1 Patient Information

1 PATIENT DETAILS

Name
Tyler J. Harmon

Date of Service
05/06/2026

DOB
09/14/2003

Provider
Dr. Rachel M. Torres, MD — Primary Care Sports Medicine

Age / Sex
22 / Male

MRN
SM-2026-0714

Visit Type
Initial Evaluation — Acute Injury

Sport / Activity
Division I Collegiate Soccer — Midfielder, University of North Carolina

Affected Body Part / Laterality
Right proximal hamstring / ischial tuberosity + right hip flexor

CC Chief Complaint

2 PRIMARY SPORTS-RELATED CONCERN

Patient presents with sudden-onset severe right posterior hip/buttock pain and right anterior hip pain that occurred during a soccer match yesterday (05/05/2026). He states: 'I felt a massive pop in my right buttock when I kicked the ball — I went down immediately and couldn't finish the match. Then I also felt my right hip flexor grab at the same time. I can barely walk and I'm terrified about what this means for my season — we have NCAA tournament play starting in two weeks.' He was unable to return to play after the injury.

S Subjective

3 PATIENT-REPORTED SYMPTOMS, INJURY HISTORY & ACTIVITY LIMITATIONS

3a MECHANISM OF INJURY

Injury occurred during the 67th minute of an NCAA regular season match (05/05/2026) at UNC. Tyler was executing a maximum-force instep kick with the right foot to clear the ball while simultaneously in hip flexion and knee extension — classic mechanism for proximal hamstring avulsion. He felt an immediate audible 'pop' and tearing sensation at the right ischial region, fell to the ground, and was unable to bear weight initially. He was removed from the game on a cart. He also reports a coincident right anterior hip 'grab' — possibly occurring as a secondary strain as he compensated during the kick. No collision, external impact, or fall mechanism involved.

3b SPORT / ACTIVITY CONTEXT

Division I NCAA soccer, University of North Carolina. Position: Central midfielder — high kicking, sprinting, and pivoting demands. Level: Top-ranked program, NCAA tournament seeded; first match in 14 days (05/20/2026). Training load: Pre-tournament peak — averaging 90 minutes of training plus 2 matches/week over the past 3 weeks; increased kicking volume in the past week for set-piece preparation. Playing surface: Natural grass (home field). Equipment: Nike Mercurial boots, no orthotic insoles. He reports no significant training load changes in the immediate run-up beyond the routine increase expected before tournament play. He carries an athletic scholarship contingent on maintaining competitive participation.

3c PAIN LOCATION & CHARACTERISTICS

PRIMARY PAIN: Right posterior buttock/ischial tuberosity region — 9/10 at injury, currently 7/10 at rest and 10/10 with any attempt at hip extension or knee flexion. Pain is sharp, tearing in quality. No radiation below the knee. SECONDARY PAIN: Right anterior hip/proximal thigh — 5/10, aching, consistent with hip flexor strain. No radiation. Both pains exacerbated with ambulation; unable to take full strides. Sleep disrupted by inability to find a comfortable position — 3/10 at rest only when lying supine with hip and knee in slight flexion.

3d FUNCTIONAL IMPACT

Currently unable to walk without significant antalgic limp and right-hand crutch support. Cannot sit on hard surfaces without severe pain. Unable to perform any sport-specific activity: sprinting, kicking, jumping, or change of direction all impossible. Cannot sit in a standard classroom chair; attending class is currently not possible. Unable to drive. NCAA tournament eligibility: If unable to return within 14 days, he misses the first round and potentially the entire tournament — this is his final season as a collegiate player.

3e ASSOCIATED SYMPTOMS

Significant swelling and ecchymosis to the right posterior buttock and upper posterior thigh — developed overnight. Diffuse bruising tracking distally toward the mid-posterior thigh. Sitting is severely limited (cannot weight-bear on the right ischium). No neurologic symptoms reported (no radiating pain beyond posterior thigh, no foot numbness or tingling, no weakness below knee). No hip clicking, catching, or prior labral symptoms. No concussion or head injury.

3f PRIOR INJURY / TREATMENT

LEFT ACL reconstruction with hamstring autograft (June 2024) — used LEFT semitendinosus and gracilis as graft. Fully cleared for return-to-play January 2025 after 7-month rehabilitation. Currently considered fully recovered left side. No prior right hamstring or hip injuries. No prior right-side imaging. Prior treatment for this injury: Ice and NSAIDs (ibuprofen 600 mg TID) applied since yesterday — partial pain relief only. Ace wrap compression applied by athletic trainer. No injection history. Team athletic trainer provided initial evaluation yesterday — referred here today.

3g PERTINENT NEGATIVES

Able to bear weight with crutch — not completely unable. No deformity visible beyond swelling. No paresthesias below the knee. No progressive lower extremity weakness. No bowel or bladder dysfunction. No saddle anesthesia. No loss of consciousness, confusion, or head impact. No fever or systemic symptoms. No history of bleeding disorder or anticoagulant use.

O Objective

4 MEASURABLE & OBSERVED SPORTS MEDICINE FINDINGS

V VITAL SIGNS

Temperature	98.1°F
Blood Pressure	118/70 mmHg
Heart Rate	68 bpm
Respiratory Rate	14 breaths/min
Oxygen Saturation	99% on room air
Weight / BMI	168 lbs (76.4 kg) / BMI 22.1
Pain Score	7/10 at rest; 10/10 with hip extension or knee flexion attempts

4a INSPECTION

Right posterior buttock: Significant swelling (estimated 3–4 cm prominence at ischial region compared to left). Extensive ecchymosis — deep purple/blue bruising tracking from right ischial tuberosity down the posterior thigh to mid-thigh level. No visible deformity of bony landmarks. Right anterior hip: Mild swelling at the right iliac fossa/inguinal region consistent with hip flexor involvement. Gait: Severe right-sided antalgic limp, using single forearm crutch on right side, unable to achieve full right hip extension during gait. Notable right-sided pelvic drop. Left lower extremity: No swelling, no ecchymosis — well-healed arthroscopic portal scars at left knee (prior ACL reconstruction). Posture: Forward-leaning right hip posture (protective flexion).

4b PALPATION

RIGHT ISCHIAL TUBEROSITY: Exquisite point tenderness directly at the right ischial tuberosity — 10/10 with light palpation. Palpable 'step-off' defect at the right proximal hamstring origin — approximately 1.5–2 cm gap felt between the ischial tuberosity and the hamstring muscle belly, suggesting a complete avulsion or near-complete tear. Significant perituberosity swelling and hematoma. RIGHT ANTERIOR HIP: Tenderness at the right anterior inferior iliac spine (AIIS) and proximal rectus femoris — consistent with hip flexor strain at AIIS/rectus femoris junction. No palpable defect in hip flexors. LEFT COMPARISON: Left ischial tuberosity non-tender, firm hamstring origin palpable — confirming asymmetry and loss of normal tissue structure on the right.

4c RANGE OF MOTION

Active ROM — Right Hip
Hip flexion: 60° (painful, severely limited). Hip extension: 0° (cannot extend beyond neutral — 10/10 pain). Knee flexion: 80° (limited and painful).

Passive ROM — Right Hip
Hip flexion: 75° with pain. Hip extension: neutral only with 9/10 pain. Knee flexion: 90° passive (pain at end range).

Active ROM — Left (Comparison)
Hip flexion: 130°. Hip extension: 20°. Knee flexion: 140°. Normal and pain-free.

Pain-Limited Motion
ALL hip extension and active knee flexion against gravity severely pain-limited on right. Sitting ROM severely restricted.

4d STRENGTH

RIGHT HAMSTRINGS: Manual muscle testing unable to be completed — attempt at resisted knee flexion (0–10°) produces 10/10 pain and no effective force generation. Estimated 0–1/5 due to pain inhibition and suspected avulsion. RIGHT HIP FLEXORS (rectus femoris, iliopsoas): Resisted hip flexion 3+/5 — painful but functional force generated. RIGHT QUADRICEPS: 5/5 (unaffected). LEFT LOWER EXTREMITY: 5/5 throughout. GLUTEAL STRENGTH (right): Difficult to assess — pain limits maximal contraction; estimated 2/5 due to protective inhibition.

4e STABILITY / SPECIAL TESTS

PURANEN-ORAVA TEST (proximal hamstring): Positive right — flexed hip with knee in extension produces immediate severe pain at ischial tuberosity. BENT KNEE STRETCH TEST: Positive right — posterior ischial pain with progressive knee extension in 90° hip flexion. ACTIVE STRAIGHT LEG RAISE: Unable to perform right — immediate pain at ischial origin. ISCHIAL PALPATION (prone): Palpable gap/defect confirmed in prone position — gap estimated 1.5 cm between ischial bony origin and hamstring musculotendinous unit. FABER/FADIR: Positive right FADIR (limited, painful at end range — consistent with hip flexor involvement; no labral catch or click). HIP FLEXOR SPECIAL TESTS: Thomas test — right hip unable to fully extend (hip flexion contracture approximately 15° right). Ely test — positive right (limited knee flexion in prone — quadriceps tightness/compensation).

4f NEUROLOGIC / VASCULAR STATUS

Sensation
Intact to light touch throughout right lower extremity including posterior thigh and foot. No dermatomal sensory loss. Sciatic nerve region intact.

Motor Function
No focal neurologic deficit below the knee. Tibialis anterior, EHL, gastrocnemius 5/5 bilaterally.

Reflexes
Patellar 2+ bilateral. Achilles 2+ bilateral. No pathologic reflexes.

Distal Pulses / Capillary Refill
Dorsalis pedis and posterior tibial 2+ bilaterally. Capillary refill <2 sec. No vascular compromise.

4g FUNCTIONAL TESTING

Unable to perform sport-specific functional testing today given pain severity. Single-leg hop: Not attempted. Squat: Partial squat to 45° hip flexion only — right side. Running/jogging: Not attempted. Gait analysis: Severe right antalgic pattern with forearm crutch; right stance phase severely abbreviated; no right hip extension during terminal stance. Balance: Single-leg stance right not attempted. All sport-specific functional testing deferred until pain and structural integrity allow — minimum 4–6 weeks post-injury.

CH Concussion / Head Injury Assessment

5 HEAD INJURY SCREEN

Loss of Consciousness
None

Amnesia
None

Confusion / Dizziness
None

Headache / Nausea
None

Visual Symptoms
None

Balance / Cognitive Symptoms
None

No head contact or concussion mechanism. Head injury assessment not applicable to this encounter. SCAT5 not administered.

L Lab & Imaging Results

6 REVIEWED DATA

6a IMAGING STUDIES

X-RAY RIGHT HIP / PELVIS (AP and lateral, obtained today — UNC Sports Medicine radiology): RIGHT ISCHIAL TUBEROSITY: Avulsion fracture of the right ischial tuberosity confirmed — bony fragment visible with estimated displacement of 2.1 cm from the ischial tuberosity. Fragment size approximately 2.5 x 1.8 cm. This is a complete proximal hamstring avulsion with osseous component. No other pelvic fractures identified. Symphysis pubis: normal. Sacrum: intact. RIGHT ANTERIOR INFERIOR ILIAC SPINE (AIIS): Subtle lucency/irregularity at right AIIS — cannot exclude apophyseal injury/avulsion at rectus femoris origin on plain film; MRI required for definitive evaluation. MRI RIGHT HIP/PELVIS WITHOUT CONTRAST (ORDERED URGENTLY — scheduled 05/07/2026): To assess: (1) Degree of proximal hamstring tendon avulsion and retraction (complete vs. partial, retraction distance); (2) AIIS/rectus femoris avulsion vs. soft tissue strain; (3) Sciatic nerve involvement/proximity; (4) Hematoma extent. Ultrasound not used — X-ray sufficient for bony avulsion; MRI superior for soft tissue characterization.

6b LABORATORY STUDIES

No labs ordered today — not clinically indicated for acute sports injury without systemic concerns. CBC, CMP not required at this visit.

6c OTHER DIAGNOSTICS

No prior imaging of the right hip available. Prior left knee MRI (06/2024, pre-ACL surgery): Left ACL rupture confirmed; hamstring graft harvest (semitendinosus/gracilis) documented — LEFT hamstrings only partially functional post-harvest, but right hamstrings are the primary focus. Athletic trainer's field evaluation (05/05/2026): Documented positive ischial tuberosity palpation, severe antalgic gait, inability to perform kicking motion.

A Assessment

7 SPORTS MEDICINE CLINICAL INTERPRETATION

Tyler Harmon is a 22-year-old Division I collegiate soccer midfielder presenting with a high-energy, kicking-mechanism injury resulting in: (1) COMPLETE PROXIMAL HAMSTRING AVULSION WITH ISCHIAL TUBEROSITY FRACTURE (right) — bony avulsion confirmed on X-ray (2.1 cm displacement, ~2.5 x 1.8 cm fragment). This is a complete injury given the palpable gap at the ischial origin, absent hamstring force generation, and 2.1 cm bony displacement. Injuries >2 cm displacement in active athletes have strong evidence supporting surgical fixation over conservative management; this case warrants urgent orthopedic surgery consultation. Mechanism: maximum-force kicking with simultaneous hip flexion and knee extension — the classic avulsion mechanism. (2) CONCURRENT RIGHT HIP FLEXOR STRAIN (Grade II, probable rectus femoris at AIIS) — secondary injury, confirmed by AIIS tenderness, positive Thomas test, and X-ray lucency at AIIS. MRI will clarify severity. (3) Prior left ACL reconstruction (hamstring autograft) — this history is particularly relevant: if surgical repair of the right proximal hamstring is required, autograft options are limited (left hamstrings partially harvested); this affects surgical planning. Sport participation status: OUT — unable to participate in any training or competition. NCAA tournament implications are significant but do not change the medical management strategy. Risk factors for delayed recovery: high athletic demands, upcoming tournament pressure, bilateral hamstring history.

P Plan

8 SPORTS MEDICINE MANAGEMENT

8a ACTIVITY MODIFICATION & SPORT RESTRICTION

FULL SPORT RESTRICTION effective immediately. Non-weight-bearing or touch weight-bearing right lower extremity with forearm crutches until orthopedic surgery evaluation and MRI review determine definitive management. No kicking, sprinting, or resisted hip extension/knee flexion of any kind. No soccer participation — including standing on the sideline for extended periods if it exacerbates pain.

8b RETURN-TO-PLAY / RETURN-TO-ACTIVITY GUIDANCE

Return-to-play timeline is dependent on MRI findings and surgical decision: CONSERVATIVE MANAGEMENT (if displacement <2 cm on MRI and surgical team concurs): Minimum 8–12 weeks before sport-specific activity, 4–6 months for full RTP at Division I level. SURGICAL REPAIR (expected given 2.1 cm displacement): Minimum 4–6 months post-op before return to unrestricted play; some cases require 6–9 months for competitive return. NCAA tournament play in 14 days is NOT feasible under either management pathway. This must be communicated clearly and compassionately to the athlete, athletic department, and coaching staff. Medical clearance letter to athletics to be provided following MRI review and surgery consultation outcome.

8c PHYSICAL THERAPY & REHABILITATION

Formal PT referral to be placed following MRI review and surgical consultation. Pre-surgery: Gait training with crutches. Pain control. Gentle hip flexor stretching (unaffected directions only). Proximal core and upper body conditioning to maintain fitness. Post-surgery (if applicable): Standard proximal hamstring repair rehabilitation protocol — phases: protective (0–6 weeks, NWB), progressive weight-bearing (6–12 weeks), early strengthening (12–16 weeks), sport-specific training (16–24 weeks), return-to-play testing (6 months). Referral placed to UNC Sports Medicine PT team (Dr. Janet Wells, DPT, SCS).

8d BRACING, TAPING, ORTHOTICS & EQUIPMENT

Forearm crutches — continue until surgical/conservative plan confirmed. Hip compression shorts for soft tissue support and comfort (UNC athletic trainer to fit). Ice 20 minutes Q2–3h to right posterior hip and anterior hip. Cushioned donut pillow for sitting — ischial offloading when sitting is necessary. No taping or bracing for the avulsion acutely. Return to athletic footwear will be addressed in rehabilitation phase.

8e MEDICATIONS, INJECTIONS & PROCEDURES

Continue ibuprofen 600 mg PO TID with food for 5 days (anti-inflammatory and analgesic benefit in acute phase). Add: Acetaminophen 1000 mg PO Q8h (multi-modal analgesia). Consider: Tramadol 50 mg PO Q6h PRN for severe pain if NSAIDs/acetaminophen insufficient — prescribed x5 days. NO INJECTION at this time — corticosteroid injection at the hamstring origin would impair healing of an avulsion injury. Ice compression per above.

8f PATIENT / ATHLETE EDUCATION

Tyler and his parents (present today) were counseled extensively (35 minutes): (1) X-ray confirms a bony avulsion fracture of the ischial tuberosity with 2.1 cm displacement — this is a significant injury requiring orthopedic surgery evaluation; (2) Based on current evidence, displacement >2 cm in young active athletes generally warrants surgical repair for best long-term outcomes, though MRI findings will guide final decision; (3) NCAA tournament participation in 14 days is medically not possible under any scenario; (4) Left hamstring graft history was explained in the context of surgical planning; (5) With optimal management, return to Division I soccer is the expected long-term outcome; (6) Warning signs requiring ER: new foot weakness or numbness, inability to urinate, worsening swelling or redness; (7) Academic accommodations letter provided for disability services — need for standing desk and exam accommodations given inability to sit.

F Follow-Up

9 REASSESSMENT GOALS

Follow-Up Schedule

MRI right hip: 05/07/2026 (tomorrow). Orthopedic surgery consultation (Dr. Marcus Webb, MD — Hip Reconstruction): 05/08/2026 — urgent, same-week referral placed. Sports medicine follow-up after surgical decision: 05/12/2026. Communication to UNC athletics and head coach: Letter to be sent by 05/08/2026 following surgical consult outcome.

TIME DOCUMENTATION & BILLING

Total Time	**E/M Level**
48 minutes	99204 — New patient, moderate-high complexity
Counseling / Coordination Time	**Basis for Billing**
20 minutes	Medical Decision Making — High Complexity
Primary ICD-10 Code	**Secondary ICD-10 Code(s)**
S76.311A — Strain of muscle, fascia and tendon at thigh level, right, initial encounter	M84.352A — Stress fracture, right hip (ischial tuberosity avulsion); S76.111A — Strain of right hip flexor, initial encounter

PROVIDER NAME	CREDENTIALS	DATE & TIME
Rachel M. Torres, MD	MD — Primary Care Sports Medicine | CAQ Sports Medicine	05/06/2026, 10:15 AM