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June 28, 2022

Office seen at:
Dolphin Family Chiropractic, P.C.
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Re: Lopez, Lauren
DOB: 03/01/1974
DOA: 04/21/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, left wrist, and left hand pain.

HISTORY OF PRESENT ILLNESS: A 48-year-old right-hand dominant female involved in a motor vehicle accident on 04/21/2022. The patient was a rear passenger and was wearing a seatbelt. The vehicle was struck on the front driver'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 Long Island Jewish Hospital and was treated and released the same day. The patient presents today complaining of right shoulder, left shoulder, left wrist, and left hand 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 not working.

PAST MEDICAL HISTORY: Diabetes, hypertension, and hyperlipidemia.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n., metoprolol 40 mg, and atorvastatin 10 mg.

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

ADL CAPABILITIES: The patient states that she can walk for 5 blocks. She can stand for 20 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, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain.

Left shoulder: Left shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain.

Left wrist: Left wrist pain is 10/10, described as constant, dull, achy pain. Admits to weakness, numbness, and tingling. The patient has pain with lifting and carrying.

Left hand: Left hand pain is 10/10, described as constant, dull, achy pain. The patient has pain with use.

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 4 feet 11 inches, weight is 123 pounds, and BMI is 24.8. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 130/180 degrees, adduction 30/45 degrees, forward flexion 135/180 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 right upper extremity.

The left shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. 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 135/180 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 left wrist reveals pain to palpation over the ulnar styloid and scaphoid. Grip strength is 3/5. Positive Tinel sign. Positive Phalen test. Range of motion reveals flexion 50/80 degrees, extension 45/70 degrees, radial deviation 10/20 degrees, ulnar deviation 15/30 degrees.

The left hand reveals no deformity. Grip strength is 3/5. ROM diminished 50%.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 05/24/2022, shows supraspinatus tendon is inhomogeneous extending toward its anterior leading edge and distally representing insertional tendinosis/tendinopathy. Distal subscapularis tendinosis/tendinopathy. Fluid long head of biceps tendon sheath, which may be seen with tenosynovitis. Intracapsular long head of biceps tendinosis/tendinopathy at its critical zone. Anteriorly more than laterally down sloping type II acromial configuration, which abuts the underlying supraspinatus with fairly modest acromioclavicular joint hypertrophic change. Subacromial bursitis in degraded images were encountered and the best possible study was performed as discussed above. MRI of the left shoulder, done on 05/24/2022, shows supraspinatus tendon is enlarged and inhomogeneous extending toward its anterior leading edge and distally representing tendinosis/tendinopathy where there is fluid causing some distention of the subacromial bursa representing subacromial bursitis. Subscapularis tendinosis/tendinopathy, lesser in severity comparing to the degree of involvement of the supraspinatus. Slightly low-lying position and anteriorly more than laterally downsloping Type II acromial configuration which abuts the underlying supraspinatus. Paucity of fluid at the subscapularis and axillary recesses of the glenohumeral joint and there is fluid in the long head of the biceps tendon sheath at the level of the bicipital groove which may be seen with tenosynovitis. Intracapsular long head biceps tendinosis/tendinopathy. Focal region of subcortical reactive change at the anterior humeral head convexity. Motion-degraded images reduce the clarity and detail on the examination and the best possible study was performed in this respect as discussed above. MRI of the left wrist, done on 06/24/2022, shows extensor carpi ulnaris tendon is inhomogeneous with tendinosis/tendinopathy and is medially and anteriorly displaced with respect to its typical location at the groove of the distal ulna which is congenitally shallow. It is perched at the medial to slightly dorsomedial margin of the ulnar styloid and the findings are compatible with ECU subsheath insufficiency. Fluid at the distal radioulnar joint. Triangular fibrocartilage is attenuated approximately 1-2 mm in size at its radial attachment site compatible with partial tear/fenestration at the ulnar surface but without full thickness communication. First metacarpophalangeal joint space narrowing and thinning of the chondral surfaces and hypertrophic changes. First carpal-metacarpal joint space narrowing with primarily medial spur formation, subcortical reactive changes and cortical thinning at the lateral articular margins of the first metacarpal base with respect to the trapezium.

First carpal-metacarpal synovial fluid and there is lateral position of the metacarpal base with respect to the trapezium. Small cystic change involving the proximal lateral capitate. Some narrowing of the triscaphe articulation. The patient had a great deal of difficulty remaining still for the examination. There is clarity reduction due to patient motion which persisted throughout the examination. The best obtainable study was performed in this respect. MRI of the left hand, done on 06/24/2022, shows prominent fluid distension of the fourth flexor tendon sheath extending from the mid metacarpal level through the proximal to mid proximal phalangeal level, compatible with fourth flexor tenosynovitis. There is some edema in the adjacent volar subcutaneous tissues anterior to the fourth flexor tendon at the metacarpal level. Increased T1 signal involving the first and second flexor tendons at the metacarpal level, more prominently involving the second flexor tendons, representing tendinosis/tendinopathy. There is limitation on the examination due to a combination of suboptimal positioning and considerable motion-related artifact. The study was completed as per the patient's limits and as per the patient's wishes. Please see above discussion. We would be happy to repeat the study if the patient is able to cooperate for motion-free images.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M65.811 Tenosynovitis, right shoulder.
6. M75.51 Bursitis, right shoulder.
7. M75.21 Bicipital tendinitis, right shoulder.
8. M25.511 Pain, right shoulder.
9. S49.91XA Injury, right shoulder.
10. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
11. M25.411 Joint effusion, right shoulder.
12. Type II acromial, right shoulder.
13. S46.012A Partial rotator cuff tear, left shoulder.
14. M24.812 Internal derangement, left shoulder.
15. M75.82 Shoulder tendinitis, left shoulder.
16. M75.42 Impingement, left shoulder.
17. M65.812 Tenosynovitis, left shoulder.
18. M75.52 Bursitis, left shoulder.
19. M75.22 Bicipital Tendinitis, left shoulder.
20. M25.512 Pain, left shoulder.
21. S49.92XA Injury, left shoulder.
22. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
23. M25.412 Joint effusion, left shoulder.
24. Type II acromial, left shoulder.
25. Tendinopathy, left wrist.
26. Cartilage tear fluid, left wrist.
27. Pain, left hand.
28. Tendinopathy, left hand.
29. Tenosynovitis, left hand.

PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, left wrist, and left hand.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder, left shoulder, left wrist, and left hand 3 days/week.
6. Recommend steroid injections with pain management for right shoulder, left shoulder, left wrist, and left hand. The patient refuses due to side effects.
7. Discussed right shoulder, left shoulder, left wrist, and left hand 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 right shoulder, left shoulder, left wrist, and left hand 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 right shoulder, left shoulder, left wrist, and left hand 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 wrist and the patient will be scheduled for left wrist 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