1 Patient Information

1 PATIENT DETAILS

Name
James R. Kowalski

Date of Service
05/06/2026

DOB
04/22/1971

Provider
Dr. Nathaniel T. Brooks, MD — Orthopedic Surgery

Age / Sex
54 / Male

MRN
OS-2026-1147

Visit Type
Pre-Operative Consultation

Affected Body Part / Laterality
Left knee — medial compartment

CC Chief Complaint

2 PRIMARY ORTHOPEDIC CONCERN

Patient presents with a 6-week history of acute-onset left knee locking, medial joint line pain rated 8/10 at its worst, and inability to fully extend the knee following a twisting injury while playing recreational basketball. He states: 'My knee locks up and I can't straighten it all the way — it catches and then gives out on me.' He has a history of prior left ACL reconstruction (2009) and chronic medial compartment osteoarthritis diagnosed on X-ray in 2023.

S Subjective

3 PATIENT-REPORTED SYMPTOMS & ORTHOPEDIC HISTORY

3a ONSET & MECHANISM

Acute onset 6 weeks ago (03/22/2026) during a non-contact pivoting mechanism while playing recreational basketball — planted left foot, rotated body quickly to the right, felt a pop followed by immediate severe medial knee pain and swelling. Unable to continue playing; required assistance walking off the court. Seen in urgent care the following day; X-rays showed no acute fracture. Recurrent locking episodes since then — approximately 3–4 times/week — each resolving spontaneously or with gentle manipulation within 30–60 minutes.

3b LOCATION & LATERALITY

Left knee — medial joint line, centered over the posteromedial corner. No lateral joint line tenderness. No patellofemoral symptoms. Pain radiates proximally along the medial thigh with prolonged weight-bearing. No radiation below the knee. No contralateral knee symptoms.

3c PAIN CHARACTERISTICS

Sharp, catching quality with locking episodes (8/10 peak). Baseline aching medial pain at rest (4/10) and with ambulation (6/10). Worse with stairs (descending > ascending), squatting, and pivoting. Morning stiffness resolves in 15–20 min. Progressively worsening over 6 weeks despite NSAIDs and rest.

3d FUNCTIONAL LIMITATIONS

Construction supervisor currently on partial medical leave x3 weeks. Cannot squat, crouch, climb ladders, or descend stairs safely. Ambulates with antalgic limp using forearm crutch on right. Unable to drive comfortably. Sleep disrupted 4–5 nights/week from medial knee pain.

3e PRIOR TREATMENT

Left ACL reconstruction with patellar tendon autograft (2009). Medial compartment OA diagnosed 2023 on weight-bearing X-rays; managed with naproxen PRN and activity modification. Viscosupplementation (sodium hyaluronate, 2024) — ~4 months moderate relief. PT x8 sessions (2024). MRI ordered by urgent care (03/24/2026) — reviewed today.

3f ASSOCIATED SYMPTOMS

Moderate left knee effusion since acute injury. Mechanical locking at ~15–20° flexion; unable to extend until episode resolves. No instability beyond locking (ACL graft intact per MRI). No fever, erythema, or warmth. No lower leg swelling or calf tenderness.

3g PERTINENT NEGATIVES

Denies acute neurovascular compromise, open wound, fever, bowel/bladder dysfunction, saddle anesthesia, DVT history, anticoagulant use, or contralateral knee symptoms.

O Objective

4 MEASURABLE & OBSERVED ORTHOPEDIC FINDINGS

V VITAL SIGNS

Temperature
98.2°F

Blood Pressure
128/78 mmHg

Heart Rate
72 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
99% on room air

Weight / BMI
218 lbs (98.9 kg) / BMI 29.8

Pain Score
6/10 at rest; 8/10 with active ROM

4a INSPECTION

Left knee: Moderate joint effusion — medial and lateral parapatellar fullness. No ecchymosis. Mild left quadriceps atrophy (~1.5 cm circumferential difference at 10 cm above patella). Well-healed vertical midline scar from prior ACL reconstruction (~6 cm). Mild varus alignment left lower extremity. Right knee: No swelling, normal alignment.

4b PALPATION

Moderate effusion on ballottement — positive patellar tap. Exquisite medial joint line tenderness maximal at posteromedial corner and posterior horn. McMurray's: Positive — palpable clunk with valgus stress + external rotation in flexion, reproducing medial pain. Bounceback test: Positive — extension blocked ~15° with firm endpoint. No lateral JL tenderness. ACL: Negative Lachman (firm endpoint), negative pivot shift.

4c RANGE OF MOTION

Active ROM (Left)
Flexion 115° (limited by pain/effusion); Extension -15° (extensor lag)

Passive ROM (Left)
Flexion 120°; Extension -12° — firm block to full extension

Active ROM (Right)
Flexion 140°; Extension 0° (full)

Limitations
Flexion limited by effusion/pain; extension block consistent with locked bucket-handle tear

4d STRENGTH

Left Quadriceps
3+/5 — limited by pain/effusion inhibition

Right Quadriceps
5/5

Left Hamstrings
4/5

Right Hamstrings
5/5

Left Hip Abductors
4/5

Right Hip Abductors
5/5

4e STABILITY / SPECIAL TESTS

Lachman: Negative bilaterally — ACL graft intact. Pivot shift: Negative left. MCL/LCL valgus/varus stress: Grade I medial laxity at 30° left (consistent with medial OA). McMurray's medial: Strongly positive — clunk + reproduction of pain. Apley compression: Positive at 90° with internal rotation. Thessaly test: Positive at 20° — pain and catching sensation medially. Posterior drawer: Negative — PCL intact.

4f NEUROVASCULAR STATUS

Sensation
Intact to light touch L3–S1 bilaterally; no paresthesias

Motor Function
EHL, FHL, tibialis anterior 5/5 bilaterally

Distal Pulses
Dorsalis pedis and posterior tibial 2+ bilaterally

Capillary Refill
<2 seconds bilaterally; no cyanosis

4g GAIT / FUNCTIONAL TESTING

Antalgic gait — shortened left stance phase, reduced knee flexion during swing. Uses forearm crutch on right. Unable to perform single-leg squat on left. LEFT heel-walk: Cannot maintain >3 steps. Weight-bearing: Partial left with assistive device.

L Lab & Imaging Results

5 REVIEWED DATA

5a IMAGING STUDIES

MRI left knee without contrast (03/24/2026): (1) BUCKET-HANDLE TEAR medial meniscus — displaced, anterior fragment in intercondylar notch; 'double PCL' sign present; fragment ~2.8 cm. (2) Grade III medial compartment OA — bone-on-bone contact ~1.2 cm², subchondral sclerosis, marginal osteophytes. (3) ACL patellar tendon graft: intact, appropriate signal/tension. (4) MCL: intact. (5) Moderate joint effusion, synovial thickening; no loose bodies. Standing AP X-rays (urgent care 03/23/2026): Medial joint space narrowing (grade 3 — near bone-on-bone); no acute fracture. Mechanical axis films (today): 3° varus alignment left lower extremity.

5b LABORATORY STUDIES

Pre-op labs (today): CBC WNL. CMP WNL, Cr 0.9. PT/INR 1.0, aPTT 29s. Type & Screen: A+, antibody screen negative. CRP 14 mg/L (mildly elevated — synovitis). ESR 28 mm/hr (mild).

5c OTHER DIAGNOSTICS

No EMG/NCS required. Arthrocentesis deferred — no septic arthritis concern. Joint fluid analysis can be obtained intraoperatively if indicated.

A Assessment

6 ORTHOPEDIC CLINICAL INTERPRETATION

Mr. Kowalski is a 54-year-old male with a displaced bucket-handle medial meniscus tear of the left knee confirmed on MRI (anterior fragment displacement, 'double PCL' sign), occurring with acute pivoting trauma superimposed on Grade III medial compartment OA and prior ACL reconstruction. Mechanical extension block at -12 to -15° and positive McMurray/Thessaly tests corroborate the imaging. The displaced fragment causing symptomatic mechanical locking is not amenable to conservative management — urgent arthroscopic intervention is indicated. Concurrent Grade III medial OA complicates decision-making: TKA could address both pathologies but at age 54 implant longevity considerations favor deferral. Preferred approach: arthroscopic partial medial meniscectomy (resection of unstable displaced fragment) with concurrent medial compartment evaluation; TKA deferred until age ~60+. Surgical candidacy excellent: ECOG 0 baseline, normal pre-op labs, BMI 29.8.

P Plan

7 ORTHOPEDIC MANAGEMENT

7a NON-OPERATIVE TREATMENT

Non-operative management not appropriate as primary treatment — displaced bucket-handle tear with mechanical extension block is a surgical emergency. Pre-op: continue naproxen 500 mg BID + acetaminophen 1000 mg TID. Knee immobilizer fitted today for comfort/fragment protection until surgery. No PT until post-operative period.

7b SURGICAL PLAN

Procedure: Left knee diagnostic arthroscopy + arthroscopic partial medial meniscectomy. Laterality: LEFT. Timing: Urgent — scheduled 05/13/2026 (7 days). Rationale: Mechanical extension block from displaced fragment requires urgent intervention; delay risks further articular damage. Concurrent: Intraoperative chondral assessment; arthroscopic debridement of loose cartilage if identified. Anesthesia: General/spinal — pre-op clearance requested. OR booking confirmed 05/13/2026 at 07:00.

7c WEIGHT-BEARING STATUS & ACTIVITY RESTRICTIONS

Weight-Bearing Status
Partial weight-bearing with forearm crutch (pre-op); WBAT immediately post-op for partial meniscectomy

Activity Restrictions
No pivoting, squatting, or stair climbing until post-op evaluation; no return to sport or labor until 6-week clearance

7d MEDICATIONS & INJECTIONS

No intra-articular injection pre-operatively (effusion + acute tear present). Post-op: tramadol 50 mg Q6h PRN + celecoxib 200 mg BID x14 days + omeprazole. TXA intra-articular intraoperatively per protocol. No steroid injection at this time.

7e WOUND / CAST / BRACE CARE & ADDITIONAL WORKUP

Post-op: arthroscopic portal sites — dry dressing x48h, Steri-strips; no submersion until suture removal 10–14 days. Knee immobilizer x48h post-op for comfort then discontinue. DVT prophylaxis: Aspirin 325 mg BID x2 weeks. Anesthesia pre-op 05/09/2026 (Dr. Maria Chu, MD). NPO after midnight 05/12. Report 05:30 AM on 05/13.

7f PATIENT EDUCATION

Surgical education (40 min): (1) Displaced bucket-handle tear requires urgent arthroscopy — delay risks articular damage. (2) 85–90% success rate for mechanical symptom relief at 2 years. (3) Concurrent Grade III OA means full symptom resolution is not guaranteed — surgery addresses locking, not OA. (4) Future TKA discussion: deferral to age 60+ preferred for implant durability. (5) Warning signs for immediate ER: fever >101°F, severe calf pain/swelling, worsening neurovascular symptoms, wound drainage. Informed consent signed.

F Follow-Up

8 REASSESSMENT PLAN

Follow-Up Schedule
Anesthesia pre-op: 05/09/2026. Surgery: 05/13/2026 at 07:00. Post-op wound check: 05/20/2026. Suture removal + ROM: 05/27/2026. 6-week functional eval + RTW clearance: 06/24/2026. Repeat weight-bearing X-rays at 6-week visit.

TIME DOCUMENTATION & BILLING

Total Time
52 minutes

E/M Level
99204 — New patient, moderate-high complexity

Counseling / Coordination Time
20 minutes

Basis for Billing
Medical Decision Making — High Complexity

Primary ICD-10 Code
M23.202 — Derangement of medial meniscus, left knee

Secondary ICD-10 Code(s)
M17.12 — Primary OA, left knee; Z96.641 — Presence of right artificial knee joint

PROVIDER NAME	CREDENTIALS	DATE & TIME
Nathaniel T. Brooks, MD	MD, FACS — Orthopedic Surgery | Sports Medicine	05/06/2026, 10:30 AM