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October 17, 2022

Office seen at:
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Re: Baker, Merle
DOB: 02/29/1952
DOA: 06/07/2022

FOLLOW-UP NOTE

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

HISTORY OF PRESENT ILLNESS: The patient presents today in followup with continued pain in the right knee and left knee.

ADL CAPABILITIES: The patient states that she can walk for 1/2 block. She can stand for 5 minutes before she has to sit. She 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 she is unable to do the following activities: carrying heavy objects, laundry, shopping, running errands, kneeling, squatting, negotiating stairs, jogging, and exercising.

PRESENT COMPLAINTS: Right knee: Right knee pain is 10/10, 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, buckling, and intermittent locking.

Left knee: Left knee pain is 1/10, described as intermittent, sharp, stabbing, dull, achy pain. The patient has difficulty rising from a chair and has difficulty going up and down stairs. The patient had a TKR.

Right knee arthroscopy done 10 years ago. Left knee replacement in 2016.

PHYSICAL EXAMINATION: The right knee reveals tenderness along the medial joint line, lateral joint line, superior pole of patella, and inferior pole of the patella. There is swelling and crepitus appreciated. There is no heat, 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 right lower extremity.

The left knee reveals tenderness along the medial joint line. There is swelling crepitus. There is no heat, erythema, crepitus or deformity appreciated. Negative McMurray test. Negative Lachman test. Negative patellofemoral grinding test. Negative anterior drawer. Negative posterior drawer. Range of motion reveals flexion 120/130 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 left lower extremity.

DIAGNOSTIC TESTING: MRI of the right knee, done on 06/25/2022, shows bone marrow edema seen at the medial lateral tibial plateau as well as the femoral condyles. Increased signal on the proton density along the ACL and ACL fibers are not visualized indicating a tear. Medial collateral ligament contains adjacent edema and is bulging. Medial and lateral meniscal tears in the posterior horn. Supraspinatus joint effusion present, prepatellar edema. MRI of the left knee, done on 06/25/2022, shows limited study due to metallic artifact. Prepatellar likely fluid. Suprapatellar joint fluid present.

ASSESSMENT:

1. S83.241A Medial meniscus tear, right knee.
2. M83.281A Lateral meniscus tear, right knee.
3. M23.91 Internal derangement, right knee.
4. M22.2X1 Patellofemoral chondral injury, right knee.
5. M25.461 Joint effusion, right knee.
6. M12.569 Traumatic arthropathy, right knee.
7. S80.911A Injury, right knee.
8. M25.561 Pain, right knee.
9. M93.261 Osteochondral lesion, right knee.
10. S80.912A Injury, left knee.
11. M25.562 Pain, left knee.
12. Total knee replacement in 2016, left knee.

PLAN:

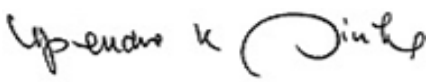
1. Imaging studies and clinical examinations were reviewed with the patient.
2. All treatment options discussed with the patient.
3. Cold compresses for right knee and left knee.
4. Continue anti-inflammatory and muscle relaxant medications p.r.n.
5. Continue physical therapy for right knee and left knee 3 days/week.
6. Discussed right 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 wants to think about surgery.
7. 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 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.

8. Discussed the length of the arthroscopy, the postoperative instructions, and the option of continuing with conservative management alternatives to surgery, including no surgery.
9. All the benefits and risks of the right 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.
10. All the questions in regard to the procedure were answered.
11. Follow up in 4 weeks.

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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