Summary of Mandell Case #1

This 60-year-old, 5'5", 160-pound female patient sustained an injury at work on 2/2/2000 resulting in symptomatic arthritis and meniscal tearing within her LEFT knee. Conservative treatment was initially rendered. She didn't get better.

She consulted her physician. An MRI scan showed tricompartmental degenerative changes within the LEFT knee. Surgery was recommended.

Subsequently she was taken to surgery on 1/10/01, where an arthroscopic chondroplasty and lateral meniscal debridement was performed. She was able to get back to light duty work, but, unfortunately, her employer could not accommodate ongoing light duty, so she was eventually let go from her job.

Then she had increasing symptoms in the LEFT knee and had a second procedure on 4/15/2002, consisting of a total knee replacement. After that she had ongoing instability of the LEFT knee. For that reason she was returned to surgery in September 2002, where a thicker tibial liner was placed. That surgery did help.

In January 2004 the patient developed RIGHT knee problems. She had been limping around and favoring her LEFT knee. To date, only conservative treatment has been recommended for the RIGHT knee. Her past RIGHT knee history is significant. In 1964 she had a motor vehicle accident resulting in RIGHT knee damage and subsequent RIGHT knee surgery. Apparently that surgery was to "relocate her kneecap." There was a second RIGHT knee surgery in 1980 following an injury. Apparently some sort of ligament repair was performed. Once again, after recovering, she did well. Additional significant lower extremity history includes a motor vehicle accident in which she shattered her LEFT acetabulum. That was treated with a LEFT total hip replacement. Once again, she did well from that.

At the time of the injury of 2/2/2000 she was working as a CNA. She was on her feet all day. She would have to move and lift patients. She would have to squat and kneel. She indicated that she did all those activities without restrictions. She worked 32 hours a week. She had started working for this employer a month before the injury in question. She worked for another month after the injury in question and then had to go off because of persisting symptoms.

After her LEFT knee surgery she did go back on light duty. She worked about three months and then her employer could no longer accommodate light duty.

At the time of my examination on 4/22/04, this woman had about equal come and go pain in both knees. Both knees swelled. She limped all the time. She used a cane all the time in her RIGHT hand. She couldn't run, dance, do any sports, squat, or kneel. Stairs bothered her knees. On a good day she could walk about 20 minutes. Then she'd have to stop and rest. On a bad day she couldn't go that far. When specifically asked, she indicated that her LEFT total hip didn't bother her at all.

On physical examination she had the following:

- A marked limp with ambulation.
- She used a cane in her RIGHT hand.
- There were well-healed scars about the LEFT hip and both knees.
- There were restrictions of motion of both knees.
- There was an inability to squat, kneel, or hop on the lower extremities.
- There was a 2+ effusion of the RIGHT knee (not the LEFT).
- There was measurable atrophy of the RIGHT thigh.

CASE #1

Ladies and Gentlemen:

Ms. X was interviewed and examined in my office today.

This is an Agreed Medical Examination.

HISTORY OF INJURY:

Ms. X indicates that she slipped and fell at work on 2/2/2000. In the process she hurt her LEFT knee. She did finish work that day. The next day she went to the doctor. She used ice. Some X-rays were taken. She used an Ace bandage. The LEFT knee didn't get better.

HISTORY OF INJURY (Cont'd)

Subsequently she was seen by Dr. Y. He ordered an MRI scan. That showed tricompartmental degenerative changes within the LEFT knee. Dr. Y recommended surgery. Ms. X was taken to surgery on about 1/10/2001, where an arthroscopic debridement was performed. At surgery it was noted that she had a lateral meniscal tear and arthritis within the LEFT knee. She got a little bit of relief from that surgery. After that surgery she did go back to work at the convalescent hospital. She was doing lighter work. She did that work for about three months. At that point her employer said they could no longer accommodate the light duty, so she went off work. That happened in 2002 and was the last time that she worked.

Subsequently Ms. X's LEFT knee continued to bother her. For that reason she was taken back to surgery on 4/15/02, where a LEFT total knee replacement was performed. She had trouble with buckling of her LEFT knee after that, so in September of 2002 the LEFT total knee was revised using a thicker tibial liner. That surgery did help.

Ms. X remains under the care of Dr. Y. She last saw him on 1/20/04. She is going to see him again in July for a six month followup.

In January of this year Ms. X's RIGHT knee started bothering her. She had been limping around. She was favoring the LEFT knee and putting more weight on the RIGHT knee, she tells me. She told Dr. Y about her RIGHT knee. Conservative treatment was recommended. That's all the treatment that she's had for her RIGHT knee.

CURRENT COMPLAINTS:

She has come-and-go pain in both knees. Both knees are about equally painful. On the RIGHT knee the pain is lateral. On the LEFT knee the pain is anterior. Both knees swell. She limps all the time. She uses a cane all the time in her RIGHT hand. She can't run, dance, do any sports, squat, or kneel. Stairs bother her knees. On a good day she can walk maybe 20 minutes and then she has to stop

CURRENT COMPLAINTS (Cont'd):

and rest. On a bad day she can't even go that far. When she sits for awhile and gets up, her knees are stiff and sore.

She did have a LEFT hip replacement in 1989. Her LEFT hip doesn't bother her at all.

She recalls no other symptoms except as listed above.

PAST AND OTHER MEDICAL HISTORY:

She is in good health otherwise. She is allergic to Sodium Pentothal and morphine. Current medications include hydrocodone 5 mg. (four to six a day) and Bextra.

Previous surgeries include a hysterectomy. She does note in 1964 she had surgery on her RIGHT knee to relocate her kneecap. Then in 1980 she had another surgery to do what sounds like a repair of ligaments and tendons following an industrial accident. She also had the three LEFT knee surgeries listed above. She also had a LEFT total hip replacement in 1989. She recalls no other surgeries or hospitalizations.

Family history is unremarkable.

She did have prior injuries to her RIGHT knee. In 1964 she was involved in a motor vehicle accident. She damaged the RIGHT knee and underwent the above-noted RIGHT knee surgery. After that she did well. She also had an injury to the RIGHT knee in 1980, for which she had her second RIGHT knee surgery. Again, she recovered from that and did well. The motor vehicle accident also shattered her LEFT acetabulum and pelvic area, apparently. That eventually resulted in a LEFT total hip replacement. She has done well with her LEFT hip, as noted above. She recalls no other difficulties with the above complained-of areas except as listed above.

WORK HISTORY:

At the time of the injury in question she was working as a CNA at a nursing home. She was on her feet all day. She would have to move patients, lift patients, squat, kneel, etc. She was able to do all that

PAST AND OTHER MEDICAL HISTORY (Cont'd):

without restrictions. She worked 32 hours a week. She started working there in January 2000. She worked for another month after the injury of 2/2/2000. At that point she was taken off the schedule by her employer because they were fearful she couldn't do the work because of her knee injury. After she had her RIGHT knee surgery she was off for a time. Then she went back on light duty. She worked about three months at light duty. At that point her employer could not accommodate any more time, and she has been off work ever since. The last time she worked was probably about January 2002.

She was retrained to be a receptionist but couldn't find work in that field.

LOWER EXTREMITY EXAMINATION:

Stated ht: 5'5" Stated wt: 160 lbs. Stated Age: 60

The patient states she is LEFT-handed.

The comparative circumferential measurements of the lower extremities are as follows:

	RIGHT	LEFT
Thighs, 6" above patella:	23-1/2	24-3/4 inches (old RIGHT knee injuries)
Knees:		
Mid-patella:	18-3/8	18-3/8 inches

The patient walks with a marked limp and uses a cane in the RIGHT hand. There is a scar about the LEFT hip. There is no tenderness about the anterior capsule or trochanters. Patrick and Trendelenburg tests are negative. Hip range of motion is as follows:

		NORMAL
Flexion:	90/98	(110 degrees)
Internal rotation:	0/20	(35 degrees)
External rotation:	10/20	(50 degrees)

LOWER EXTREMITY EXAMINATION (Cont'd):

Abduction:	40/40	(50 degrees)
Adduction:	25/25	(30 degrees)

There is good gluteal strength.

KNEES:

There is a valgus deformity of the LEFT knee. The patient is unable to squat, kneel, or hop. There is 2+ knee fluid on the RIGHT. The patellae are not ballotable. There are bilateral knee scars. There is no knee tenderness. There is a trace of anterior sagittal laxity. Collateral ligament stability is within normal limits. Pivot shift test is normal. McMurray's and Apley's tests are negative. There are no popliteal masses. There is a trace of retropatellar crepitus on the RIGHT. Active knee range of motion is as follows:

		NORMAL
Extension:	20/0	(0 degrees)
Flexion:	95/85	(135 degrees)

LEGS-ANKLES-FEET:

There are no visible or palpable deformities noted. There is no ankle fluid. There is no ankle swelling. There is no tenderness about the ankle capsule, malleoli, collateral ligaments, or sinus tarsi. Ligament stability is within normal limits. Range of motion is as follows:

		NORMAL
Dorsiflexion:	10/10	(15 degrees)
Plantarflexion:	40/40	(50 degrees)
Inversion:	35/35	(35 degrees)
Eversion:	20/20	(20 degrees)

VASCULAR EXAMINATION:

Dorsalis pedis pulsations are intact. There is no elevation pallor, trophic changes, varices, edema, or dependent rubor.

X-RAYS:

None were submitted or ordered.

REVIEW OF SUBMITTED MEDICAL RECORDS:

Please see enclosed review.

DISCUSSION:

Ms. X indicates that she did sustain an injury at work on 2/2/2000. As a result of this injury she developed symptomatic arthritis and meniscal tearing within her LEFT knee. She was taken to surgery on 1/10/01, where an arthroscopic chondroplasty and lateral meniscal debridement was performed. She gained some relief from that. She was able to get back to light duty work. Unfortunately, her employer could not accommodate ongoing light duty, so she was let go from her job. Subsequently she had increasing symptoms in the LEFT knee. She was taken to surgery on 4/15/2002, where a total knee replacement was performed. That had some problems, so on 9/9/2002 it was revised. She did improve after that.

From favoring the LEFT lower extremity, Ms. X aggravated some previously arthritic problems with her RIGHT knee. Those had gone back as far as 1964, involving a motor vehicle accident of that year. She indicates that after surgery in 1964 and additional surgery following an industrial accident to the RIGHT knee in 1980, her knee was just fine. However, in looking at her today, it's quite apparent to me that she was left with residuals such as restrictions of motion, which could basically only be explained by those ancient injuries and not by favoring the LEFT knee. Her old RIGHT knee problems certainly made her RIGHT knee more vulnerable to load shifting and things of that sort but would have resulted in disability, in and of themselves.

DISCUSSION (Cont'd):

Ms. X's condition is permanent, stationary, and ratable. That probably became so on 2/18/03. Factors of disability for the lower extremities include:

1. A marked limp with ambulation.
2. The need to use a cane at all times in the RIGHT hand.
3. Well-healed scars about the LEFT hip and both knees.
4. Restrictions of motion bilaterally.
5. An inability to squat, kneel, or hop on the lower extremities.
6. A 2+ effusion of the RIGHT knee (not reversed).
7. Restrictions of knee motion bilaterally.
8. Measurable atrophy of the RIGHT thigh.
9. Subjective complaints as stated.

Taking all of Ms. X's lower extremity disabilities together, she is limited to *sedentary work*—at least on a prophylactic basis. Under the "old rules" and as a result of her 1964 and 1980s RIGHT knee problems, her disability now would be such as to preclude *heavy lifting*. When factoring in the LEFT total hip replacement, her disability would increase to a preclusion from *heavy lifting, climbing, walking over uneven ground, squatting, kneeling, crouching, crawling, pivoting, and other activities involving comparable physical effort*. The remainder of her disability would probably relate to the specific injury of 2/2/2000, which damaged what apparently was a previously asymptomatic arthritic LEFT knee.

Under the "new rules," approximately 67% of the causation of Ms. X's overall lower extremity disability relates to:

- her old RIGHT knee problems

DISCUSSION (Cont'd):

- her LEFT total hip
- and the arthritic disease process which was asymptomatic but certainly made her LEFT knee more vulnerable to the fall she sustained.

The remainder of her disability relates to the specific injury of 2/2/2000.

Ms. X will require additional treatment for her LEFT knee such as analgesic medication, physical therapy, or perhaps even more surgery (e.g., another revision), and provision should be made for that.

Very truly yours,

Peter J. Mandell, M.D.

PJM/ae