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July 2, 1993

**Paul H. Saltzen**
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**1912 "I" Street, Suite 102**
**Sacramento, CA 95814**

Re: **MEIDINGER, Donald**
**Date of Evaluation: May 11, 1993**
**Place of Evaluation: Stockton, California**

Dear Mr. Saltzen:

Thank you very much for having referred Mr. Donald Meidinger to me for interview and evaluation. I interviewed and evaluated Donald Meidinger, in Sacramento, California, on May 11, 1993 (12:15 hours - 12:47 hours). I reviewed the medical records kindly provided.

Mr. Meidinger lives in Lockeford, California, and he is 40 years old. He had injured his right knee in 1988, and his left knee in September 1990. (The patient had right knee arthroscopy in 1989 and left knee arthroscopy in April of 1992.) He had injured his left knee when he stepped in a hole. He missed about three months of work. He returned to work in July of 1992 and is working now. He has worked for the San Joaquin County in mosquito abatement, as a mosquito control technician. His job involves checking properties, looking for larvae, walking on difficult terrain, and working the aquatic dipper, carrying a 30-lb sprayer, and doing a lot of driving.

The patient noted some upper spinal and shoulder symptoms while hefting some spraying equipment in January of 1992. Date of injury is January 27, 1992, and there was conservative treatment and some work loss. At the time of the injury, he noted the onset of neck pain, left arm pain, and a feeling of numbness in the left hand. He still has occasional hand symptoms which bother him. The left hand tends to tingle more than the right hand.

He has difficulty with the full efforts of his job because of left knee pain and he has left knee pain with running. He had originally hurt his right knee, as noted above, when he fell on a boarded plank, in 1988, had right knee scope in 1989, and he states that his right knee is "pretty good - not perfect," but he still has difficulties with his left knee. He has had, as noted above, therefore, arthroscopics of both knees.

He has no history of any lung or heart disease, high blood pressure, diabetes or circulatory problems. The balance of the medical review of systems is negative.

The family history is noncontributory. The patient has no known allergies, does not smoke, consumes maybe two or three beers a day, and has no history of drug misuse.

He was born in Sacramento, California, and is a life-long California resident. He is married, has a high school education and some junior college. He is able to read and write well, and is skilled as a mosquito control technician II, state certified.

He has worked for San Juaquin Mosquito Abatement. He is working at the present time as an assistant supervisor - control technician. He does not employ crutches, a cane or a brace. He has a driver's license, is left-handed, can walk five blocks, climb more than a flight of steps, and is able to lift more than 40 lbs. He has given up his hobby of baseball because of his knees difficulties, but he can do household chores. His height is 6'0", weight is 210 lbs.

The postoperative diagnosis after the March of 1992 (not April of 1992) arthroscopy was a comminuted tear of the posterior horn of the medial meniscus, medial plica, Grade II chondromalacia, and then old cruciate tear. The postoperative diagnosis was a left knee derangement. There was not any history of previous left knee problem before an injury which was described as stepping in a hole on April 4, 1990.

In 1991, Dr. Kitayama had made a clinical diagnosis of a left knee derangement. The March of 1992 surgery was discussed by Dr. Kitayama. Follow-up knee examination - left knee showed ongoing pain, but a full range of motion, conservative treatment postoperatively, including physical therapy, was offered. The September 4, 1990 left knee injury was noted in the work records.

There was a previous June 10, 1988 injury (right leg was caught in a bridge - right knee injury). Meniscal degeneration was noted in the right knee MRI and right knee arthroscopy was done by Dr. Leary in June of 1989.

Dr. Pfeifle had taken note of January 27, 1992 injury with neck and shoulder pain and complaint of left hand and arm numbness and tingling.

## PHYSICAL EXAMINATION

My own physical examination of the patient, performed at this time, revealed no gross abnormalities of general appearance or of mental status. Vision and hearing were satisfactory. Blood pressure was 140/90, pulse was 80 and regular, and no dyspnea, cyanosis, edema or cough were noted. Eyes, funduscopic examination and cranial nerves were normal. Ears, nose, mouth, teeth and throat were normal. Neck showed no abnormalities of trachea, veins or thyroid. No scars were noted. Lungs, heart and pulses were normal. Abdominal and skin examinations were normal.

Musculoskeletal examination revealed no current abnormalities to inspection, palpation or range of motion of neck, mid back, low back, hips or knees. There was tenderness to palpation over the knees (left worse than right). The patient was able to hop satisfactorily on the right knee but only poorly on the left knee. He able to heel and toe walk satisfactorily. Range of motion of each knee was full, and I observed no swelling or instability, but There was tenderness to palpation over the left knee, mainly on the lateral aspect.

The neurological examination revealed no gross sensory or motor deficits. Tone, stance and speech were normal. All tendon reflexes were 2+. No pathological reflexes were noted.

## DIAGNOSTIC IMPRESSION

1. Knee difficulties, status post bilateral derangements and bilateral surgeries, with ongoing left knee symptoms, and rather minimal right knee symptoms.

2. Spinal strain syndrome, status post January of 1992 spraying-hefting incident, some intermittent hand numbness, left worse than right.

**DISCUSSION**

This patient, who does not appear to be superb with dates, hurt his right knee in June of 1988, had right knee arthroscopy with minimal residual symptoms. He hurt his left knee in September of 1990, and then had left arthroscopy, as noted above, in March of 1992. He had in December of 1990, some left eye pain, possibly related to flash or foreign body. (He says foreign body).

On January 27, 1992, he noted spinal, shoulder and left-right hand symptoms while spraying. Although mention is made of a February 4, 1992 injury, I think that is just a day he filled out some paperwork, and I think he had stopped working on January 31, 1992. I don't believe that any further injury happened on February 4, 1992. He returned to work in February of 1992.

In any event, the patient describes ongoing knee symptoms, and describes modest residual spinal, shoulder and hands symptoms at this time. I found no evidence of neurological difficulty, deficit or disability. I defer-refer to orthopedists, regarding his knees difficulties, but it must be noted that the patient is back on the job, and since his arthroscopy is only about a year old (left knee), he may improve further. He appears to have only modest residual symptoms and no real difficulties as a result of the right knee arthroscopy.

At the present time, despite hands numbness complaint, I do not demonstrate any neurological deficits, and I do not currently demonstrate any derangement relevant to neck, shoulder and hands area. The patient's spinal, shoulder and hands symptomatology is apparently secondary to the January 27, 1992 event. His left knee difficulties are due to the September of 1990 injury, and his previous right knee difficulties are due to the June of 1988 right knee injury.

The patient's condition may or may not be permanent, stationary, stable and ratable (relevant to knee problems). It may be permanent, stationary, stable and ratable due to his spinal-shoulder-hands symptoms, in my opinion. He has intermittent left worse than right hands tingling. I would state that the patient's current level of hands tingling (left worse than right) and neck-shoulder difficulties are symptomatology of the magnitude of pain intermediate between none and slight. I was not impelled at this time to order any further testing. If the patient's hand, arm and shoulder-neck symptoms worry or alarm, a repeat

evaluation of the patient combined with imaging studies and electrodiagnostics might conceivably yield useful information but, as noted above, at the present time it does not appear that the patient has any worrisome worsening or "big-league" neck-shoulder-arm-hand symptoms. Differential diagnosis might include entities such as root irritation or carpal tunnel syndrome but as noted above I was not impelled to order any further testing on this patient's behalf at this time. The patient therefore might well be, as described as noted above relevant to his neck, shoulder, arm and hand symptoms as permanent, stationary, stable and ratable but if things change or worsen, a repeat evaluation might be helpful. The patient is not a qualified injured worker, and is capable of continuing to work for County of San Joaquin Mosquito Abatement District. I advise ongoing conservative care. He does not appear to have any residual eye problems.

Thanks for the referral. I have filled out IMC and SAAG forms.

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me and, except as noted herein, that I believe it to be true.

Respectfully yours,

Michael M. Bronshvag, M.D.
Diplomate in Neurology, ABP&N
Diplomate in Internal Medicine, ABIM

Date 9 July 93

County SJC

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