UK Sinha Physician, P.C.

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September 09, 2022

Re: Guerrier, Yolette
DOB: 02/05/1957
DOA: 05/09/2022

FOLLOW-UP NOTE

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

HISTORY OF PRESENT ILLNESS: The patient presents today in followup with continued pain in the right shoulder, left shoulder, right knee, and left knee. This patient comes from KMR Medical, 222-01 Hempstead Avenue, Queens Village, NY 11429.

ADL CAPABILITIES: The patient states that she can walk for 1 block. She can stand for 30 minutes before she has to sit. She can sit for 30 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: garden, play sports, driving, lifting heavy objects, carrying heavy objects, reaching overhead, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging and exercising.

PRESENT COMPLAINTS: Right shoulder: Right shoulder pain is 6/10, described as constant, sharp, stabbing, dull, achy pain. 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 5/10, described as constant, sharp, stabbing, dull, achy pain. The patient is unable to reach overhead, unable to reach behind the back, and unable to sleep at night due to pain. the patient had left shoulder arthroscopy and need medical clearance.

Right knee: Right knee pain is 9/10, described as intermittent, 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, and buckling.

Left knee: Left knee pain is 9/10, 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, and buckling.

PHYSICAL EXAMINATION: The right shoulder reveals tenderness to palpation over supraspinatus tendon region. 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 100/180 degrees, adduction 35/45 degrees, forward flexion 120/180 degrees, extension 50/60 degrees, internal rotation 65/90 degrees, and external rotation 65/90 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. 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 100/180 degrees, adduction 40/45 degrees, forward flexion 115/180 degrees, extension 50/60 degrees, internal rotation 70/90 degrees, and external rotation 70/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The right knee reveals tenderness along the medial joint line and superior pole of patella. There is no heat, swelling, erythema, crepitus or deformity appreciated. Negative 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 0/5 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 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 100/130 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.

DIAGNOSTIC TESTING: MRI of the right shoulder, done on 06/08/2022, shows high-grade bursal sided tear supraspinatus measuring 10 mm AP by 9 mm medial to lateral dimension with additional interstitial type tear anterior infraspinatus. Tendinosis subscapularis with interstitial tear cephalad insertional fibers. Slight posterior translation humeral head with blunting of the posterior and posterior superior labrum. Suspected tear of the biceps tendon at the labral anchor with retraction into the upper arm. AC joint arthrosis with adjacent subacromial subdeltoid bursitis. MRI of the left shoulder, done on 06/08/2022, shows full-thickness tear supraspinatus and anterior infraspinatus measuring 18 mm AP by 13 mm medial to lateral dimension with additional interstitial delaminating tear extends posteriorly throughout the infraspinatus. Tendinosis and tenosynovitis proximal biceps tendon. AC joint arthrosis with moderate subacromial subdeltoid bursitis. MRI of the right knee, done on 06/16/2022, shows tricompartmental osteoarthrosis as described above. Approximately 14.5 x 16.9 x 48.0 mm, lobulated dissecting Baker's cyst. MRI of the left knee, done on 06/16/2022, shows broad tear throughout the body of the medial meniscus extending to the peripheral free margin and portion of extruded meniscal fragment into the para-meniscal space. There is also slight displacement

and concomitant MCL sprain. There is concomitant femoral tibial effusion and complex tear posterior horn medial meniscus, as well as suspicion for component of meniscal capsule separation, and position of extruded meniscal fragment into the para-meniscal space. MCL tear. Quadriceps and patellar tendinopathy. Tricompartmental osteoarthritis as described, moderate to severe medial facet chondromalacia patella.

ASSESSMENT:

1. M75.121 Complete rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.01 Adhesive capsulitis, right shoulder.
4. M75.41 Impingement, right shoulder.
5. M65.811 Tenosynovitis, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. M25.411 Joint effusion, right shoulder.
9. M75.122 Complete rotator cuff tear, left shoulder.
10. M24.812 Internal derangement, left shoulder.
11. M75.02 Adhesive Capsulitis, left shoulder.
12. M75.42 Impingement, left shoulder.
13. M75.52 Bursitis, left shoulder.
14. M25.512 Pain, left shoulder.
15. S49.92XA Injury, left shoulder.
16. M25.412 Joint effusion, left shoulder.
17. M23.91 Internal derangement, right knee.
18. M94.261 Chondromalacia, right knee.
19. M25.461 Joint effusion, right knee.
20. M12.569 Traumatic arthropathy, right knee.
21. S80.911A Injury, right knee.
22. M25.561 Pain, right knee.
23. M65.161 Synovitis, right knee.
24. M24.661 Adhesions, right knee
25. M23.92 Internal derangement, left knee.
26. M94.262 Chondromalacia, left knee.
27. M25.462 Joint effusion, left knee.
28. M12.569 Traumatic arthropathy, left knee.
29. S80.912A Injury, left knee.
30. M25.562 Pain, left knee.
31. M65.162 Synovitis, left knee.
32. M24.662 Adhesions, left knee.

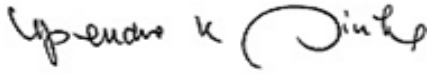
PLAN:

1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right shoulder, left shoulder, right knee, and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.

5. Continue physical therapy for right shoulder, left shoulder, right knee, and left knee 3 days/week.
6. Discussed left 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 would like to proceed with surgery.
7. The patient needs medical clearance 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 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.
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 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 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.
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.



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UKS/AEI