CLEVELAND ORTHOPAEDIC ASSOCIATES. *INC.*
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August 1, **1994**

DOC. 253

James H. Sennett, L.P.A.
Williams & Sennett Co.
126 West Streetsboro St. - Suite #4
Hudson, Ohio **44236**

Re: Robin [redacted]
D.A: 03-03-92

Dear Mr. Sennett:

I examined [redacted] at your request in my office on August 1, 1994. This twenty-four year old white female stated that she was injured in a motor vehicle accident which occurred on March 3, 1992. On that date, while the unrestrained driver of an automobile traveling at approximately thirty-five miles per hour, her automobile struck another vehicle which turned in front of her. As a result of the collision, she was thrown forward onto the steering wheel and her right knee struck the dash. She struck her head on the windshield but, fortunately, the visor was in the turned down position and no cuts were sustained.

Ms. [redacted] was taken to a hospital via the ambulance where **she** was examined, x-rayed, and released. She was not given crutches or an immobilizer. However, because she had bruising, pain, and limping, she went to an orthopaedic surgeon. Because she did not improve, she sought the help of another orthopaedic surgeon who then performed an arthroscopy wherein torn cartilage was stated to have been removed. She stated that this did not significantly help her and she went for physical therapy treatments which were of no help.

She continued to have pain in the knee with frequent giving way of the knee, especially on going down steps. **A MRI** study was performed which showed, according to her, more damage to the cartilages and that the ligament was stretched. More physical therapy treatments ensued which again were of no help to her and she still continued to **have** the frequent giving way of the knee.

Ms. [redacted] finally had an anterior cruciate ligament reconstruction procedure carried out on March 14, 1994. She wore a brace for approximately three months and was not on weight-

bearing for approximately six weeks. At this time, she does not use the brace and she does take occasional Darvocet for pain. The knee does not give way and has happened only one time since the surgery. She stated that the knee does frequently swell, mostly by nightfall. She is only allowed to do regular walking and swimming; she is not allowed as yet to do any running. She works part-time, five hours per day, as a clerk because of the pain which she experiences. No other areas were stated to give her any problems.

Previous medical history regarding the knee revealed her to deny having any prior problems with the knee or any subsequent problems with the knee.

Examination revealed a well developed, well nourished, slightly overweight, white female who did not appear to be in acute distress. She walked without a limp. Examination of the knee revealed that she had recent operative scars in the midline and small arthroscopic scars about the knee. None of the scars were tender and they were still somewhat red in color. No joint effusion was present. She had complete extension of the knee; she lacked five degrees of full flexion when compared to the opposite uninjured knee.

By measurement, no atrophy of the thighs was present; in fact, one-half inch greater circumference of the right thigh when compared to the left thigh was present and this was in an individual who stated that she was left-handed. No instability of the knee was present in any direction. Lachman test was negative; a definite end point was present when performing the test. Slight genu valgus was present. No crepitation was present on flexion and extension of the knee. McMurray test was negative.

Review of the submitted material was conducted. It was noted that her initial examination by Dr. Peter Ricci was felt to be positive for probable chondromalacia and torn medial meniscus. His arthroscopic findings consisted of a tear of the posterior horn of the lateral meniscus with no chondromalacia. He stated that probing of the anterior cruciate ligament was normal. He subsequently showed that the anterior cruciate ligament was deficient and, under anesthesia, she showed instability of the knee. Ms. [redacted] therefore, underwent an anterior cruciate reconstruction by using a patella tendon graft which, at this time, appears to be functioning adequately. She has not fully recovered from her operative procedure, but is expected to improve with time.

To: James A. Sennett, L.P.A.
Re: [redacted]
From: Ralph J. Kovach, M.D.

It was also noted that she had a previous rear-end motor vehicle accident on November 9, 1991, approximately four months before the accident in question. At that time, she had problems with her low back and there was no indication that she had any knee injury from that particular incident. I feel that this is unrelated to the problems with her knee.

Whatever problems she had from the accident in question have all subsided, except for the knee, and there are no other areas of which she currently complains.

It is, however, somewhat unusual to discover the deficient anterior cruciate ligament at such a late date following an initial arthroscopic examination. It is possible that the operating surgeon was in error at the time of the first arthroscopic procedure in making the evaluation of the anterior cruciate ligament.

It was noted that the surgical procedure of February 9, 1993 does not describe examining the knee under anesthesia prior to performing the arthroscopic procedure. It only mentions that the anterior cruciate ligament was probed throughout its entirety and was noted to be normal.

It is difficult to state that, if the cruciate ligament was indeed normal by examination, how could it become lax at a later date. I cannot explain the discrepancy, other than perhaps probing was not adequate for an examination and perhaps the knee was not examined while the patient was under anesthesia to determine if it indeed were unstable in the anterior posterior direction, as is usually examined prior to performing an arthroscopy.

Very truly yours,

Ralph J. Kovach, M.D.

RJK/adm