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Administrator

Novembver 5, 1992

Keenan and Associates
392 D Connors Court
Chico, CA 95926

**ATTN:** Elena Piazzisi
Senior Claims Examiner

**RE:** **MEIDINGER, Donald**
**DOI:** **09-04-90 & 06-10-88**
**CL#:** **6938-91-0003**

Dear Ms. Piazzisi:

I examined Donald Meidinger at your request on November 5, 1992. The following is a report based on my history and physical examination, review of records you provided, and x-rays all obtained on that date.

**HISTORY**
This 40-year-old male states that he was in good health until sustaining two injuries - one to each knee - in 1988 and 1990.

He states that on June 10, 1988, when he was walking across a makeshift bridge in his job as a mosquito abatement control technician, the bridge swayed and his right leg was caught in the bridge. Since that injury he has had pain as well as locking of his right knee. He sought care by Dr. Clarence Leary of Lodi, California. Dr. Leary treated the patient with an arthroscopy of his knee and resection of a torn medial meniscus. Since that time, Mr. Meidinger says his knee has done well; it does not limit him in activities; however, he continues to have soreness on the medial side of the knee occurring several times per week. He also has an ache there. He chooses not to run because of the soreness, but is otherwise not limited.

His second injury was to his left knee on September 4, 1990. Again working in his job as a control technician, he was walking across a field that was covered with water and his left leg stepped into a post hole. He sustained a hyperextension injury as he fell forward. He had significant pain of his knee, aching over the medial side of the knee and swelling. He was treated by Dr. Darryl Kitayama of Lodi who eventually performed an

arthroscopy in March 1992, with resection of the medial meniscus and a medial plica of the left knee. Since that time, the knee has substantially improved; it no longer swells. He does have an achy sensation of the medial side of the knee similar to the right knee which is exacerbated with his long-time spending on his legs at his job, but he is not limited in his activities except that he chooses not to run. He has no locking of either knee. He has no giving-way of either knee.

Dr. Kitayama's evaluation of Mr. Meidinger was that he had some posterior instability of the left knee. Mr. Meidinger does not describe any symptoms of instability.

He has tried an anti-inflammatory, specifically, Lodine, which eliminated pain in his knees; however, it did give him diarrhea and he chose not to take that at this time.

**PAST MEDICAL HISTORY**
The patient has had no other major medical problems. He has had no surgeries except those as listed above. He takes no regular medications.

**OCCUPATIONAL HISTORY**
He has worked as a control technician for the Mosquito Abatement District for the past 18 years. He also works as a volunteer in a fire department.

**PHYSICAL EXAMINATION**
The patient is 5'11" in height and weighs 205 lbs. He is a healthy-appearing male in no acute distress. He walks with a normal gait. He can squat with some description of tenderness to the medial side of both knees. He has full extension and flexion to 140° bilaterally. He has equal thigh circumferences bilaterally. He has no effusion and negative McMurray tests. He has no medial joint line tenderness or other tenderness. The left knee does have anterolateral rotatory instability with a positive rotator drawer test with the knee at 90°. He has a negative Lachman's test. He has negative sag sign. He has a negative posterolateral drawer test. His neurovascular status is intact.

**X-RAYS**
X-ray examination of the knee that the patient brings with him from Dr. Kitayama's office of April 1991, is normal.

I have taken a standing film of both knees which shows a mild increased sclerosis of the medial tibial plateaus bilaterally. No other abnormalities.

**REVIEW OF RECORDS**

There are follow-up notes from Dr. Kitayama, the last one dated on June 24, 1992, describing "a slight flare-up of pain along the medial joint". He had a minimal popping sensation, but no locking or giving-way. He had taken some Advil so he prescribed Lodine to try to decrease his symptoms.

Other postoperative notes are of good progress following arthroplasty.

There is a physical examination from Lodi Memorial Hospital with pertinent exam of the left knee showing full range of motion, no effusion, 2+ anterior drawer as well as a posterior sag, 2+ opening to valgus with good end-point.

MRI scan report showed a tear of the medial meniscus.

There is an Operative Note dated March 23, 1992, describing a resection of a large medial plica as well as a partial medial meniscectomy. There is an area of chondromalacia beneath the medial plica as well as grade II chondromalacia of the medial femoral condyle. A tear of the medial meniscus was in the posterior horn; it was a complex tear. Cruciate ligaments were intact as was the lateral compartment.

There is a letter from Dr. Kitayama dated April 11, 1991, stating the patient had injured his left knee in a fall as he described it to me on April 4, 1990. He had been previously treated conservatively by Vinewood Family Practice. He continued to have symptoms in the knee, stating they were unchanged. He had medial pain and pain posteriorly on standing for a long period of time or with a lot of walking. There was no locking, popping or giving-way. Physical examination showed tenderness about the superior pole of the patella, tenderness in the medial joint line, positive posterior drawer as well as posterior sag, 2+ opening to valgus stress with good end-point. He felt the patient had a partial tear of the posterior cruciate ligament and medial collateral ligament as well as an internal derangement. He thought this should be treated conservatively.

There is a doctor's first report of injury signed by James Grady dated September 27, 1990, describing injury to the patient's left knee on September 4, 1990. Objective findings were no swelling or effusion, negative drawer sign, ligaments were stable and it was felt to be an inflammatory problem of the knee, rule out torn meniscus. He was given prescription for Naprosyn. If he was not better, to seek orthopedic consultation.

There is a report by Michael R. Klein Jr., M.D., of Carmichael, dated October 2, 1990, regarding the patient's injury of June 10, 1988. Following Mr. Meidinger's arthroscopy in June of 1989, he returned to work in August 1989, however, continued to have pain in the knee. He was treated with Orudis and Dr. Leary told him that he felt a repeat MRI scan may be helpful to rule out retained fragments of the meniscus. At the time of his examination, Dr. Klein mentioned that the patient stated his symptoms were pain in the knee most of the time. He was unable to squat or kneel. He had some buckling of the knee. His pain was posteromedial. He also described swelling toward the end of the day. Physical examination showed a "very mild antalgic gait". There was 1 cm atrophy of the right thigh compared to the left. He had a full range of motion. There was tenderness along the posteromedial joint line and Dr. Klein's impression was a tear of the medial meniscus with retained meniscal fragment.

There is a follow-up note from Dr. Klein to the patient stating that a follow-up MRI scan had been approved and asking the patient to contact his office.

There are follow-up notes from Dr. Clarence Leary of Lodi following his right knee arthroscopy of the patient which were routine until the note of August 15, stating that when he went back to work the previous Monday, he had been bothered on the following Friday and it hurt over the weekend when he was working hard. He had a little bit of swelling and a little stiffness. He was given a few Orudis tablets.

There is an Operative Report dated June 21, 1989, signed by Dr. Leary, describing a jagged tear of the posterior horn of the medial meniscus which was excised.

There is a report of an MRI of the right knee dated May 25, 1989, signed by Chull Song, M.D., with the impression of intrameniscal degenerative change, posterior horn, medial meniscus, without evidence of a frank tear.

There is a letter from Dr. Leary dated May 4, 1989, stating he had seen the patient on May 3, 1989, for injuries sustained on June 10, 1988. His description of the injury was the same as the patient states to me today. He described the sensation of locking in the knee until about three weeks before Dr. Leary saw him and then completely subsided. He described morning stiffness. He was unable to squat. Physical exam showed a slight limp on ambulation. He lacked 5° of complete flexion on the right compared to the left. He had good extension. He had a positive Apley test with a negative McMurray test. He reviewed the MRI scan and x-rays, and did not find any specific pathology. He felt that the patient could have a post-traumatic

bursitis or tear of the medial meniscus. He recommended a wedge on the medial side of the shoe and if that did not resolve his symptoms, an MRI scan.

There is a note from Dr. Demski describing the patient having persistent pain after physical therapy and he was going to be scheduled for surgery. This was dated for April 7, 1989.

There is a first note from Dr. Demski dated February 2, 1989, at which time he described "symptoms and findings compatible with a medial meniscus tear". He felt physical therapy was indicated. If that was not successful, arthroscopic surgery was indicated.

**DIAGNOSES**
1. Status post medial meniscectomy, right knee
2. Status post medial meniscectomy, left knee

**DISCUSSION**
Mr. Meidinger has had two separate work-related injuries: The first was on June 10, 1988 when, while walking across a bridge, he slipped and injured his right knee catching it in the bridge. Subsequent to that he had locking, swelling and pain and underwent an arthroscopic medial meniscectomy in 1989 by Dr. Leary. This resolved any recurrence of the locking and he has done well after his first few months. He persists in having mild discomfort on the medial side of the knee with prolonged walking or sitting. He also chooses not to run because of the pain.

On physical examination, he has no tenderness of the knee; he has a full range of motion; he has some soreness with squatting; he has negative McMurray test; he has no ligamentous laxity.

X-ray examination of the knee is essentially normal.

His second injury was on September 4, 1990, when he sustained a hyperextension and probable twisting injury to the left knee. Following this he has been treated by Dr. Kitayama who noted a laxity of the posterior structures of the knee as well as a probable medial meniscal tear. In March 1992, he performed an arthroscopic partial medial meniscectomy. Following this procedure, the patient has noticed a significant decrease in the knee, pain and swelling of the knee. He has never had locking of the left knee. He says that currently it is similar to the right in that it bothers him some with prolonged walking and that he chooses not to run because of the pain. His pain is over the medial side of the knee.

Physical examination shows no tenderness of the knee and a full, active range of motion. He has some soreness with squatting. He has a negative McMurray test. He has a negative Lachman's test.

He has a negative posterior drawer, but he has anterolateral rotatory instability. He has a negative posterior lateral drawer test. He has a negative sag sign.

Dr. Kitayama described injury to the posterior cruciate and medial collateral ligament of the left knee. I would differ somewhat in that I think the injury is to the posterolateral corner of the knee, but in any event, the mild laxity of the left knee does not seem to be symptomatic. Mr. Meidinger's problems are with pain over the medial side of both knees. There was a description from Dr. Kitayama's Operative Report of chondromalacia over the medial femoral condyle where the plica was and also in the area of the medial meniscal tear. I feel this may explain his continued soreness in the knee. It is also possible that a small meniscal fragment may remain. These same considerations exist for the continued symptomatology in the right knee.

Mr. Meidinger has had good relief of his pain with an anti-inflammatory; however, the one which he took - Lodine - did give him diarrhea, so he stopped taking it. I feel that at this stage, he should be treated symptomatically. I think Nuprin, Advil or possibly another prescription anti-inflammatory may be useful to decrease his symptoms and that they may be used periodically. I doubt he will elect to use them on a regular basis.

I think consideration may need to be given sometime in the future, to a repeat arthroscopy of one or both knees to try to decrease his symptomatology. It does not appear to be necessary at this time and Mr. Meidinger is not interested in surgery. He states that after his physical therapy following both surgeries, his knees felt much better and it is also possible that a vigorous program of quadriceps strengthening may help decrease his symptoms. I do not feel that physical therapy is indicated at this time.

I feel that periodic medical evaluations by Dr. Kitayama or the surgeon of his choice, are indicated. I do not feel that regular on-going treatment is necessary.

I do feel that he is permanent and stationary at this time; I feel it is very unlikely that his symptoms will substantially change. I do feel that he has a disability having had partial meniscectomies of both knees. I feel he is limited in running and jumping. I feel that he can lift; I feel that he can walk as tolerated. I see no limitation in his being able to continue in his job as a control technician in the Mosquito Abatement District. I feel that he falls under Category A of the guidelines of work capacity.

I see no evidence of pre-existing injury and I feel that apportionment is not indicated. I feel that his injuries were wholly responsible for the meniscal tears in both knees, also for the ligamentous damage to the left knee.

If there are questions about this report, please feel free to contact me.

Sincerely,

George W. Westin, M.D.

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