UK Sinha Physician, P.C.

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

August 05, 2022

Re: Etienne, Magalie
DOB: 11/29/1971
DOA: 05/25/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left shoulder and left elbow pain.

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

ADL CAPABILITIES: The patient states that she can walk for 2 blocks. She can stand for 30 minutes before she has to sit. She can sit for 15 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: lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to sleep at night due to pain.

Left elbow: Left elbow pain is 8/10, described as intermittent, dull, achy pain. The patient has lateral epicondylitis. The patient has Tylenol and Lidocaine cream.

PHYSICAL EXAMINATION: The patient's height is 4 feet 11 inches, weight is 180 pounds, and BMI is 36.4. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, trapezius, 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 130/180 degrees, adduction 30/45 degrees, forward flexion 135/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and external rotation 65/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left elbow reveals muscle strength is 4/5. Negative Varus test. Negative Valgus test. Negative Tinel sign. Range of motion reveals flexion 140/150 degrees, extension full/150 degrees, supination 85/90 degrees, pronation 85/90 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 06/29/2022, shows increased signal at the greater tuberosity of the glenoid humerus. There is no osteonecrosis. Increased signal seen at the anterior leading edge of the supraspinatus with fluid inferiorly representing partial tear at the articular surface. Increase fluid seen in the subacromial subdeltoid bursa indicating bursitis. Hypertrophy contributing to supraspinatus outlet obstruction. Long head biceps tendon is within the bicipital groove with tenosynovitis.

ASSESSMENT:

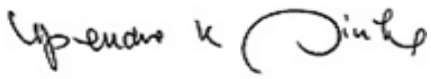
1. M24.812 Internal derangement, left shoulder.
2. M75.02 Adhesive Capsulitis, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. S43.432A Labral tear, left shoulder.
5. M75.42 Impingement, left shoulder.
6. M65.812 Tenosynovitis, left shoulder.
7. M75.52 Bursitis, left shoulder.
8. M75.22 Bicipital Tendinitis, left shoulder.
9. M25.512 Pain, left shoulder.
10. S49.92XA Injury, left shoulder.
11. M67.212 Hypertrophic synovitis, left shoulder.
12. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
13. M25.412 Joint effusion, left shoulder.
14. Lateral epicondylitis, left elbow.

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 elbow.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and left elbow 3 days/week.
6. Cortisone injection consisting of 4 mL of 0.25% Marcaine and 0.5 mL of Depo was given to the left shoulder today.
7. Follow up in 1 week for cortisone injection to the left elbow.

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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