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August 23, 2022

Office seen at:
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Re: Martinez Marte, Estarlin
DOB: 09/28/1995
DOA: 08/14/2021

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, left knee, and left finger pain.

HISTORY OF PRESENT ILLNESS: A 27-year-old right-hand dominant male involved in a motor vehicle accident on 08/14/2021. The patient was riding an electric scooter. The EMS arrived on the scene. The police were called to the scene of the accident. The patient was transported via ambulance to BronxCare Health System and was treated and released the same day. The patient presents today complaining of left shoulder, left knee, and left finger pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 1 year with no relief.

WORK HISTORY: The patient is currently working.

PAST MEDICAL HISTORY: Noncontributory. There is a previous history of MVA about 8 years ago.

PAST SURGICAL HISTORY: Left elbow surgery 8 years ago.

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 drinks alcohol socially. The patient does not use recreational drugs.

ADL CAPABILITIES: The patient states that he can walk for 1/2 block. He can stand for 5 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: playing sports, reaching overhead, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. Worse with range of motion and improves with rest. The patient is unable to reach overhead but able to reach behind the back.

Left knee: Left knee pain is 7/10, described as intermittent, sharp, stabbing, dull, achy pain. Worse with range of motion and improves with rest. The patient has difficulty rising from a chair and difficulty going up and down stairs.

Left finger pain is 8/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has pain with lifting and carrying.

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 200 pounds, and BMI is 33. The left shoulder reveals tenderness to palpation over supraspinatus tendon region. Negative drop arm test. Negative cross-over test. Negative empty can test. Negative Yergason test. Negative deltoid atrophy. Positive O'Brien test. Negative impingement sign. Negative Lift-off test. Negative Hawkins test. Range of motion, as per goniometer, abduction 180/180 degrees, adduction 45/45 degrees, forward flexion 175/180 degrees, extension 60/60 degrees, internal rotation 90/90 degrees, and external rotation 90/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals no tenderness to palpation. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 130/130 degrees and extension 5/5 degrees. Knee is stable with varus and valgus stress test. The patient has no motor or sensory deficit of the left lower extremity.

Left finger reveals fifth digit deformity. ROM is limited.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 10/13/2021, shows hypertrophic change of the AC joint capsule with a Type II acromion. The proximal biceps tendon is seated in the bicipital groove. Mild tenosynovitis. MRI of the left knee, done on 10/13/2021, shows grade I MCL sprain. Small knee joint effusion. Slit-like ruptured subcentimeter medial popliteal cyst. X-ray of the left finger, done on 10/13/2021, shows bony contour irregularity at the fifth proximal phalanx near the base as well as at the fifth metacarpal neck indicates changes suggesting healing fracture deformities. Correlate clinically and with prior imaging for further determination. There appears to be degenerative changes involving the joint spaces at the fifth digit at the DIP and questionable PIP joint levels. Apparent degenerative changes at the radiocarpal joint level. Correlate clinically. There appears to be persistent flexion deformity at the fifth PIP joint location. It is possible that the apparent joint space narrowing at this level could alternatively be related to this deformity. This may either reflect the sequela of poor patient positioning versus possible extensor tendon malfunction related change. Correlate clinically to determine whether additional imaging evaluation with MR would be required.

ASSESSMENT:

1. M67.212 Hypertrophy synovitis, left shoulder.
2. S83.412A Medial collateral ligament sprain, left knee.
3. Left fifth finger fracture deformity, left finger.

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 and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder and left knee 3 days/week.
6. Recommend steroid injections with pain management for left shoulder and left knee. The patient refuses due to side effects.
7. X-ray ordered of left finger ordered and follow up with Dr. Sinha after the x-ray.
8. Discussed left shoulder and 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.
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 shoulder and 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 shoulder and 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 shoulder and the patient will be scheduled for left shoulder 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.

MellitaShakhmurov, PA-C

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

MS/AEI