

UK Sinha Physician, P.C.

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October 19, 2022

Office seen at:
Brooklyn Medical
5205 Church Avenue
Brooklyn, NY 11203
Phone# (845) 201-5909

Re: Lancaster, Anthony
DOB: 08/07/1983
DOA: 08/20/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, right knee, left knee, right hip, right ankle, left ankle, right wrist, neck, and low back pain.

HISTORY OF PRESENT ILLNESS: A 39-year-old right-hand dominant male involved in a motor vehicle accident on 08/20/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the front side. The airbags deployed. 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, left shoulder, right knee, left knee, right hip, right ankle, left ankle, right wrist, neck, and low-back pain sustained in the motor vehicle accident. The patient was attending physical therapy 3 times a week with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking Motrin and albuterol inhaler p.r.n.

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 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 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

Left shoulder: Left shoulder pain is 6/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and 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 difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes clicking, popping, buckling, and intermittent locking.

Left knee: Left 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.

Right hip: Right hip pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has pain with standing, walking, climbing, and standing from sitting.

Right ankle: Right ankle pain is 7/10, described as intermittent, dull, achy pain. The patient has pain with standing, walking and climbing.

Left ankle: Left ankle pain is 7/10, described as intermittent, dull, achy pain. The patient has pain with standing, walking and climbing.

Right wrist: Right wrist pain is 10/10, described as constant, dull, achy pain. Admits to weakness, numbness, and tingling. The patient has pain with lifting, carrying, and driving.

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 160 pounds, and BMI is 23.6. The right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 right upper extremity.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 80/90 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 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. Negative 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 right lower extremity.

The left knee reveals tenderness along the medial joint line. There is swelling appreciated. There is no heat, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 115/130 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.

The right ankle reveals swelling, hematoma and bruises noted over lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. ROM: Dorsiflexion 20/20 degrees, plantarflexion 40/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

The left ankle reveals swelling, hematoma and bruises noted over lateral malleolar aspect. Negative anterior drawer test. Negative inversion stress test. Tenderness to palpation noted in the lateral aspect. ROM: Dorsiflexion 20/20 degrees, plantarflexion 40/50 degrees, inversion 10/15 degrees, eversion 10/15 degrees.

The right wrist reveals pain to palpation over the distal radius. Grip strength is 4/5. Range of motion reveals flexion 40/80 degrees, extension 30/70 degrees, radial deviation 10/20 degrees, ulnar deviation 10/30 degrees.

DIAGNOSTIC TESTING: MRI of the right knee, done on 09/08/2022, shows an intrasubstance signal in the posterior horn of medial meniscus, which may represent an intrasubstance tear. Sprain of the anterior cruciate ligament. Mild synovial effusion. The patellar cartilage is swollen and reveals hyperintense signal, without erosions of the underlying bone. This can be due to injury or can represent chondromalacia patellae (grade I). Clinical correlation is suggested. Mild subcutaneous edema around the knee joint. Mild contusion/edema in the infra-patellar fat pad.

ASSESSMENT:

1. M24.811 Internal derangement, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M24.812 Internal derangement, left shoulder.
7. M75.02 Adhesive Capsulitis, left shoulder.
8. M75.42 Impingement, left shoulder.
9. M25.512 Pain, left shoulder.
10. S49.92XA Injury, left shoulder.
11. M23.91 Internal derangement, right knee.
12. M12.569 Traumatic arthropathy, right knee.
13. S80.911A Injury, right knee.
14. M25.561 Pain, right knee.
15. M23.92 Internal derangement, left knee.
16. M12.569 Traumatic arthropathy, left knee.
17. S80.912A Injury, left knee.
18. M25.562 Pain, left knee.
19. Grade III sprain lateral collateral ligament, right ankle.
20. Grade III sprain lateral collateral ligament, left ankle.

PLAN:

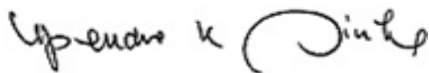
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, right knee, left knee, right hip, right ankle, left ankle, and right wrist.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, right knee, left knee, right hip, right ankle, left ankle, and right wrist 3 days/week.
6. Discussed right 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 right 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 right 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 right knee and the patient will be scheduled for right 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

UKS/AEI