

UK Sinha Physician, P.C.

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November 07, 2022

Office seen at:
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5205 Church Avenue
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Phone# (845) 201-5909

Re: Littles, Keyanta
DOB: 01/06/1974
DOA: 08/30/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Right shoulder, left shoulder, neck, and low back pain.

HISTORY OF PRESENT ILLNESS: A 48-year-old right-hand dominant female involved in a motor vehicle accident on 08/30/2022. The patient was a rear passenger and was wearing a seatbelt. The car hit from behind. The vehicle was struck on the rear end and rear passenger's side. The police were called to the scene of the accident. The patient did not go to any hospital that same day. The patient presents today complaining of right shoulder, left shoulder, neck, and low back pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 3 weeks with little relief.

WORK HISTORY: The patient is currently working as an office manager.

PAST MEDICAL HISTORY: Noncontributory. There is no previous history of trauma.

PAST SURGICAL HISTORY: Noncontributory.

DRUG ALLERGIES: NO KNOWN DRUG ALLERGIES.

MEDICATIONS: The patient is taking pain medications p.r.n.

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

ADL CAPABILITIES: As a direct result of the injuries sustained in this accident, the patient states that she is unable to do the following activities: driving, lifting heavy objects, carrying, reaching overhead, laundry, shopping, running errands, and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has stiffness, weakness, popping, and clicking. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

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 unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain.

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 6 inches, weight is 172 pounds, and BMI is 27.8. The right shoulder reveals tenderness to palpation over supraspinatus tendon region and AC joint. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 110/180 degrees, adduction 40/45 degrees, forward flexion 120/180 degrees, extension 20/60 degrees, internal rotation 70/90 degrees, and external rotation 80/90 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, crepitus or deformity appreciated. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Negative Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 140/180 degrees, adduction 40/45 degrees, forward flexion 150/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 80/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 09/22/2022, shows finding suggesting a partial tear of the mid portion of the subscapularis tendon. Fluid in the subdeltoid bursa. MRI of the left shoulder, done on 09/22/2022, shows partial non-retracted intrasubstance tear of the distal aspect of the supraspinatus tendon. Fluid in the acromioclavicular joint.

ASSESSMENT:

1. S46.011A Partial rotator cuff tear, right shoulder.
2. M75.01 Adhesive capsulitis, right shoulder.
3. M75.41 Impingement, right shoulder.
4. M25.511 Pain, right shoulder.
5. S49.91XA Injury, right shoulder.
6. M25.411 Joint effusion, right shoulder.
7. S46.012A Partial rotator cuff tear, left shoulder.
8. M24.812 Internal derangement, left shoulder.
9. M75.02 Adhesive capsulitis, left shoulder.
10. M75.42 Impingement, left shoulder.
11. M25.512 Pain, left shoulder.
12. S49.92XA Injury, left shoulder.
13. M25.412 Joint effusion, left shoulder.

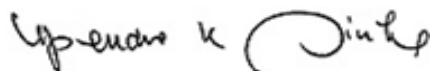
PLAN:

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 and left shoulder.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right shoulder and left shoulder 3 days/week.
6. Discussed right shoulder 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.
7. 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 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.
8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the right shoulder 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.
10. All the questions in regard to the procedure were answered.
11. Follow up in 2 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.

A handwritten signature in black ink, appearing to read "U.K. Sinha", written over a horizontal line.

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

UKS/AEI