

# UK Sinha Physician, P.C.

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October 17, 2022

Office seen at:

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Re: Lorand, Julio  
DOB: 06/29/1977  
DOA: 04/28/2022

## FOLLOW-UP NOTE

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

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

**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:** Left shoulder: Left shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is able to reach overhead and able to reach behind the back, but is unable to sleep at night due to pain.

Left knee: Left knee pain is 8-9/10, 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 rest.

**PHYSICAL EXAMINATION:** The left shoulder reveals tenderness to palpation over supraspinatus tendon region and proximal biceps tendon. There is crepitus appreciated. There is no heat, swelling, erythema or deformity 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 110/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 45/60 degrees, internal rotation 40/90 degrees, and external rotation 55/90 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 the patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive 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 left lower extremity.

**DIAGNOSTIC TESTING:** MRI of the left shoulder, done on 09/27/2022, shows cuff tendinosis and tendinitis and intrasubstance tearing. Synovitis. Impingement and outlet syndrome. Hypoplastic labrum and biceps tendon. MRI of the left knee, done on 06/16/2022, shows edema along the myofascial planes of the partially imaged head of the gastrocnemius muscle consistent with myofascial strain. Significant hyperintense signal of the patellar tendon at the insertion compatible with patellar tendonitis.

**ASSESSMENT:**

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, 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. M67.212 Hypertrophic synovitis, left shoulder.
9. M25.412 Joint effusion, left shoulder.
10. Outlet syndrome, left shoulder.
11. M23.92 Internal derangement, left knee.
12. M25.462 Joint effusion, left knee.
13. M25.562 Pain, 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. Recommend steroid injections with pain management for left shoulder and left knee. The patient refuses due to side effects.

7. Discussed left shoulder and 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. The patient needs medical clearance prior to surgery. Fax clearance by cardio.
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 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.
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 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.
12. All the questions in regard to the procedure were answered.
13. The patient verbally consents for the arthroscopy of left shoulder 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.

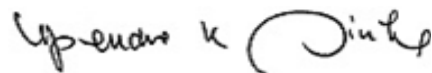
**CAUSALITY:** It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to 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

MS/AEI



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Board Certified Orthopedic Surgeon