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June 7, 2022

Office seen at:
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Re: Barnes, Clifford
DOB: 09/28/1975
DOA: 05/19/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and left elbow pain.

HISTORY OF PRESENT ILLNESS: A 46-year-old right-hand dominant male involved in a motor vehicle accident on 05/19/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the driver's front side. The airbags did not deploy. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient went by via car to Jamaica Hospital and was treated and released the same day. The patient presents today complaining of left shoulder and left elbow pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

SOCIAL HISTORY: The patient is a nonsmoker. The patient drinks alcohol socially. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for 2 blocks. He can stand for 7 minutes before he has to sit. He can sit for 7 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: play sports, lifting heavy objects, carrying heavy objects, reaching overhead, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness, popping, and clicking. 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 elbow: Left elbow pain is 6/10, described as intermittent, dull, achy pain. Admits to weakness and tingling. The patient has pain with lifting and carrying. 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 6 feet 1 inch, weight is 200 pounds, and BMI is 26.4. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, 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 125/180 degrees, extension 35/60 degrees, internal rotation 50/90 degrees, and external rotation 45/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left elbow muscle strength is 4/5. There is tenderness to palpation over the olecranon process. Positive Varus test. Positive Valgus test. Positive/Negative Tinel sign. Range of motion reveals flexion 100/150 degrees, extension 110/150 degrees, supination 60/90 degrees, pronation 60/90 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 05/28/2022, shows mild fluid in subacromial-subdeltoid bursa compatible with bursitis or may be seen with full thickness rotator cuff tear. Tenosynovitis of the extra articular long head of the biceps tendon. AC joint

hypertrophy may contribute to rotator cuff impingement. MRI of the left elbow, done on 05/28/2022, shows small bone contusion of the capitellum of humerus. Joint effusion.

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. M65.812 Tenosynovitis, left shoulder.
6. M75.52 Bursitis, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
10. M25.412 Joint effusion, left shoulder.
11. Bone contusion, left elbow.
12. Joint effusion, left elbow.
13. Pain, 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. Recommend steroid injections with pain management for left shoulder and left elbow. The patient refuses due to side effects.
7. Discussed left shoulder 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 wants to think about surgery.
8. 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 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.
9. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
10. All the benefits and risks of the left shoulder 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.
11. All the questions in regard to the procedure were answered.
12. Follow up in 4 weeks.

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