

UK Sinha Physician, P.C.

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August 09, 2022

Office seen at:
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2598 3rd Avenue
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Re: Arias, Lewis
DOB: 08/12/1992
DOA: 04/26/2022

INITIAL ORTHOPEDIC CONSULT EXAMINATION

CHIEF COMPLAINT: Left shoulder, and left knee pain.

HISTORY OF PRESENT ILLNESS: A 29-year-old right-hand dominant male involved in a work-related accident on 04/26/2022. The patient was a construction worker; escalator collapsed and fell on left side of body. The EMS did not arrive on the scene. The police were not called to the scene of the accident. The patient went by car to NYC Health + Hospitals/Lincoln and was treated and released the same day. The patient presents today complaining of left shoulder and left knee pain sustained in the work-related accident. The patient was attending physical therapy for the last 3.5 months with no relief.

WORK HISTORY: The patient is currently not working.

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

PAST SURGICAL HISTORY: Right shoulder surgery and arthroscopy in 2016.

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: The patient states that he can walk for 5 blocks. He can stand for 10 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: lifting 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, popping, and clicking. The patient is able to reach overhead, able to reach behind the back, and unable to sleep at night due to pain. Worse with range of motion and improves with physical therapy.

Left knee: Left knee pain is 8/10, 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 intermittent locking. Worse with range of motion and improves with physical therapy.

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 10 inches, weight is 200 pounds, and BMI is 28.7. The left shoulder reveals tenderness to palpation over supraspinatus tendon region. 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. Negative O'Brien test. Positive impingement sign. Positive Lift-off test. Positive Hawkins test. Range of motion, as per goniometer, abduction 130/180 degrees, adduction 40/45 degrees, forward flexion 135/180 degrees, extension 50/60 degrees, internal rotation 60/90 degrees, and external rotation 55/90 degrees. Internal rotation to the sacrum. The patient has no motor or sensory deficit of the left upper extremity.

The left knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, and inferior pole of the patella. There is crepitus appreciated. There is no heat, swelling, erythema or deformity appreciated. Positive McMurray test. Positive Lachman test. Positive patellofemoral grinding test. Positive 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 left lower extremity.

DIAGNOSTIC TESTING: MRI of the left shoulder, done on 08/01/2022, shows no fracture or focal bony lesion. Intact acromioclavicular and glenohumeral joints. Tendinopathy of the supraspinatus tendon. No additional focal soft tissue abnormality. MRI of the left knee, done on 08/01/2022, shows no fracture; bone bruises in the medial and lateral femoral condyle and in the patella. tear of the posterior horn of the medial meniscus. Tear of the posterior horn of the lateral meniscus and meniscal cyst in the anterior horn of lateral meniscus. Strain of the anterior cruciate ligament and medial collateral ligament. Chondromalacia patella. effusion. Prepatellar bursitis.

ASSESSMENT:

1. M75.82 Shoulder tendinitis, left shoulder.
2. M25.512 Pain, left shoulder.
3. S49.92XA Injury, left shoulder.
4. S83.242A Medial meniscus tear, left knee.
5. S83.282A Lateral meniscus tear, left knee.
6. M23.92 Internal derangement, left knee.
7. S83.512A Anterior cruciate ligament sprain, left knee.
8. S83.412A Medial collateral ligament sprain, left knee.
9. M94.262 Chondromalacia, left knee.
10. M25.462 Joint effusion, left knee.
11. S80.912A Injury, left knee.
12. M25.562 Pain, left knee.
13. M70.42 Prepatellar bursitis, 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 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. 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.
8. Workers' Compensation Board authorization needed 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 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.

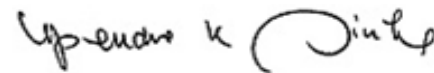
11. All the benefits and risks of the left shoulder and left knee arthroscopy have been discussed with the patient. The risks include, but not limited to bleeding, infection, pain, stiffness, muscle injury, nerve injury, DVT, and recurrence.
12. All the questions in regard to the procedure were answered.
13. The patient verbally consents for the arthroscopy of left knee and the patient will be scheduled for left knee 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.

IMPAIRMENT RATING: 100%.

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