# UK Sinha Physician, P.C.

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October 04, 2022

Office seen at:
Gurvansh Anand Chiropractic PC
2598 3rd Avenue
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Re: Ruiz, Angel
DOB: 09/28/1957
DOA: 04/15/2022

## INITIAL ORTHOPEDIC CONSULT EXAMINATION

**CHIEF COMPLAINT:** Right shoulder and left shoulder pain.

**HISTORY OF PRESENT ILLNESS:** A 65-year-old right-hand dominant male involved in a motor vehicle accident on 04/15/2022. The patient was a driver and was wearing a seatbelt. The vehicle was struck on the rear side. The airbags did not deploy. The EMS did not arrive 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 right shoulder and left shoulder pain sustained in the motor vehicle accident. The patient was attending physical therapy for the last 5 months with no relief.

**WORK HISTORY:** The patient is currently not working.

**PAST MEDICAL HISTORY:** Hypertension and hyperlipidemia. There is no previous history of trauma.

**PAST SURGICAL HISTORY:** Left BKA with prosthesis about 30 years ago, status post trauma and left foot TMA with prosthesis 30 years of age.

**DRUG ALLERGIES:** NO KNOWN DRUG ALLERGIES.

**MEDICATIONS:** The patient is taking pain medications p.r.n., unable to recall.

**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 he 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 10/10, described as constant, 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.

Left shoulder: Left shoulder pain is 10/10, described as constant, sharp, stabbing, dull, achy pain. The patient has stiffness and weakness. The patient is able to reach overhead and able to reach behind the back. Worse with range of motion and improves with rest.

**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 or irregular heart rate. The patient has 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 7 inches, weight is 190 pounds, and BMI is 29.8. The right shoulder reveals tenderness to palpation over supraspinatus tendon region, AC joint, and proximal biceps tendon. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 90/180 degrees, adduction 30/45 degrees, forward flexion 100/180 degrees, extension 30/60 degrees, internal rotation 30/90 degrees, and external rotation 50/90 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, AC joint and proximal biceps tendon. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Negative drop arm test. Positive cross-over test. Positive empty can test. Positive Yergason test. Negative deltoid atrophy. Positive O'Brien test. Positive impingement sign. Positive 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 35/60 degrees, internal rotation 45/90 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.

**DIAGNOSTIC TESTING:** MRI of the right shoulder, done on 08/15/2022, shows ventrally, high grade partial thickness delaminating tear of the distal supraspinatus tendon extending to the bursal surface and approaching the articular membrane. Suture anchor ventrally within the proximal humeral shift consistent with a prior biceps tendon repair. The biceps tendon is torn away from the proximal insertion with no visible tendon at the level of the bicipital groove. SLAP tear extending into the posterior glenoid labrum extending from the approximate 9 o'clock to 12 o'clock position. Linear interstitial tear approaching the distal insertion of the subscapularis tendon. Hypertrophic changes of the AC joint and ventrally downsloping amnion which abuts the bursa' surface of the rotator cuff. MRI of the left shoulder, done on 08/15/2022, shows supraspinatus tendon demonstrates partial thickness tear with thinning ventrally and irregularity over the bursal surface. Long head of the biceps tendon is torn away from the proximal insertion and retracted. The tendon is not visible at the levels of the bicipital groove. SLAP tear extending into the posterior glenoid labrum which is diffusely deficient extending from the approximate 10 o'clock to 12 o'clock position. Trace fluid within the glenohumeral joint. Hypertrophic changes of the AC joint and ventrally downsloping acromion which abuts the bursal surface of the rotator cuff. Spurs lining the superior margin of the AC joint extending into the overlying subcutaneous fat. Humeral head demonstrates fibrocystic and erosive bony changes over the posterior lateral aspect above the greater tuberosity.

**ASSESSMENT:**

1. M75.121 Complete rotator cuff tear, right shoulder.
2. M24.811 Internal derangement, right shoulder.
3. M75.81 Shoulder tendinitis, right shoulder.
4. S43.431A SLAP tear, right shoulder.
5. M75.41 Impingement, right shoulder.
6. M25.511 Pain, right shoulder.
7. S49.91XA Injury, right shoulder.
8. S46.101A Biceps tendon tear, right shoulder.
9. M89.311 Acromioclavicular joint hypertrophy, right shoulder.
10. M25.411 Joint effusion, right shoulder.
11. S46.012A Partial rotator cuff tear, left shoulder.
12. M24.812 Internal derangement, left shoulder.
13. M75.82 Shoulder tendinitis, left shoulder.
14. S43.432A SLAP tear, left shoulder.
15. M75.42 Impingement, left shoulder.
16. M25.512 Pain, left shoulder.
17. S49.92XA Injury, left shoulder.
18. S46.102A Biceps tendon tear, left shoulder.
19. M89.312 Acromioclavicular joint hypertrophy, left shoulder.
20. 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. Recommend steroid injections with pain management for right shoulder and left shoulder. The patient refuses due to side effects.
7. Discussed right shoulder and 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.
8. The patient needs medical clearance prior to 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 right shoulder and 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.
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 right shoulder and 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.
12. All the questions in regard to the procedure were answered.
13. The patient verbally consents for the arthroscopy of right shoulder and the patient will be scheduled for right 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.

Mellita Shakhmurov, PA-C

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

MS/AEI