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July 19, 2022

Office seen at:
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Re: McFadden, Timothy
DOB: 11/07/1970
DOA: 04/26/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left knee and left ankle pain.

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

ADL CAPABILITIES: The patient states that he can walk for 5 blocks. He can stand for 10 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: play sports, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 6/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. The patient has difficulty rising from a chair and difficulty going up and down stairs. The patient also notes clicking and popping. Worse with range of motion and improves with rest.

Left ankle: Left ankle pain is 6/10, described as intermittent, dull, achy pain. Pain with standing. Worse with range of motion and improves with rest.

PHYSICAL EXAMINATION: The left knee reveals tenderness along the medial joint line, superior pole of patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Positive anterior drawer. Negative posterior drawer. Range of motion reveals flexion 85/130 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.

The left ankle reveals swelling noted over lateral malleolar aspect. Positive anterior drawer test. Positive inversion stress test. Tenderness to palpation noted in the lateral aspect. Range of motion is full. Dorsiflexion 15/20 degrees, plantarflexion 45/50 degrees, inversion 10/15 degrees, eversion 15/15 degrees.

DIAGNOSTIC TESTING: MRI of the left knee, done on 05/04/2022, shows diffuse increased signal throughout the ACL suspicious for ACL sprain/interstitial tear as described above. Posteromedial meniscal grade 2b signal as discussed in the body of the report. Clinical confirmation of a posteromedial meniscal tear is requested. Almost total obliteration of the lateral compartment with subchondral degenerative changes and spur impingement upon the otherwise intact lateral collateral ligament complex. Presence of joint fluid compatible with synovitis. MRI of the left ankle, done on 05/04/2022, shows presence of ankle joint fluid compatible with synovitis and soft tissue edema. Prominent fluid in the three flexor tendon sheaths, most prominent around the myotendinous portion of the flexor hallucis longus, compatible with flexor tendinopathy/tenosynovitis. Findings compatible with sprain/interstitial tear of the ATFL. No acute osseous abnormalities.

ASSESSMENT:

1. S83.242A Medial meniscus tear, left knee.
2. M23.92 Internal derangement, left knee.
3. S83.512A Anterior cruciate ligament sprain, left knee.
4. M25.462 Joint effusion, left knee.
5. S80.912A Injury, left knee.
6. M25.562 Pain, left knee.
7. M65.162 Synovitis, left knee.
8. ATFL tear, left ankle.
9. Tenosynovitis, 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 left knee and left ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left knee and left ankle 3 days/week.
6. Recommend steroid injections with pain management for left knee and left ankle. The patient accepts. The patient was given a card to schedule.
7. Discussed left knee and left ankle arthroscopy versus conservative management with the patient. The patient refused surgery due to inability to miss work.
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 knee and left ankle 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 knee and left ankle 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

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MS/AEI