CLARENCE M. LEARY, M.D., INC.
PRACTICE LIMITED TO ORTHOPAEDIC SURGERY
1240 WEST VINE STREET
LODI, CALIFORNIA 95240
TELEPHONE 334-4000

May 4, 1989

Tammy Chacon
Claims Examiner
Bierly and Associates
1850 North Gateway Blvd.
Fresno, California 93727

Re: MEIDINGER, Donald
Emp: San Joaquin MAD
D/A: 06-10-88
File #:888-5079

Dear Ms. Chacon:

I saw Mr. Meidinger on 05-03-89 to evaluate the injury to his right knee that he sustained on 06-10-88.

History of injury - The patient states that he was walking along the very edge of a bridge when one of the planks, which was unsecured, tilted when he put his right foot on the end of the plank. It tilted up and he started to fall. His left leg was on another plank. As his weight shifted, the first plank started to tilt back but his leg had slid between the tilted plank and the one that his left lower extremity was on. In so doing it squeezed his knee between the two planks and he had immediate symptoms on the medial aspect of the right knee. The patient states that he has continued to work in spite of the symptoms that he has and probably has missed a total of three days work and that being for medical care.

The patient states that he had a sensation of locking in his knee until about three weeks ago but it has apparently subsided. It would lock when his knee was almost completely extended or when it was flexed to about 90 degrees. When it would lock, he could not bend it or straighten it out. He would relax and it would then return to the normal soreness. The patient states that he has a lot of stiffness in the morning, that the best time of day is when he finishes work, sits down, and is able to rest the knee. Driving an auto or a pickup with the knee partially flexed causes him a great deal of pain. He has excruciating pain when he bumps the medial aspect of the right knee. He is unable to squat. The patient has had two weeks of physical therapy without any essential change. He was told that he had atrophy of his right thigh as compared with the left.

Past History - He is not taking any medications at this time. He had not injured the knee previously. There is a family history of diabetes in his father. The patient had an arthrogram at Lodi Memorial Hospital on 08-23-88.

I reviewed the reports from Vinewood Medical Group in Lodi where he first sought treatment and the letters of Doctor Demski in Lodi.

On physical examination, the patient is a well developed, well nourished 36-year-old male who stands 6 feet tall and weighs 208 pounds. As he walks into the office, he has a slight limp favoring the right lower extremity. As he stands, the pelvis is level. He is able to walk on his heels and toes. In the supine position, both lower extremities are equal in length. Both knees measure 15" in circumference. The lower thigh on either side measures 18" and 6" above the patella. The right, the injured, is 19-3/4" and the left is 20". The patient lacks 5 degrees of complete flexion on the right as compared with the left. He can extend either of them equally well. There is a slight rubbery sensation with complete extension. In the sitting position, there is no obvious swelling. The cruciates are intact. The collateral ligaments are intact. The patellofemoral articulation is normal. External rotation, sudden external rotation of the right leg causes pain on the medial aspect of the joint. The patient has point tenderness about 1 cm. in diameter at the level of the joint line under the medial collateral ligament. I am unable to get a positive McMurray however in the prone position he does have consistent Apley test. There is no rotatory instability. The tendon reflexes are equal and physiological. There is good strength in the extensor hallucis longus.

I reviewed the arthrogram and the plain films of his knee and there is no definite evidence that I can see of an injury to the meniscus or to the bony structures.

The clinical impression is one of two problems. One, he could well have post-traumatic bursitis under the medial collateral ligament. The other is that he has a tear of the medial meniscus which did not show on the arthrogram and would account for a probable positive Apley.

Advise - If it is a post-traumatic bursitis under the medial collateral ligament, a wedge on the inside of his heel will take some of the tension off the collateral ligament and along with taking an anti-inflammatory, his symptoms should improve. If they do not improve and one anticipates arthroscopy of the knee, I would certainly recommend an MRI prior to a surgical procedure. It would give a better demonstration of the intra-articular pathology than did the arthrogram. He may well need arthroscopy but I would not recommend it at this time.

Sincerely,

Clarence M. Leary, M.D.

CML:kr