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November 5, 1984

Mr. Richard J. Giffels
Attorney at Law
800 Leader Building
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Re: Herbert Stockard

Dear Mr. Giffels:

Herbert Stockard was examined on November 5, 1984 regarding an accident which occurred on May 30, 1983. This 53-year-old male informed me, in the presence of his counsel, that he was injured on May 30, 1983 when he was riding a motorcycle which was moving when he was involved in a collision with a cat. tfe recalled that the motorcycle struck the left ride of the automobile, behind the front wheel, and that he "flew over the car and landed on the hood". He did not lose consciousness and was aware of pain in his left thumb and left leg, "the end of the femur". He was taken to St. John & West Shore Hospital where he came under the care of Dr. Angley and remained hospitalized until June 17, 1983. He stated that his left leg was "fractured/crushed". He underwent surgery on approximately June I, 1983 at which time Dr. Angley inserted a "steel plate" and eight screws to immobilize a "T-type fracture with an area that was crushed". Post operatively, he used a knee exerciser in bed and was discharged with a walker, non-weight bearing. He wore no brace.

Thereafter, he continued under Dr. Angley's care and was examined by him on a monthly basis. Sometime thereafter, he was referred to Lynn Wallace, the physical therapist, by his attorney. Mr. Wallace subsequently referred him to Dr. Stanley Beekman, a podiatrist. A 5/8 inch to 1/4 inch continuous heel and sole lift was prescribed for shortening of the left lower extremity.

Mr. Stockard continued under Dr. Angley's care during 1984 and was examined by him in April and October. He has not again been hospitalized nor has he been treated by other physicians.

At the time of this examination, Mr. Stockard stated that his left leg and knee were "still sore. I have pain in my knee all the time. My knee feels like it is in a vise". He had pain throughout his knee and was most symptomatic in the lateral aspect. After walking for more than a block, he was required to use a cane in his right hand. After standing for more than one to two hours, both legs would "ache". He stated that he was unable to stoop or kneel for he could not get back onto his heels. His left knee did not bend as did his right knee. He stated that he had "110 degrees on the left and 140 on the right".

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He also stated that he did have injuries to his shoulders but they "came back approximately to normal". While describing this, he gestured indicating he had a full range of shoulder motion bilaterally.

His past medical history indicated no symptoms referable to his left knee prior to his accident. He had sustained no new injuries. Prior to the accident, he worked as a crane operator, heavy equipment operator and mechanic. Since the accident, he had worked at "light duty" performing those occupations which required only the use of his right foot. He stated that he was unable to work both brakes and that he was unable to climb onto machinery. During the last three weeks, he had worked approximately 20 hours a week.

Physical examination revealed a male of approximately his stated age who was of average proportions. He stated that he was approximately 6 feet tall and weighed 184 pounds. He arose from the sitting position without difficulty, Without his shoes, he ambulated with a short-leg limp on the left. With his shoes, he had a barely perceptible limp. In the standing position, his left hemipelvis was lower than the right. His general standing alignment was within normal limits. He could only perform a 1/2 squat and actually flexed his right knee more so than his left.

Further examination of his left lower extremity revealed a well-healed, non-tender incision extending from the distal 1/3 of the femur onto the proximal tibia. True leg length measurements indicated that the left lower extremity was approximately 2.5 cm. shorter than the right, The circumference of the left distal thigh was approximately 1.5 cm. less than that of the right. There was no palpable effusion, The range of left knee motion was from 0 to; 115 degrees compared to 0 to 142 degrees on the right. There was tenderness to palpation over the medial femoral condyle but no joint line or patellar tenderness. The Lachman and anterior drawer tests were minimally positive, The abduction stress and adduction stress tests were negative.

Radiographs of the left knee revealed the residuals of a well-aligned, well-healed, left supracondylar fracture. The fracture had been immobilized with a compression screw, side plate and multiple screws.. There was no evidence of intra-articular extension of the fracture or degenerative changes.

The material forwarded to me has been reviewed and does not include the reports of Dr. Angley or Mr. Wallace. It would be helpful to review Mr. Wallace's last assessment of Mr. Stockard for, if he performed a Cybex evaluation and Mr. Stockard cooperated during this testing, this test would give an indication of Mi-. Stockard's rehabilitation,

The records from St. John E West Shore Hospital indicate that Mr, Stockard was first examined in the emergency room on May 30, 1983 and then admitted to the hospital. The impression of the examining physician was "Simple comminuted intracondylar and supracondylar fracture of the left femur. Abrasion of the left hand". I have reviewed copies of the left distal femur and knee obtained on May 30, 1983. These indicate a T-shaped comminuted displaced supracondylar fracture of the femur. On June 1, 1983, the patient underwent "Open reduction and internal fixation with a supracondylar compression screw and plate". The discharge summary indicates "Following the surgery, the patient made a satisfactory recovery. He was ambulating well with crutches, non-weight bearing to his left leg..."

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Based on the information available to ma, I believe that Mr. Stockard was involved in a vehicular accident on May 30, 1983 and that he sustained a closed comminuted displaced T-fracture of the left distal femur. This injury necessitated his hospitalization at St. John & West Shore Hospital as well as the surgery and follow up care provided by Dr. Angley.

At the time of this examination, almost a year and a half after the accident, Mr. Stockard continues to be symptomatic with respect to his left knee. His fracture has been treated in an excellent fashion by his orthopaedic surgeon, and there is nothing to indicate that he has developed traumatic arthritis. The symptoms and physical findings which he has with respect to the lateral aspect of his left knee will be eliminated by the removal of his internal fixation devices. During the operative procedure, and prior to the removal of the internal fixation devices, gentle manipulation of his knee might increase his range of motion. Postoperatively, he would require protection for approximately three months, while the bone regained its strength. He could continue on a quadriceps rehabilitative program during this period of time. Although the leg length discrepancy which he has is permanent in nature, it is well compensated by the continuous heel and sole lift which he has. Although Mr. Stockard might have some difficulty with those occupations that require kneeling and working in a full crouch, I do believe that he will be able to return to his occupation as a heavy equipment operator,

Very truly yours,

DBBrooks MD

Dennis B. Brooks, M.D.

DBB/anm