UK Sinha Physician, P.C.

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

August 23, 2022

Office seen at:
Gurvansh Anand Chiropractic PC
2598 3rd Avenue
Bronx, NY 10454
Phone# (718) 975-7144

Re: Richards, Derwin
DOB: 04/11/1975
DOA: 06/11/2022

FOLLOW-UP NOTE

CHIEF COMPLAINT: Follow up of left shoulder, left knee, and left wrist pain.

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

ADL CAPABILITIES: The patient states that he can walk for 4 blocks. He can stand for less than 5 minutes before he has to sit. He can sit for less than 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 shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is able to reach overhead and able to reach behind the back. Worse with range of motion and improves with rest and physical therapy.

Left knee: Left knee pain is 8/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. 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

Left wrist: Left wrist pain is 9/10, described as constant, dull, achy pain. The patient has pain with lifting, carrying, and driving. Worse with range of motion and improves with rest.

PHYSICAL EXAMINATION: The left shoulder reveals tenderness to palpation over supraspinatus tendon region. There is crepitus appreciated. There is no heat, swelling,

erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Negative 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 135/180 degrees, adduction 40/45 degrees, forward flexion 150/180 degrees, extension 50/60 degrees, internal rotation 55/90 degrees, and external rotation 65/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the medial joint line 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. Negative 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 wrist reveals pain to palpation over the ulnar styloid. Grip strength is 4/5. Positive Tinel sign. Positive Phalen test. Range of motion reveals flexion 60/80 degrees, extension 50/70 degrees, radial deviation 10/20 degrees, ulnar deviation 15/30 degrees.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 08/12/2022, shows moderate tendonopathy/tendonitis of the supraspinatus tendon as discussed above. Joint effusion. The glenohumeral joint appears intact. Remaining findings as discussed above. MRI of the left knee, done on 07/15/2022, shows bone bruises in the medial femoral condyle and lateral femoral condyle; no fracture. Nondisplaced tear of the posterior horn of the medial meniscus. Strain of the medial collateral ligament. Chondromalacia patella. Effusion. Prepatellar bursitis. MRI of the left wrist, done on 07/29/2022, shows focal areas of abnormal signal along the distal ulna and ulnar styloid suggesting bone marrow edema secondary to bony contusions. Underlying non-displaced fracture cannot be entirely excluded. Remaining bony findings as noted above. Clinical correlation and follow up plain films are suggested to insure stability/healing of the bony structures. Findings consistent with partial tear of the triangular fibrocartilage. Joint effusion.

ASSESSMENT:

1. M24.812 Internal derangement, left shoulder.
2. M75.82 Shoulder tendinitis, left shoulder.
3. M25.512 Pain, left shoulder.
4. S49.92XA Injury, left shoulder.
5. M25.412 Joint effusion, left shoulder.
6. S83.242A Medial meniscus tear, left knee.
7. M23.92 Internal derangement, left knee.
8. S83.412A Medial collateral ligament sprain, left knee.
9. M94.262 Chondromalacia, left knee.
10. M25.462 Joint effusion, left knee.
11. S80.912A Injury, left knee.
12. M25.562 Pain, left knee.
13. M70.42 Prepatellar bursitis, left knee.

14. Tear of the triangular fibrocartilage, left wrist.
15. Joint effusion, left wrist.

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, left knee, and left wrist.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, left knee, and left wrist 3 days/week.
6. Recommend steroid injections with pain management for left shoulder, left knee, and left wrist. The patient accepts and was given a card.
7. Discussed left shoulder, left knee, and left wrist 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. 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, left knee, and left wrist 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, left knee, and left wrist 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 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.
13. 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