis recess of the glenohumeral joint. There is technical limitation due to patient motion throughout the examination. Most severely of affecting oblique coronal and oblique sagittal images. Please see above discussion. MRI of the left knee, done on 09/11/2022, shows lateral patellar subluxation. Synovial fluid accumulating medially and laterally at the level of the patellofemoral articulation. Distal patellar and distal quadriceps tendinosis/tendinopathy. Peripheral obliquely oriented tear involving the medial meniscal posterior horn intersecting the inferior meniscal surface of the junction of the middle and peripheral third of the meniscus. There is also free edge truncation and radial tearing involving the medial meniscal body which its remnant is almost completely extruded outside the confines of the medial tibiofemoral joint compartment where there is medial tibiofemoral joint space narrowing. Thickening and sprain of the medial collateral ligament at its femoral attachment site. Radial tearing involving the lateral meniscal body which its remnant is almost completely extruded outside the lateral tibiofemoral joint compartment. There is central type I signal alteration in the posterior horn and body-posterior horn junction of the lateral meniscus. Insertional strain of the iliotibial band. Paucity of fluid in the medial gastrocnemius-semimembranosus bursa.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive Capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M75.22 Bicipital Tendinitis, left shoulder.
6. M25.512 Pain, left shoulder.
7. S49.92XA Injury, left shoulder.
8. M25.412 Joint effusion, left shoulder.
9. S83.242A Medial meniscus tear, left knee.
10. S83.282A Lateral meniscus tear, left knee.
11. M23.92 Internal derangement, left knee.
12. M25.462 Joint effusion, left knee.
13. M12.569 Traumatic arthropathy, left knee.
14. S80.912A Injury, left knee.
15. M25.562 Pain, left knee.
16. M65.162 Synovitis, 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 shoulder and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and 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.

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

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