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June 15, 2022

Office seen at:
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Re: Wilson, Andrew
DOB: 06/26/1977
DOA: 03/03/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, right knee, and left hip pain.

HISTORY OF PRESENT ILLNESS: A 44-year-old left-hand dominant male involved in a motor vehicle accident on 03/03/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the front-end driver side. The airbags did not deploy. The EMS arrived on the scene. The police were called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder, right knee, and left hip pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 12 weeks with no relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Hypertension, asthma and lupus.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient does not recall the medications.

SOCIAL HISTORY: The patient smokes one-fourth pack per day. The patient does not drink alcohol.

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: driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. Worse with range of motion and improves with rest. The patient is able to reach overhead and behind the back but unable to sleep at night due to pain.

Right knee: Right 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. Worse with range of motion and improves with medication and physical therapy.

Left hip: Left hip pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has locking. The patient has pain with standing, walking, climbing, and standing from sitting. Worse with range of motion and improves with rest.

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 9 inches, weight is 173 pounds, and BMI is 25.5. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, proximal biceps tendon. There is no swelling, heat, erythema, or deformity appreciated. There is crepitus appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 135/180 degrees, adduction 40/45 degrees, forward flexion 135/180 degrees, extension 40/60 degrees, internal rotation 65/90 degrees, and external rotation 60/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the right upper extremity.

The right knee reveals tenderness along the medial joint line. 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 90/130 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 right lower extremity.

The left hip reveals positive Trendelenburg test. Tenderness to palpation in the greater trochanter. Range of motion is limited and painful. ROM: Abduction 30/45 degrees, adduction 25/35 degrees, flexion 90/120 degrees, extension 15/30 degrees, internal rotation 30/45 degrees, and external rotation 35/45 degrees.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 05/03/2022, shows acromioclavicular joint impinging upon the supraspinatus myotendinous junction. Tendinosis and partial tear of the bursal surface of the supraspinatus tendon with moderate fluid in the glenohumeral joint and the subacromial/subdeltoid bursa. MRI of the right knee, done on 05/31/2022, shows study was terminated prematurely due to pain. No coronal sequences were performed, limiting evaluation. Partial meniscocapsular tear along the posterior horn of the medial meniscus. Tendinopathy of the medial gastrocnemius tendon at the insertion. Tendinopathy of the distal semimembranosus tendon. Small joint effusion 3 cm popliteal cyst. MRI of the left hip, done on 06/07/2022, shows moderate joint narrowing and cartilage loss at the hip with subchondral cystic change. Mild to moderate joint narrowing and cartilage thinning at the left hip. 1 mm tear/perforation within the anterior left hip labrum. No tendon/muscle injury.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M65.811 Tenosynovitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
9. M25.411 Joint effusion, right shoulder.
10. 83.241A Medial meniscus tear, right knee.
11. M23.91 Internal derangement, right knee.
12. M25.461 Joint effusion, right knee.
13. S80.911A Injury, right knee.
14. M25.561 Pain, right knee.
15. Popliteal cyst, right knee.
16. Labral tear, left hip.

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, right knee, and left hip.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, right knee, and left hip 3 days/week.

6. Recommend steroid injections with pain management for right shoulder, right knee, and left hip. The patient refuses due to side effects.
7. Discussed right shoulder, right knee, and left hip 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 right shoulder, right knee, and left hip 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 right shoulder, right knee, and left hip 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 right shoulder and the patient will be scheduled for right 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

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

MS/AEI