UK Sinha Physician, P.C.

102-31 Jamaica Ave.
Richmond Hill, NY 11418
Ph: 718-480-1130 Fax: 718-480-1132

August 31, 2022

Office seen at:
Chiro 4226
4226-A 3rd Ave
Bronx, NY 10457
Phone# (718) 684-7676

Re: Cousins, Gilbert
DOB: 01/29/1951
DOA: 04/01/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee pain.

HISTORY OF PRESENT ILLNESS: A 71-year-old right-hand dominant male involved in a motor vehicle accident on 04/01/2022. The truck hit on left side of body and the patient fell to ground. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to St. Barnabas Hospital 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 5 months with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Diabetes and HIV. There is no previous history of trauma.

PAST SURGICAL HISTORY: Repair of laceration of cranial in teens.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n. and Trulicity, unable to recall rest of medication.

SOCIAL HISTORY: The patient smokes one-fourth pack of cigarettes per day. The patient drinks alcohol socially. The patient does use recreational drugs occasionally.

ADL CAPABILITIES: The patient states that he can walk for 2 blocks. He can stand for 45 minutes before he has to sit. He can sit for 15 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: running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 6-7/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has weakness. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient also notes buckling. 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, 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 inches, weight is 170 pounds, and BMI is 22.4. The left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, and inferior pole of the patella. There is swelling and crepitus appreciated. There is no heat, erythema or deformity appreciated. Positive McMurray test. Positive 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.

DIAGNOSTIC TESTING: MRI of the left knee, done on 04/25/2022, shows there is a complete comminuted nondisplaced acute to subacute fracture of the patella extending to both superior and inferior poles and the patellofemoral articulation. There is extensive associated marrow edema and large joint effusion is well as prepatellar and infrapatellar soft tissue edema. There tears of the patellar retinacula with no subluxation. There is also a 2 centimeter area of subchondral marrow edema in the central weight-bearing aspect of the lateral femoral condyle-extending to the trochlea due to a nondisplaced trabecular fracture versus evolving osteochondral defect There also juxta-articular areas of subchondral marrow edema in the lateral tibial plateau. There is a long flap tear of the inferior articular surface of the posterior horn and body of the medial meniscus extending to its root attachment. There is posterior capsular disruption with subcapsular fluid and soft tissue edema. There is also a tear of the anterior horn and body of the lateral meniscus. Finally there is a high-grade tear of the posterior horn of the lateral meniscus

extending to its root attachment. Partial tear of the anterior cruciate ligament. There is a 5 centimeter area of avascular necrosis in the distal femoral metaphysis. Large joint effusion.

ASSESSMENT:

1. S83.242A Medial meniscus tear, left knee.
2. S83.282A Lateral meniscus tear, left knee.
3. M23.92 Internal derangement, left knee.
4. S83.519A Anterior cruciate ligament tear, left knee.
5. S83.32XA Tear articular cartilage, left knee.
6. M25.462 Joint effusion, left knee.
7. S80.912A Injury, left knee.
8. M25.562 Pain, left knee.
9. M93.262 Osteochondral lesion, left knee.
10. M17.12 Osteoarthritis, 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 left knee 3 days/week.
6. Recommend steroid injections with pain management for left knee. The patient refuses due to side effects.
7. 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 would like to proceed with surgery.
8. The patient needs medical clearance prior to surgery.
9. 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.
10. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
11. 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.
12. All the questions in regard to the procedure were answered.
13. The patient verbally consents for the arthroscopy of left knee and the patient will be scheduled for left 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.
14. 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.

Mellita Shakhmurov, PA-C

U.K. Sinha, MD, MS (Ortho), FAAOS
Board Certified Orthopedic Surgeon

MS/AEI