

UK Sinha Physician, P.C.

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October 07, 2022

Office seen at:

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Re: Ritchens, Jahad
DOB: 05/03/1993
DOA: 12/21/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 29-year-old right-hand dominant male involved in a motor vehicle accident on 12/21/2021. The patient was a rear passenger and was wearing a seatbelt. The vehicle was T-boned on the passenger's side. The airbags deployed. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Saint Barnabas Medical Center and was treated and released the same day. The patient presents today complaining of left knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 10 months with good relief.

WORK HISTORY: The patient is currently not working.

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

PAST SURGICAL HISTORY: Lumbar discectomy about 2 months ago.

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

PRESENT COMPLAINTS: Left knee: Left knee pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has no difficulty rising from a chair and has no difficulty going up and down stairs. The patient also notes clicking, popping, and buckling. 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 4 inches, weight is 240 pounds, and BMI is 29.2. The left knee reveals tenderness along the superior pole of patella, inferior pole of the patella, and popliteal fossa. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 95/130 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 knee, done on 04/19/2022, shows possible lateral trauma, lateral capsular and lateral collateral ligament tearing. Erosions and/or osteochondral defects. Iliotibial band syndrome. On the inversion recovery sequence, there is heterogeneous signal in the proximal tibia particularly on sagittal plane and consider contusion or even fracture. Post contrast MRI and/or x-ray correlation may be helpful. Large effusion. suprapatellar-plica. Complete anterior cruciate ligament tear.

ASSESSMENT:

1. M23.92 Internal derangement, left knee.
2. S83.519A Anterior cruciate ligament tear, left knee.
3. S83.32XA Tear articular cartilage, left knee.
4. M25.462 Joint effusion, left knee.
5. S80.912A Injury, left knee.
6. M25.562 Pain, left knee.

7. M93.262 Osteochondral lesion, left knee.
8. M67.52 Medial plica, left knee.
9. Lateral collateral ligament tear, 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 knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for 4 weeks for the left knee. If no improvement in pain, will consider arthroscopy.
6. Discussed 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 wants to think about 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 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.
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 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.
10. All the questions in regard to the procedure were answered.
11. Follow up in 4 weeks.

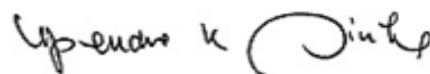
CAUSALITY: It is within a certain degree of medical certainty, that the history presented by the patient, the objective physical findings as well as the diagnosis rendered is causally related to the injury the patient incurred on the specified date. These current symptoms were nonexistent prior to the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

MS/AEI



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Board Certified Orthopedic Surgeon