Highland
Musculo-Skeletal
Associates, Inc.

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RE: Aaron Henkel

Dear Mr. Riedel:

As you are aware I previous had the opportunity to review some of the medical records from the above plaintiff, Aaron Henkel.. ,Therecords that were reviewed.were the 'Ohio Traffic Crash Report, some auto repair information, as welt as records from the University Hospitals Orthopaedic group and Lake County Rehabilitation." The previous records 'from Dr. Goodfellow had not been reviewed at the time of the initial medical records review.

The plaintiff was examined for the purpose of an Independent Medical Evaluation and to complete my review on August 29, 1997. The history as noted in my original letter of July 5, 1997, is not significant altered. He described this as a work-related injury where he was the driver and solo occupant of a Ford Econoline 250 van involved in a collision on September 18, 1995. He was in the vicinity of Route 20 and Route 91 in Willoughby, Ohio. He was wearing a lap type seatbelt. He was in the left hand turning lane. There were two left hand lanes. As he was into the turn a car pulled out in front of him. The impact occurred on the front passenger side of his car.

As you are aware, the contention is a severe right knee injury was sustained. I carefully questioned whether there was any direct impact knee and he stated there was none. At worst; this was a "jamming" injury in which he put his foot on the brake pedal "real hard". He claimed to have swelling in the knee virtually immediately. There was no emergency room care.

He subsequently followed up with Dr. Heng, his medical doctor, who initially saw him on October 5, 1995, about two weeks after the motor vehicular accident in question. At that time there was no swelling and no bruising, but he did complain of pain in and around the knee area. There was no pain along the joint line and no ligamentous laxity. He did complain of intermitter locking. It was felt that he may have had an internal derangement of the knee and e was referred back to Dr. Donald Goodfellow, who was his previous treating orthopaed surgeon.

After the motor vehicular accident in question T . Goodfellow saw him on October 19, 1995, about two weeks after the accident: He had not seen him since July of 1992 for this knee. The clinical impression was that he "stirred up his patellofemoral problem') This specific injury; however, was difficult to note. The *surgery'* and subsequent treatment noted in my riginal letter constituted,his total care to date. It was noted that by the third surg ry (second post accident surgery) that he' had documented patellofemoral arthritis Grade IV chondrosis).

e fairly well since the last operation although he has-not regained his full strength. 'He claims to be doing exercises on a regular basis but on the basis of the exam, as will be discussed below, this is doubtful. He does not have any continuing' catching and popping sensation, although it does happen occasionally, There' is no swelling. He seems to have some soreness in and about the tibial tubercle. Specific symptoms are that of patellofemoral dysfunction. Stairs are always difficult for him.

His job now is an auto body business. Instead of kneeling and squatting, he tends to use a wheeled car. He also has some difficulty standing and walking long distances. Stair climbing is also somewhat of a challenge in that the right leg is still somewhat weak. He was recently evaluated by Dr. Goodfellow and essentially released to full activity. There was only slight tenderness. Follow-up exam was scheduled in one year.

EMPLOYMENT HISTORY: He was *out* of work for about two months after the lateral retinacular release and then four months after the tibial tubercle transfer. He has not lost any **work** recently.

PAST MEDICAL HISTORY revealed a previous operation and a previously known patellofemoral abnormality. According to the medical records he was first evaluated on October 4, 1990 for a hyperextension and contusing injury along the lateral aspect of the right knee. X-rays were done and revealed an irregular area along the lateral femoral condyle anteriorly in the trochlear groove. This is articulation of the patellofemoral joint. It was felt after evaluation, including surgery which was done on November 16, 1990, at the diagnosis was Stage III osteochondritis desiccans of the lateral trochlear condyle. Actually a piece of tissue had broken off. The lesion was 2-1/2 x 2 cm which was a Stage III lesion. This was replaced and five orthosorb (absorbable) pins were inserted to hold this in place. He was followed. Some additional x-rays were reviewed at the end of 1990. Apparently these abnormalities had been present since 1988. He was followed intermittently through 1991 and doing essentially well that year. However, in April of 1992, he was having some difficulty with intermittent swelling, as well as a catching sensation his knee, and he felt that something moving around. X-rays did not show any significant abnormality but there was a "fuzzy area" in the area of surgery. Arthroscopy was recommended. This was carried out on May 6, 1992. Apparently a piece of the lesion that was fixed in 1990 had broken loose. Again, an abrasion arthroplasty was done on the lateral femoral condyle; as well as the arthroscopic removal of loose body. Postoperatively he seemed to do quite well and was rehabilitated.

In late July of 1992, he was doing some football practices and running up steps. He began to have some intermittent swelling and x-rays at that time failed to reveal any loose bodies. He was again injured in a football game on October 21, 1992, when his foot was planted and someone rolled over his legs and hyperextended his right knee. No significant ligamentous abnormality was noted. X-rays did not reveal any change in his osteochondritis area.

The plaintiff did state to me on examination quite clearly, after his operations, he was able to be a varsity kicker or punter during his years playing football. He did not, at

the time of the evaluation; however, mention that he, in fact, had more than one previous knee surgery.

PHYSICAL EXAMINATION revealed a pleasant 22 year old male who appeared in no acute distress. His gait pattern was normal. He was able to arise from a sitting position, as well as ascend and descend the exam table normally.

Examination of his right lower extremity revealed a fairly normal appearing calf region, but a somewhat abnormal right thigh area. Specifically, there were a number of incisions including multiple arthroscopic portals, a lateral patellar incision (from his first pre-accident surgery), as well as the surgery for the tibial tubercle transfer. There was no effusion in the knee joint. There was a full range of motion from 0 to 140 degrees of flexion. His medial and lateral, as well as anterior and posterior ligamental complexes were intact. There was no rotational instability detected. The patellofemoral joint revealed some tenderness along the lateral patellar facet area but absolutely no crepitance noted on active or passive movement. There was no subluxation noted. There was still approximately 2 cm of distal right thigh atrophy. This would go along with incomplete rehabilitation.

IMPRESSION: By history, aggravation of a previous patellofemoral joint abnormality. Past medical history of chronic patellofemoral abnormalities with multiple operations for loose body and Grade IV chondrosis. This is a clearly significant preexisting condition.

In my originally expressed opinions, I had difficulty understanding how a non-contact injury would be so "devastating" to his right knee as recorded in the history. There was no direct impact. There was no history of a subluxation or dislocation. At the time of the initial record review, the exact status of his patellofemoral joint was not known. It is clear that review of the medical records clearly show that there was, in fact, two previous knee surgeries. There were also intermittent symptoms through the early 1990s of loose body with definite structural abnormalities in the cartilage of distal femur. It is clear by the history presented to both Dr. Goodfellow and me that, within a reasonable degree of medical certainty, the surgeries performed were related to patellofemoral abnormalities and not to a specific contact injury. Dr. Goodfellow's opinion was that his "patellofemoral problems" were aggravated by the

accident, by the history presented. The care and treatment was solely to relieve patellofemoral joint pressures and was entirely appropriate for the condition diagnosed. The treatable condition was, in fact, a patellofemoral problem that had been extant for approximately five years. He has had a good recovery once the centralization procedure was accomplished. He still continues to improve: An active exercise program would be most appropriate in the form of progressive resistance exercises and conditioning.

It remains my opinion that is only by the patient's history that the patellofemoral problem was aggravated by the motor vehicle accident in question. Almost any type of repetitive squatting, kneeling, or prolonged sitting, can aggravate a diseased patellofemoral joint. The exact relationship between the "aggravation" and the motor vehicular accident remains obscure. As stated above, it is only by the history that there is any relationship. No additional factors were volunteered at the time of this evaluation.

In summary, the long-term prognosis is favorable. No further care or treatment is necessary or appropriate.

Sincerely,

Robert C. Corn, M.D., F.A.C.S.

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