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November 21, 2006

Mr. Reuben Doing
Attorney At Law
177 Bovet Road, Suite 600
San Mateo, Ca. 94402

RE:
DOI: 8-31-05

Dear Mr. Doing,

~~Eric Test~~ was seen by me at your request on October 17, 2006 for the purposes of an Ortnopedic Medical Legal Evaluation. The history taking, physical examination, review of medical records and preparation of this report were performed by ~~James C. Simpson, M.D.~~

RECORDS REVIEWED

1. Australian Physical Therapy Specialists
2. American Medical Response
3. Remington Podiatry Group
4. John Missirian, M.D.
5. Santa Clara Therapy
6. El Camino Hospital, Volumes I and II
7. Camino Medical Group
8. Deposition of Eric Test, M.D.

Australian Physical Therapy Specialists

Billing records were noted.

October 25, 2005: Physical therapy evaluation. Patient evaluated for left knee stiffness status post left patellar fracture. Range of motion -10 to 48 degrees.

November 8, 2005: Physical Therapy Progress Report. No longer has resting pain. Walking with a front wheel walker. Range of motion -6 to 100 degrees.

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November 18, 2005: Physical Therapy Progress Report. Patient complains of buckling. Range of motion 0 to 108 degrees.

December 20, 2005: Physical Therapy Progress Report. Patient completed 13 sessions and has occasional "near falls." Complains of weakness of the left knee.

February 3, 2006: Physical Therapy Progress Report. The patient is status post left patellar fracture. She is ambulating for 45 minutes but has difficulty with stairs. Range of motion 0 to 110 degrees. Instructed on a home exercise program.

Records of American Medical Response

Billing records are for services of August 31, 2005: \$1,221.00.

August 31, 2001: 73-year-old female with mechanical fall and complained of right knee pain. Reported she tripped over a rise in the sidewalk. Noted to have abrasion, tenderness, and swelling to left knee. Right knee pain 8 out of 10. The patient was transported to El Camino Hospital.

Records of Remington Podiatry Group

May 14, 1999: Initial consultation, Richard Koenigsberg, DPM. The patient presented with a primary complaint of chronic ulceration of the right foot. She had a history of multiple surgeries in both feet including arthrodesis second and third bilaterally, arthroplasty right fifth toe and plantar fascia release bilaterally. The patient was diagnosed with neurotrophic ulcer right foot, subfirst MP joint, bilateral keratomas, a Charcot-Marie tooth disease, hammertoes two through five on the left, two through four on right, bilateral drop foot deformities and plantar flexed first metatarsal right foot. X-rays showed no evidence of fracture or osteomyelitis. Recommended changes to the right AFO. The patient continued in 1999 to follow-up with Dr. Koenigsberg, DPM. The concentration was on adjusting the braces, treating pre-ulcers and lesions. It was noted on June 22, 1999 that the culture was positive for Staph aureus and she was treated.

January 25, 2000 and February 4, 2000: She continued to have brace adjustments.

March 15, 2000: There is complaint of drainage and bleeding into the right first metatarsal joint area and a decubitus ulcer with possible infection. This was debrided and cultured.

March 22, 2002: It was noted the wound was healed.

disease. Planned open reduction internal fixation. X-rays showed a transverse fracture with 1 cm displacement.

September 1, 2005: X-rays of the left knee showed a left patellar fracture with an associated left knee moderate joint effusion, moderate comminuted mildly distracted and transversely oriented.

September 1, 2005: Left hand x-rays. Suspected left greater multangular fracture.

September 1, 2005: ~~Lawrence Chin~~, M.D., medical consult. The patient sustained a mechanical fall on October 31, 2005 and sustained a patella fracture. The patient was admitted and cleared for surgery.

September 1, 2005: Anesthesia note. Pre-Op Diagnosis: Fracture of patella. Post-Operative Diagnosis: Same. Procedure: Open reduction internal fixation of the patella.

September 1, 2005: Post-operative x-rays of the left knee showed placement with pins and loop wires fixating the fracture.

September 2, 2005: The patient reported stabilized and begin mobilization.

September 3, 2005: Negative Homan's, stable, start CMP and physical therapy.

September 4, 2005: Orthopaedic note. Noted taking large amount of narcotics.

September 5, 2005: The patient was being treated for hyponatremia.

September 6, 2005: Reported increased pain since fall on post-operative day two. Probable loss of fixation. X-ray recommended.

September 6, 2005: X-rays show marked distraction of fracture fragments of the patella and the loop wire is unlooped.

September 7, 2005: CT of the head was normal.

September 7, 2005: Orthopaedic note. X-rays show loss of fixation. Recommend to OR for open reduction internal fixation of left knee.

September 8, 2005: The left knee wound is benign.

September 9, 2005: Operative report, ~~Eric Test~~, M.D. Pre- and Post Operative Diagnosis: Failure fixation left patella, status post open reduction internal fixation. Procedure: Removal of hardware left patella, partial patellectomy and repair of the extensor mechanism.

September 10, 2005: Orthopaedic note. No evidence of left knee infection. Believed increased bands due to JA process. Recommend physical therapy for gait training, weight bearing as tolerated but no bending of the knee.

September 10, 2005: Abdominal x-rays show prominent loops of gas filled the small bowel with multiple area of fluid levels on decubitus. May reflect early ileus.

September 11, 2005: X-rays showed placement of nasogastric tube.

September 12, 2005: X-rays are compatible with ileus or small bowel obstruction.

September 13, 2005: X-rays showed no significant change of ileus.

September 15 and September 17, 2005: X-rays noted consistent diminishing ileus.

September 12, 2005: A PICC line was placed.

September 15, 2005: Orthopaedic note. Reported the patient ambulating 40 feet with physical therapy. Progressing well.

September 15, 2005: The patient was progressed to a full liquid diet.

September 16, 2005: Orthopaedics. Recommend progress with physical therapy.

September 18, 2005: The patient was discharged and recommend follow-up with Dr. Test. Other procedures included a sigmoidoscopy performed September 14, 2005 to evaluate for possible pouchitis. It was noted the patient had a normal pouch.

September 18, 2005: Discharge summary, Jose Fuentes, M.D. Diagnosed with a resolved partial bowel obstruction status post repair open reduction internal fixation left patella fracture. anemia, and history of Charcot-Marie tooth disease. The patient was admitted post fall for patella fixation. She was treated by Dr. Test. She is now status post removal of hardware left patella and partial patellectomy. She also underwent a sigmoidoscopy for abdominal discomfort and distension and had placement of an NG tube. The patient had a slow drop in hemoglobin and was diagnosed with anemia but declined transfusion. The patient will follow-up with Dr. Test.

Records of El Camino Hospital, Volume II (pages 200-401)

Records include nursing notes, physician orders and peri-operative orders.

The patient started occupational/physical therapy on September 2. Physical therapy noted during the session she had a loss of balance. There was no indication whether the patient fell. The next several days, September 3, September 4, September 5, it was noted the

patient was confused and complained of severe pain. On September 6, 2005 physical therapy was held. Occupational therapy started working with the patient and also reported severe pain on September 3. Activities of daily living were addressed.

Records of Camino Medical Group

October 12, 2000: New patient evaluation. Betsy Strong, M.D. Past history includes Charcot-Marie tooth disease with a history of two siblings with the same disease. Her daughter has MS.

January 23, 2001: General surgery consult for possible hernia. Concerned whether musculoskeletal involvement.

February 5, 2001: B. Ferrari, M.D. Orthopaedic consult for right hip pain. Recommended bone scan to rule out metastatic cancer.

March 5, 2001: Follow-up Dr. Ferrari. Patient with bone scan results. Felt to be osteoarthritis. Recommended anti-inflammatory.

May 23, 2001: CT of the thoracoclavicular joints. Degenerative changes at clavicular heads bilaterally, right greater than left. The patient was seen for general medical issues in 2001 and 2002 which included complete physical examinations.

October 29, 2002: Follow-up, Betsy Strong, M.D. History of trigger finger, Charcot-Marie tooth disease, hypertension, and osteopenia. Recommend repeat DEXA in one to two years.

May 17, 2003: Complete physical exam, Dr. Strong. Diagnosed with controlled hypertension, depression, menopausal symptoms, Charcot-Marie tooth disease, ulcerative colitis and colectomy.

June 18, 2003: Evaluated for response to tetanus shot.

September 29, 2003: DEXA scan. Osteopenia of the lumbar spine with mild risk for vertebral fracture.

November 21, 2003: Patient had a sudden fall of unknown cause. Complained of tail bone. X-rays recommended.

November 23, 2003: X-rays of the sacrum and coccyx post fall were negative for fracture.

March 15, 2004: Susana Kuzis, M.D. The patient evaluated for recurrent trigger finger, history of arthritis of the hands and hypertension. Referred to Dr. Hay for consult and possible tendon release.

April 7, 2004: Diane Dressman, PA. Diagnosed the patient with right ring and left middle trigger fingers. Scheduled release.

July 22, 2004: Treated for menopausal symptoms.

August 27, 2004: Evaluated by Robert Hueng, M.D. for tongue nodule. Questionable traumatic fibroma or neuroma.

November 12, 2004: Betsy Strong, M.D. Follow-up for right hip pain. This has been present for several months. Difficulty lifting secondary to pain. Diagnosed with right hip pain. Prescribed Mobic and consider orthopaedic consult.

November 12, 2004: X-rays of the right hip show narrowing of the medial joint compartment compatible with degenerative changes. Cysts on the neck and proximal femur bilaterally.

December 1, 2004: MRI of the lumbar spine showed multi-level degenerative disc and bone changes in the lumbar spine without central canal or foraminal stenosis.

December 15, 2004: Heidi Tonkon, M.D. Orthopaedic consult for right lower extremity pain. History of Charcot-Marie tooth disease and right shoulder pain. Denies low back pain. Has a history of chronic sensory changes in lower extremities and uses bilateral AFO braces. X-rays show osteoarthritis of the right hip. The MRI was reviewed. An anesthetic arthrogram was recommended for the right hip. She was referred to Dr. Perksh for her lumbar spine.

January 2, 2005: Operative report, Ronald Hay, M.D. Pre- and Post Operative Diagnosis: Left middle and right ring trigger fingers. Procedure: Trigger finger releases.

September 22, 2005: Nicholas Perrotto, PA. Patient is in for follow-up for left knee surgery 13 days ago. Noted to have an irritation on the anterior left tibia from the AFO brace. Staples removed, wound care discussed and the brace was padded.

September 29, 2005: Follow-up visit Betsy Strong, M.D. The patient had been hospitalized for one month with a partial bowel obstruction and decreased hematocrit. Currently walking with a walker. Noted to have a calf abrasion which was treated, cleaned and dressed. Anemia was discussed.

October 5, 2005: Eric Test, M.D., orthopaedic follow-up. The patient is weight-bearing as tolerated. The wound is well-healed. Range of motion is 0 to 40 degrees. Recommend wean from knee immobilizer.

November 9, 2005: X-ray of the left knee showed post-traumatic, post-surgical changes with mild lateral patellar subluxation.

November 28, 2005: Follow-up Dr. Test. Follow-up patellar fracture. Doing well. Recommended continue rehab. The patient is concerned with popping and instability.

February 21, 2006: Follow-up Dr. Test. The patient is doing well post-operative. She has moderate symptoms and is currently using a cane and bilateral AFO braces. Concerned regarding left knee giving away when fatigued. Incision is well-healed. Range of motion 0 to 124 degrees. Excellent functional result. Recommended continue extension and flexion exercises.

April 27, 2006: Follow-up Betsy Strong, M.D. The patient presents for a complete physical examination. History of left knee surgery in the fall with prolonged hospitalization. Current diagnoses hypertension, hyponatremia, weakness, dizziness, bronchitis, Charcot-Marie tooth disease and lower extremities in braces. Recommend repeat bone density.

June 7, 2006: Bone density study of poor legibility.

Deposition of Eric Test, M.D., taken October 27, 2006 (40 pages):

Mr. Serverian.

Eric Test has been employed by Community Medical Group since 1984 as an orthopaedist. He finished his residency program in 1984. He became Board certified in 1987. He is up for recertification in 2007. He has hospital privileges at El Camino Hospital in Mountain View, California. He performs three intense surgeries a week.

He first saw _____ on September 1, 2005. She was admitted through the emergency room and he saw her the following morning. He evaluated her x-rays that showed a displaced fracture of the left patella. Surgical treatment was recommended and she was taken to the operating room that day. He performed an open reduction and internal fixation of the left patella involving a longitudinal incision over the patella, irrigation of the joint, reduction of the fracture, and internally fixated it with two K-wires and a figure-of-eight tension band. He described the fracture fragments as a larger proximal pole fragment and a small distal pole fragment. Regarding comminution of the patella, he noted if it was severe a patellectomy or removal of the patella is performed or a partial patellectomy. He described her comminution as mild. He described the K-wires as smooth pins placed longitudinally on the patella, medial and lateral, and a tension band as a flexible wire that is placed in a figure-of-eight fashion. This is tightened and imparts compression of the bone fragments on the joint surface. Post-operative, she was started in physical therapy and had medical issues related to a small bowel obstruction.

Approximately a week after surgery, she had increasing knee pain and x-rays showed the fracture fragments had separated and the figure-of-eight tension band was no longer affixing the patella.

Reference is made to the post-operative notes indicating on post-operative day five she noted to Dr. Test that she had increasing pain since the fall. He is aware that the hospital has a policy regarding the fall. He knows if a patient falls but he does not know the details. He also noted she has a palpable gap at the level of the patella described as a break in the smooth surface. She also had an extensor lag when she tries to straighten the quadriceps muscle and hold the knee fully straight. She is unable to do that. Based on his findings, he recommended a repair of the extensor mechanism. This was performed on September 9 which entailed re-exposing the extensor mechanism and the fracture site, removing the hardware, removing the distal pole of the patella and reattaching the patellar tendon to the proximal pole fragment of the patella. He noted the hardware was intact but no longer holding. He clarified that at the end of the second surgery she had no more hardware. She was discharged on September 18 using a walker. She had physical therapy after the second surgery.

Reference is made to the September 11, 2006 office visit. She complained of anterior left knee pain, easy fatigue and difficulty with prolonged standing and walking. She was concerned because she needed to use a cane to walk. She is not happy with her overall function compared to her preinjury status. She reported she attempted to walk without the cane, had buckling of her leg and had fallen, landing hard on her back. He had encouraged her after the second surgery to work with her therapist to gain strength, to gain functional mobility back. His physical examination at that time was not indicative of findings one year after a fall. However, she has an additional diagnosis of Charcot-Marie Tooth disease which is an explanation of ankle abnormalities and calf muscular abnormalities. The quadriceps weakness is not specifically related to the Charcot-Marie Tooth disease but is commonly seen in patellar fractures and injuries to the extensor mechanism of the knee. Hamstring weakness could be a combination of the injury as well as her disease. Her passive range of motion was 10-40 degrees; however, she does not have the muscle strength to move through a passive range of motion. X-rays showed an absent distal pole of the patella. There was calcification in the soft tissues distal to the patella, likely through the patellar tendon, and regional osteopenia. The patella is high-riding. The most significant finding was that she had no extensor lag at the last visit and the range of motion was 0 to 120 degrees. More important than the x-rays were his functional findings. He noted she was permanently disabled relative to her job at

where she was on her feet all day. He mentioned she could benefit from a patelloplasty with trimming of the anterior distal patellar remnant to prevent recurrent blunt trauma. This could be performed on an outpatient basis. He estimated the surgery takes one hour and he would leave the determination whether to do it on an inpatient or outpatient basis to her internal medicine physician. The purpose of it would be to reduce pain and decrease pressure on the skin to avoid skin breakdown. He indicated it was too early to determine if she would need a knee arthroplasty at this time. Dr. Test did mention

there is a possibility she would need a knee replacement. He is not aware if she takes any medication and she currently is doing exercises for the knee.

Regarding future medical care, he is aware she has ongoing medical problems regarding her gastrointestinal tract. She would benefit from ongoing rehabilitation and it is possible she may have deterioration in function due to early post-traumatic arthritis. Other things could include knee bracing, further physical therapy and a complete patellectomy.

He indicated a knee replacement takes two-and-a-half to three hours and the length of stay after a total knee replacement is approximately four days. Post-operatively, she would undergo inpatient physical therapy followed by home physical therapy or at a skilled nursing facility. The total recovery time for a patelloplasty is 12 weeks. There would be no need for home physical therapy or a skilled nursing facility. She would likely need outpatient physical therapy. If he had not removed the hardware when he did after the first surgery, he indicated at some point in time it would have needed to be removed. This would have been at approximately one year post-operative. He gave no opinion regarding the cause of the failure of fixation of the first surgery. He indicated if she would have fallen, that is a possibility. Other possibilities are forced flexion of the knee or an over-contraction of the quadriceps. A common complaint of patients who have pathology in the extensor mechanism is difficulty walking downhill, down ramps and a sensation of the knee giving way. A patelloplasty would improve the painful prominence on the front of the knee. He did not believe it would have a significant impact on range of motion, strength and functional abilities. There is no x-ray evidence of any progressive arthritic processes in her knee. The verbal complaints could indicate there might be some arthritic changes. Her residual condition could be causing or contributing to other orthopaedic type symptoms such as back ache or problems with her other leg. This is because the gait pattern is different and the weakness in her leg will tend to put stress on other anatomic parts with weightbearing and ambulating activities. He noted that he did not feel her change in gait would cause her feet to rub against her shoes and cause ulcerations of the foot.

He indicated to Dr. Test that she had a back ache in July 2006. He indicated this is when she told him but he does not recall when it started. He believes there is a history of her knee buckling and her falling hard on her rear-end.

He bases his surgical decisions on other things besides age including overall health, cardiac status, respiratory function, kidney function, neurologic and mental function. He has not treated her back as that is not in the realm of his practice. He does not recall if the back pain was preventing her from doing anything.

Eric Test, M.D., September 11, 2006 saw her for follow up for her left knee in which she injured it on September 1, 2005 after a mechanical fall. She also had a history of Charcot-Marie tooth disease. She underwent fixation of a transverse fracture of the patella with destruction of the extensor mechanism treated with an open reduction

internal fixation with K-wires and figure of eight tension band. She had a failure of fixation resulting in partial patellectomy with direct tendon repair. He said since her surgery she has had excellent rehabilitation and continues to have some weakness and uses a cane in the right hand for prolonged standing and walking. She also complains of low back pain. He examined her and reviewed her x-rays and found that she had some calcification within the soft tissue distal to the patellar proximal pole. He recommended she continue using a cane and that she was permanently disabled at that time with regards to her usual and customary work activities. That required her to be on her feet for thirty to forty hours per week. He said there is a possibility that she will develop post traumatic osteoarthritis within her left knee, possibly requiring a total knee arthroplasty in the future.

October 18, 2006 is an MRI report of the left knee from Redwood City MRI, Murray Solomon, M.D. The MRI report shows that she has undergone partial patellectomy with a residual portion of the patella situated 5.5cm above the knee joint line and thickening of the patellar tendon compatible with history of surgery. There is localized soft tissue edema along the anterior lateral aspect of the fibular head and neck and mild marrow edema within the lateral aspect of the fibular head which could indicate trabecular compression injury or possibly healing of an occult fracture. She also has cortically based along the lateral femoral condyle an aggregation of small fluid like cysts and cortical thickening, compatible with small osteochondral injury at that level. There is no evidence of cruciate ligament tear and no definitive meniscal tear and found there is a grade II change within the central portion of the lateral meniscus and medial meniscus.

HISTORY: [redacted] is a 74-year-old female with known Legg-Calve Perthes disease, who had a trip and fall on August 31, 2005. She fell onto her left knee sustaining a patellar fracture. She was transported by ambulance to El Camino Hospital. She was evaluated in the emergency room on August 31. Her x-rays showed a transverse comminuted fracture of the left patella. She was placed in a knee immobilizer and referred to Dr. Eric Test.

She was admitted on September 1, 2005 with the plan to undergo an open reduction internal fixation of the left knee. Apparently, on post-operative day two she had a fall which resulted in increasing pain and decreased function. Physical therapy noted during their session, the patient lost balance but there was no indication she actually fell.

Due to her increasing pain and dysfunction, new x-rays were obtained on September 6, 2005 which showed marked distraction of the fracture fragments of the patella and the loop wire was unlooped.

The patient was taken back to the operating room on September 9, 2005 by Dr. Eric Test. She underwent a hardware removal and a partial patellectomy, and direct fixation of the patellar tendon.

Post-operative physical therapy and occupational therapy were restarted. However, the patient had increasing abdominal complaints and was diagnosed with a partial bowel obstruction.

Her work-up included a sigmoidoscopy which was performed on September 14, 2005 to exclude pouchitis. The patient had undergone a complete colon resection with ilio pull through for colitis in the late 1980s. During her hospitalization she also had a nasogastric tube placed and a PICC line. Upon resolution of the small bowel obstruction she was weightbearing as tolerated on the left knee. She was discharged on September 18, 2005 to home. It was noted in her stay she was diagnosed with anemia but declined a blood transfusion.

Post-operatively she continued to follow-up with Dr. Eric Test who referred her for a course of physical therapy. She apparently underwent four sessions at Santa Clara Valley Physical Therapy. No therapy notes were available.

She also followed-up with her regular physician, Betsy Strong, M.D.

Post-operative x-rays of November 9, 2005 showed post-traumatic and post-surgical changes with mild lateral patellar subluxation.

The patient returned to her podiatrist, Dr. Richard Koenigsberg, on October 19, 2005. She had reported secondary to her surgery she had been unable to walk without a walker and had developed ulcerations of the posterior aspect of the left ankle and calf. He noted these were healed but she had some pre-ulcerous lesions on the left metatarsal phalangeal joint. He recommended brace adjustment and treated the skin breakdown areas.

On February 21, 2006 Dr. Test noted that she had done well post-operatively. She had moderate symptoms using a cane and using bilateral AFO braces for her history of Charcot-Marie tooth disease.

The patient also completed a course of physical therapy with Australian Physical Therapy Specialists on February 3, 2006. Range of motion was 0 to 110 degrees. She was able to ambulate for 45 minutes and was discharged to a home exercise program.

On August 15, 2006 she underwent an orthopaedic evaluation with John Missirian, M.D. Her complaints were left knee pain and giving away, particularly on inclines. She also noted she had had low back and left hip pain in May or June 2006. He noted she was ambulating with a cane and using AFO braces on her legs. He diagnosed her status post partial patellectomy of the left knee and history of Charcot-Marie tooth disease. He requested radiological studies. He noted that she had seen a podiatrist in the past starting from 1999 for a peripheral neuropathy condition. There were no medical records to suggest that her podiatry visits in 2005 and 2006 were related to the incident in question. It was felt that these visits were a result of her Charcot-Marie tooth disease and

unrelated to the August 31, 2005 accident. Regarding the left hip and low back pain, due to delayed onset of the symptoms it makes no cause and effect relationship to the accident in question. There was a similar history of pain in the right hip in 2004 where x-rays of the right hip and an MRI of the lumbar spine were obtained and showed multi-level degenerative disc disease. It was felt her current symptoms in the left hip and low back were related to a degenerative process of the lumbar spine and no relationship to the knee. Reportedly two weeks ago she fell at home resulting in further pain in the low back and this is unrelated to the left knee condition. The patient had full range of motion of the left knee in flexion and extension with pain to compression at the patellofemoral joint and weakness of the quadriceps strength. Physical therapy placed her in the functional status of 93% which supported the physical findings. With the passage of time and further quadriceps strengthening exercises she will regain strength in the left knee and better stamina. The period of hospitalization in El Camino and follow-up visits with Dr. Test and physical therapy are a reasonable amount of medical care regarding her knee. It was felt her present musculoskeletal condition of her left knee does not hinder her from returning to gainful employment at J.C. Penny. As long as she is not required to do prolonged standing and walking she should gradually be able to resume regular duties. Considering her age, approaching retirement, it is unlikely she will be willing to consider this option. No anticipation for any immediate or future surgical procedures of the left knee.

On September 19, 2006 Betsy Strong, M.D. indicated the patient continued to have pain over the knee and would require revision of the patella. Surgery was planned by Dr. Test and will be scheduled in the near future.

Dr. Missirian reviewed further radiological reports on September 13, 2006 and noted this did not change his opinion.

On October 3, 2006 Richard Koenigsberg, DPM summarized his treatment with the patient indicating he has treated her in the past. He first saw her on October 19, 2005 with a skin ulceration of the bottom of the left foot. He treated the lesion and recommended refitting of her braces. He again saw her on June 7, 2006. She continued with pain beneath the left first and fifth metatarsal phalangeal joints. He felt that she was having weakness in the lower extremities which was intensified by the injury and long rehabilitation. She started to redevelop wounds and pain in her foot. He noted she had pre-existing problems but had not had any problems in that particular area for some time until she injured her knee. She already has a neuromuscular disease, Charcot-Marie tooth, which causes severe weakness in the extremities and someone who has a pre-existing neuromuscular disease who then has an injury, surgery, or rehabilitation, they have a significant decrease in their existing strength and require longer to rehabilitate. As a result of the weakness, she applies more force to the plantar aspect of her foot creating more problems and skin irritation. He felt her condition was self-limited and noted he had seen her twice in a 10 month period. He does not expect the injury affecting her foot to have significant consequences. Total podiatry costs to date and possibility of future treatment would not exceed more than \$500.00.

Her current complaints are that she has ongoing pain in her left knee. The knee feels weak and she has no stamina when she walks. Walking down a slope or driveway or stairs, the knee feels as if it will buckle and actually will buckle. She can't walk without a cane. She has not had any falls from walking, however she tried to move a table once and partially fell.

Regarding her feet, she has had some ulcerations in the past and has used AFO's. She has had no more ulcerations.

PAST MEDICAL HISTORY: The patient was diagnosed with Charcot-Marie tooth disease in the late 1950s. It was also noted she had two sisters with the disease. She had had longstanding treatment with a podiatrist regarding this and has used AFO braces for years. She has been treated by Betsy Strong, M.D. for hypertension, depression, and post menopausal symptoms.

On November 12, 2004 right hip x-rays showed narrowing of the medial joint compartment compatible with degenerative changes and a cyst in the neck and at the proximal femur bilaterally.

On December 1, 2004 an MRI of the lumbar spine showed multi-level degenerative disc and bone changes of the lumbar spine without central canal and foraminal stenosis.

She was evaluated by Heidi Tonken, M.D., an orthopaedist, on December 15, 2004. She was referred to Dr. Perksh regarding the degenerative joint disease in the lumbar spine and an anesthetic arthrogram was recommended for the right hip. Her other orthopaedic history is that of bilateral trigger fingers which were treated operatively by Dr. Hay in June 2005.

In the past she has had surgery on her colon as well as an inguinal hernia surgery and had to have GI surgery September 21, 2006.

PHYSICAL EXAM: This is a well developed, well nourished white female. She has bilateral AFO's which she took off for the exam, which she has used since 1995. She has a foot drop bilaterally. On gross examination she has scars over both of her feet from multiple surgeries as well as a left knee 14cm midline incision. She has a quads lag at about 20 degrees. Range of motion is 0 to 135 degrees of both knees. There is some horizontal instability as she opens medially. She has lateral tenderness over the fibular head and lateral joint line. The remaining patella is small and there is tenderness on compression. She has a negative apprehension and some prehension. There is crepitus of the patello-femoral joint and slightly laterally. Rotational tests are not painful. McMurray's and Apley's tests were not painful.

Neurlogic exam reveals that she has weakness of her left quads graded 4+/5 with a quads lag. Sensation was poor in portions of her feet and she has weakness to dorsiflexion of her ankles and toes which were 0 due to her Legg-Calve Perthes disease. Reflexes were 2+.

Measurements of the lower extremities:

	<u>RIGHT</u>	<u>LEFT</u>
Thighs	39cm	36cm
Calves	30	30
Ankles	20	20
Feet	19	19

X-rays reviewed were August 31, 2005 showing a displaced patellar fracture with some comminution. September 1, 2005 shows the tension band open reduction internal fixation. September 6, 2005 showed the failed fixation with wire failure and July 31, 2006 showed a partial patellectomy with the patella sitting more proximally.

OPINION & DISCUSSION:

_____ suffered a transverse patellar fracture when she slipped and fell on August 31, 2005. Subsequent to that she underwent an open reduction internal fixation and then had a mild slip in the hospital and the hardware failed requiring a revision. Since that time she has undergone therapy and continues to have weakness and pain in her left knee. The weakness is certainly documented by the fact that she has had a partial patellectomy with a partial migration of the patella and has a poor extensor mechanism. She has a quads lag of about 20 degrees which is consistent with her patellectomy. She has 4+/5 strength consistent with a partial patellectomy. An MRI of her left knee is consistent with her lateral pain which is resolving bony contusion probably from the same injury and some degeneration of her menisci. It was felt that she had a healing trabecular compression injury of the fibular head and neck.

It is my medical opinion that she continues to have a disability as a result of the injury in question. I take issue with Dr. Missirian's assessment that she should improve over time as the weakness in her left leg is permanent. This is why she has difficulty walking down inclines and hills. It would be difficult for her to walk without a cane and certainly difficult for her to stand for any length of time which is necessary for her job at _____. For that reason I don't think she can return to her job at _____. Therefore Ms. _____ is totally and permanently disabled from her usual and customary job. Her future medical treatment should allow her to have ongoing orthopedic treatment to her left knee. Dr. Test has recommended possibly a patelloplasty and if she chose to have that done that would be appropriate. In the future as a result of the trauma she will probably be a candidate for a total knee replacement as the patello-femoral injury will lead to further degeneration of the rest of the joint.

Future medical costs will include office visits with Dr. Test as well as future surgeries. An estimate of patelloplasty or arthroscopic surgery is approximately \$25,000.00 including all fees; an estimate for total knee replacement is approximately

\$65,000.00 including all fees. It is likely that a patelloplasty would give her better strength and would allow her several years of a better gait; however it will not prevent knee replacement in the future. The outcome of knee replacement in her case would have a prognosis of about 85-90% success. After either procedure she should be able to walk better and have better function and should be able to stand longer and walk down stairs with more strength.

I hope this has been helpful.

Sincerely,

A handwritten signature in blue ink, which is heavily obscured by several thick, horizontal blue ink scribbles. The signature is mostly illegible due to the overwriting.

TGS/mdc