UK Sinha Physician, P.C.

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June 29, 2022

Office seen at:
Renew Chiropractic
2426 Eastchester Road
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Phone# (347) 843-6230

Re: Vaughn, Chevon
DOB: 11/08/1980
DOA: 04/19/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder and right knee pain.

HISTORY OF PRESENT ILLNESS: A 41-year-old right-hand dominant female involved in a motor vehicle accident on 04/19/2022. The patient was a bus passenger. The vehicle was struck on the front side. The patient was sitting landed behind bus driver and had an impact on left side body. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to Lincoln Medical Center and was treated and released the same day. The patient presents today complaining of left shoulder and right knee pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 2 months with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Diabetes, hypertension, hyperlipidemia, and breast CA.

PAST SURGICAL HISTORY: Left breast mastectomy and SLN biopsy in 2019.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n., lisinopril 30 mg, pravastatin, and Exemestane.

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 she can walk for 5 blocks. She can stand for 30 minutes before she has to sit. She 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 she is unable to do the following activities: lifting heavy objects, carrying heavy objects, reaching overhead, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 10/10, described as intermittent, sharp, stabbing, dull, achy pain. 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 rest.

Right knee: Right knee pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness. 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. Worse with range of motion and improves with rest.

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 or irregular heart rate. The patient has 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 0 inches, weight is 215 pounds, and BMI is 42. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, proximal biceps tendon, coracoid, and deltoid. 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. Positive O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 110/180 degrees, adduction 30/45 degrees, forward flexion 115/180 degrees, extension 45/60 degrees, internal rotation 60/90 degrees, and external rotation 55/90 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 lateral joint line, superior pole of patella, and popliteal fossa. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of

motion reveals flexion 80/130 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 right lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 05/24/2022, shows supraspinatus and infraspinatus tendons demonstrate tendinosis/tendinopathy with diffuse intrasubstance signal abnormality distally. SLAP tear extending into the anterior and posterior glenoid labra extending from the approximate 9 o'clock to 3 o'clock position. Thickening of the ventral-inferior glenohumeral joint capsule within the proper clinical setting is consistent with adhesive capsulitis (frozen shoulder). Trace fluid within the glenohumeral joint and long head biceps tendon sheath. Bursal fluid collection within the subscapularis recess. Hypertrophic changes of the AC joint and ventrally downsloping acromion which deforms the subacromial space. MRI of the right knee, done on 05/24/2022, shows body of the lateral meniscus is partially extruded from the joint space and demonstrates a complex tear and is diffusely deficient and irregular in appearance. Anterior and posterior horns of the lateral meniscus demonstrate tears and are diffusely deficient and eroded. Lateral joint compartment demonstrates joint space narrowing with cartilage loss, which is down to the bone and prominent spurs lining the lateral joint margin and ventral margin of the lateral tibial plateau. Slight narrowing of the medial joint compartment and small spurs lining the ventral and medial joint margins. Lateral sublimation of the patella and patellofemoral chondromalacia with cartilage loss, which is down to the bone over the lateral patellar facet and lateral aspect of the femoral trochlea. Spurs lining the lateral and medial patellofemoral joint margins. Effusion and synovitis are noted within the knee joint. Small popliteal fluid collection within the medial gastrocnemius/semimembranosus bursa.

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 SLAP tear, left shoulder.
5. M75.42 Impingement, left shoulder.
6. M25.512 Pain, left shoulder.
7. S49.92XA Injury, left shoulder.
8. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
9. M25.412 Joint effusion, left shoulder.
10. Type II acromion, left shoulder.
11. M23.200 Lateral meniscus derangement, right knee.
12. M23.91 Internal derangement, right knee.
13. M94.261 Chondromalacia, right knee.
14. S83.31XA Tear articular cartilage, right knee.
15. M25.461 Joint effusion, right knee.
16. S80.911A Injury, right knee.
17. M25.561 Pain, right knee.
18. M65.161 Synovitis, right 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 shoulder and right knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and right knee 3 days/week.
6. Recommend steroid injections with pain management for left shoulder and right knee. The patient refuses due to side effects.
7. Discussed left shoulder and 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 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 and 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.
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 and 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.
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