UK Sinha Physician, P.C.

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July 13, 2022

Office seen at:

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Tatay Ninong Physical Therapy
1314 Coney Island Ave
Brooklyn, NY 11230
Phone# (718) 377-0100

Re: McCardy, Denzel
DOB: 08/23/1967
DOA: 01/31/2020

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left knee, neck, and low-back pain.

HISTORY OF PRESENT ILLNESS: A 53-year-old right-hand dominant male involved in a work-related accident on 01/31/2020. While at work, the patient was in an elevator, which dropped from 30th floor. The patient did not go to any hospital that same day. The patient presents today complaining of left knee, neck, and low back pain sustained in the work-related accident. The patient was attending physical therapy for 3-4 times per week with little relief.

WORK HISTORY: The patient is currently not working.

PAST MEDICAL HISTORY: Noncontributory. No history of prior trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is not taking any medication at this time.

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

ADL CAPABILITIES: The patient states that he can walk for 2 blocks. He can stand for 1/2 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, driving, lifting heavy objects,

carrying heavy objects, childcare, shopping, running errands, kneeling, squatting, negotiating stairs, and exercising.

PRESENT COMPLAINTS: Left knee: Left knee pain is 8-9/10, 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, and buckling. Worse with range of motion and improves with medication.

Left ankle: Left ankle pain is 7/10, described as intermittent, dull, achy pain. The patient has pain with standing, walking, and climbing.

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 5 feet 7 inches, weight is 175 pounds, and BMI is 27.4. The left knee reveals swelling along the medial 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. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 110/130 degrees and extension -10/5 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 ROM: Dorsiflexion 10/20 degrees, plantarflexion 45/50 degrees, inversion 5/15 degrees, eversion 10/15 degrees

DIAGNOSTIC TESTING: MRI of the left knee, done on 06/12/2020, shows lateral patellar subluxation and tilt. Distal quadriceps and distal patellar tendinosis/tendinopathy with a focal involvement. Extending from the anterior tibiofemoral articular margins a thin septated presumptive ganglion cyst measuring 2.5 cm anteroposteriorly x 1.0 x 1.8 transverse and superoinferior dimensions with thin septations. Thin septated ganglion cyst tracking superiorly and inferiorly from the joint margin. Free edge truncation and radial tearing of the medial meniscal body. MRI of the left ankle, done on 06/12/2020, shows fluid within the posterior tibial tendon sheath with tenosynovitis. There is inhomogeneity at the site of attachment of the posterior tibial tendon on the navicular, representing insertional tendinosis/tendinopathy. Trace

tenosynovitis of the flexor digitorum longus and flexor hallucis longus tendons. Synovial fluid accumulating in anterior and posterior recesses of the tibiotalar articulation. Plantar calcaneal spur and there is edema in the heel pad. Dorsal talonavicular spur formation is present with capsular thickening of the dorsal talonavicular articulation. Talonavicular spur formation extends more prominently dorsolaterally.

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. S83.412A Medial collateral ligament sprain, left knee.
5. M94.262 Chondromalacia, left knee.
6. S83.32XA Tear articular cartilage, left knee.
7. M22.2X2 Patellofemoral chondral injury, left knee.
8. M25.462 Joint effusion, left knee.
9. M12.569 Traumatic arthropathy, left knee.
10. S80.912A Injury, left knee.
11. M25.562 Pain, left knee.
12. M65.162 Synovitis, left knee.
13. M24.10 Chondral lesion, left knee.
14. M24.662 Adhesions, left knee.
15. Grade III sprain of lateral collateral ligament, left ankle.
16. Tenosynovitis of tibialis posterior tendon, left ankle.
17. Chronic tear of ulnar collateral ligament MP joint, right thumb.

PLAN:

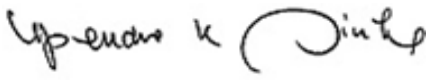
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for left knee and left ankle.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left knee and left ankle 3 days/week.
6. 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.
7. The patient needs medical clearance prior to surgery. Workers' Compensation Board authorization needed prior to 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 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 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. 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.
13. The patient will follow up 1-2 weeks postop or in 2 months if surgery has not been performed yet.
14. The patient also had right thumb torn ulnar collateral ligament although MRI showed radial collateral ligament, which I do not think so. The patient will need reconstruction of ulnar collateral ligament of right thumb after left knee surgery.

IMPAIRMENT RATING: 50%.

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.



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Board Certified Orthopedic Surgeon

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