UK Sinha Physician, P.C.

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November 11, 2022

Office seen at:
S.P. Physical Therapy
1320 Louis Nine Boulevard
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Phone # (347) 862-0003

Re: Hamilton, Shadea
DOB: 02/27/1987
DOA: 09/03/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

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

HISTORY OF PRESENT ILLNESS: A 35-year-old right-hand dominant female involved in a motor vehicle accident on 09/03/2022. The patient was a front seat passenger and was wearing a seatbelt. The vehicle was struck on the rear end. The airbags did not deploy. The EMS arrived on the scene. 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 left shoulder, right knee and left knee 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: Noncontributory. There is a previous history of MVA in 2002.

PAST SURGICAL HISTORY: Positive for right upper thigh debridement of tissue with skin graft placement about 20 years ago status post trauma.

DRUG ALLERGIES: PENICILLIN.

MEDICATIONS: The patient is taking metformin 500 mg, Ozempic and insulin long acting 20 units.

SOCIAL HISTORY: The patient smokes socially. The patient drinks alcohol socially. The patient takes recreation drugs daily.

ADL CAPABILITIES: The patient states that she can walk for 5 blocks. She can stand for 10 minutes before she has to sit. She can sit for 10 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, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Left shoulder: Left shoulder pain is 7/10, described as constant sharp, stabbing, dull, achy pain. The patient has weakness. The patient is able to reach overhead and behind the back, but unable to sleep at night due to pain. Worse with range of motion and improves with rest and medication.

Right knee: Right knee pain is 7/10, described as constant sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and 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 and medication.

Left knee: Left knee pain is 7/10, described as constant sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient has difficulty rising from a chair and 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 and medication.

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 8 inches, weight is 220 pounds, and BMI is 33.5. The left shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint and proximal biceps tendon. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus 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 115/180 degrees, adduction 35/45 degrees, forward flexion 130/180 degrees, extension 45/60 degrees, internal rotation 40/90 degrees, and

external rotation 55/90 degrees. Internal rotation to the sacrum back. The patient has no motor or sensory deficit of the left upper extremity.

The right knee reveals tenderness along the medial joint line. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus appreciated. Positive McMurray test. Negative Lachman test. Positive patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 80/130 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 right lower extremity.

The left knee reveals tenderness along the medial joint line. There is no heat, swelling, erythema, or deformity appreciated. There is crepitus 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 right lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 10/25/2022, shows high-grade partial tear of the distal supraspinatus tendon. Edema in the distal clavicle and adjacent acromion with fluid in the acromioclavicular joint consistent with recent trauma. Fluid in the lone head of the biceps tendon sheath consistent with tenosynovitis. Fluid in the subacromial / subdeltoid bursa suggestive of underlying rotator cuff tears and/or subacromial / subdeltoid bursitis, in an appropriate clinical setting. MRI of the right knee, done on 10/18/2022, shows oblique tear in the posterior horn of the medial meniscus. 5.0 mm erosive/osteochondral lesion on the anterior articular surface of the lateral femoral condyle. Anterior subcutaneous soft tissue swelling and edema, consistent with recent trauma, in an appropriate clinical setting. Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting. MRI of the left knee, done on 10/18/2022, shows intrameniscal tear in the posterior horn of the medial meniscus. 1.0 x 0.9 cm multilocular cyst in the mid tibial plateau which appears to be communicated with joint. Anterior subcutaneous soft tissue swelling and edema, consistent with recent trauma, in an appropriate clinical setting. Mild joint effusion consistent with recent trauma or synovitis, in an appropriate clinical setting.

ASSESSMENT:

1. S46.012A Partial rotator cuff tear, left shoulder.
2. M24.812 Internal derangement, left shoulder.
3. M75.82 Shoulder tendinitis, left shoulder.
4. M75.42 Impingement, left shoulder.
5. M65.812 Tenosynovitis, left shoulder.
6. M75.52 Bursitis, left shoulder.
7. M25.512 Pain, left shoulder.
8. S49.92XA Injury, left shoulder.
9. M25.412 Joint effusion, left shoulder.
10. S83.241A Medial meniscus tear, right knee.
11. M23.91 Internal derangement, right knee.

12. M25.461 Joint effusion, right knee.
13. S80.911A Injury, right knee.
14. M25.561 Pain, right knee.
15. M65.161 Synovitis, right knee.
16. S83.242A Medial meniscus tear, left knee.
17. M23.92 Internal derangement, left knee.
18. M25.462 Joint effusion, left knee.
19. S80.912A Injury, left knee.
20. M25.562 Pain, left knee.
21. M65.162 Synovitis, left knee.
22. M93.262 Osteochondral lesion, left knee.

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, right knee and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for left shoulder, right knee and left knee 3 days/week.
6. Recommend steroid injections with pain management for left shoulder, right knee and left knee. The patient refuses due to side effects.
7. Discussed left shoulder, right knee and left knee arthroscopies 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, right knee and left knee pathologies 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, right knee and left knee arthroscopies 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 shoulder, right knee and left knee 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.
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
MS/AEI

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