CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE
A MEDICAL CORPORATION

John P. Belzer, M.D.
Frederic W. Bost, M.D.
Peter W. Callander, M.D.
Christopher V. Cox, M.D.
Jon A. Dickinson, M.D.
Keith C. Donatto, M.D.
Robert J. Gilbert, M.D.
William L. Green, M.D.
Adrian J. Rawlinson, M.D.
Taylor K. Smith, M.D.

3838 California St., Suite #715
San Francisco, CA 94118
(415) 668-8010
FAX: (415) 752-2560

2100 Webster St., Suite 109
San Francisco, CA 94115
(415) 923-3920
FAX (415) 923-3921

1240 South Eliseo, Suite 101
Greenbrae, CA 94904
(415) 461-1600
FAX: (415) 461-1840

PATIENT: MAX CONSERVA
DOS: Oct 23 2007

MRN: 01338004
DOB: Feb 02, 1981

Patient: CONSERVA, MAX

This 26-year-old young man was seen for the second time regarding his right lower extremity and knee problems. He was seen one time before on March 20, 2006 requesting a brace refurbishing. This young man was injured at age 8 by a semi-truck, which collided with him and, apparently, partially ran over his leg. The exact details were not described, but he had major injury with soft tissue loss and some bone loss over the distal femur on the right leg, which resulted in growth arrest. He has approximately 1-1/8-inch shortening following numerous surgeries to his knee region. He, apparently, had a growth arrest laterally and thus had a femoral growth arrest carried out surgically to the medial femur and subsequently to the left normal lower extremity at both distal femur and proximal tibia. He has had valgus deformity since the injury. He once saw me a-year-and-a-half ago when he injured himself snowboarding with a hyperextension to the knee. We did an MRI at that time, which showed marked bone loss and abnormal tissues while the anterior cruciate ligament and medial collateral ligament seemed to survive. He demonstrated a lot of bone defect laterally and a pseudoarticulation between patella and lateral absent portions of the femur. He seems to have absent meniscal tissue on the lateral side of the joint and possibly a radial tear of the posterior horn of the medial meniscus. We treated him conservatively at that time. He has used a long leg brace with ankle included, and has had refurbishment of the brace from time to time. He keeps in contact with his Southern California surgeon and orthotist, but Walter Racette of UCSF is communicating with the Southern California orthotist and fabricating a new brace at this time. The patient describes that he wears a shorter knee brace and tried playing tennis, and began to develop a feeling of instability while playing tennis, the short brace slides down the leg and he is determined to try to keep up an athletic activity. He states that it appears that with tennis, he has more valgus stresses occurring on the knee. He finds that he can tolerate his walking after tennis better with the knee extended and thus it appears that the knee is beginning to fail due to the marked valgus instability and his attempt to overload the knee.

I discussed the fact that he might not be able to play tennis and I discussed the fact that possibly positions of the foot because of his external rotation tibial deformity, might adjust the brace as this is being made in a way to help stabilize his knee.

I wrote the requested prescription for brace refurbishment and told him to suggest to his brace men experimenting with position of the foot ankle. He has a flexion contracture. He has had an anterior tibial splint transfer to give him dorsiflexion since he has had a varus and plantarflexion deformity of the foot and ankle. I do not see how he can apply a lot of stress on his leg without the long leg brace.

I suggested that he see Dr. Kevin Louie who might, with Ilizarov procedure or with major bone reconstruction plus realignment of the knee, might have something to offer. Certainly, Dr. Louie's expertise in major fracture

reconstruction would be worthwhile. I do not see that he is going to be able to maintain the function he wants to with the leg intact. He may want to consider an amputation, although an A-K amputation would not offer him as much stability or any more stability as what he has now.

Frederic Bost, M.D.

FB:mtpinoy.com/cbg::mmr
D: 10/27/2007 T: 10/29/2007
cc: File

CONSERVA, MAX
WorkType:
MRN: 01338004. Visit: 604262
Age: 26. Gender:
CalPac Ortho Sports Medicine

Electronically signed by:FREDERIC W. BOST M.D. Nov 19 2007 4:54PM PST

CALIFORNIA PACIFIC ORTHOPAEDICS & SPORTS MEDICINE
A MEDICAL CORPORATION

John P. Belzer, M.D.
Frederic W. Bost, M.D.
Peter W. Callander, M.D.
Christopher V. Cox, M.D.
Jon A. Dickinson, M.D.
Keith C. Donatto, M.D.
Robert J. Gilbert, M.D.
William L. Green, M.D.
Adrian J. Rawlinson, M.D.
Taylor K. Smith, M.D.

3838 California St., Suite #715
San Francisco, CA 94118
(415) 668-8010
FAX: (415) 752-2560

2100 Webster St., Suite 109
San Francisco, CA 94115
(415) 923-3920
FAX (415) 923-3921

1240 South Eliseo, Suite 101
Greenbrae, CA 94904
(415) 461-1600
FAX: (415) 461-1840

PATIENT: MAX CONSERVA
DOS: Oct 23 2007

MRN: 01338004
DOB: Feb 02, 1981

Kevin Louie, M.D.
2100 Webster Street, Suite 117
San Francisco, CA 94115

Patient: CONSERVA, MAX

Dear Kevin:

I wish you would see Max Conserva in consultation regarding his marked dysfunction and abnormal right lower extremity. I saw this 25-year-old gentleman only one other time on March 20, 2006 and obtained an MRI after he had injured himself snowboarding with what he called a hyperextension injury.

In short, he had a major injury when a semi-truck ran over his leg at age 8. He lost a portion of his distal femur and has had a valgus deformity of the knee since. He had numerous soft tissue surgeries in Southern California and a growth arrest of the medial distal femur along with some kind of Ilizarov procedure in the years following the injury. He also had growth arrest on the left side to try to equalize leg lengths, but this was done on the distal femur and proximal tibia leaving him with 1-1/8-inch shortening on the right.

His valgus deformity is secondary to a loss of lateral femoral condylar portions and his patellofemoral joint has a very marked abnormal configuration. He has external rotation naturally with flexion. He has also lost peroneal function, so a split anterior tibial transfer has given him some dorsiflexion and attempted to correct some of his inversion. He generally wears a long leg brace, but has tried to play tennis with a shorter leg brace and, thus now, is having pain.

I am wondering what you might have to offer with the combination of either an Ilizarov procedure with some kind of bone grafting and later considering knee replacement.

My sense is that this patient has greatly overloaded the structure of the knee as it now is and that in the future, he will be considering amputation versus major bone grafting with rotational realignment along with a later knee replacement.

Possibly, you have something to offer or could refer him appropriately. I can certainly continue to support his bracing prescriptions.