

January 21, 2005

Patient: CONSERVA, MAX

This self-referred, 32-year-old gentleman comes in with fresh injury to his right knee snowboarding at Heavenly Valley. He has snowboarded for years, but has had major disability in his right knee following a major injury at age 8. He was dragged by a semi-truck, losing his lateral femoral condyle and part of his lateral tibia. He had major reconstruction laterally and replacement of the knee has eventually been felt necessary, but has been put off as long as possible because of his great bone loss. He states that he thought he could flex about 90 degrees, but had major valgus external rotation occur in the knee. During that, he wears a long leg brace constantly, which controls the valgus, and he is able to weightbear with stability normally. Since his injury and feeling of a pop in his knee, he feels a little more unstable without the brace on, but he can walk fine without crutches and only a slight feeling of swelling when the brace is on. He has a free knee with long leg brace. The ankle is a polypropylene hinge and he has had a major nerve injury, so it is probably he had a posterior tibial transfer. The foot tends to varus because the brace holds it straight while the entire tibia tries to rotate and this has caused a forefoot varus and some inversion to the ankle. This has never been painful and it should not change now. The exam shows that he has got a positive Lachman and falls into valgus of about 45 degrees in any low degree of flexion and certainly at full extension. Thus, the question is has he torn his ACL or his MCL or both. He feels uncomfortable flexing more than 45 degrees at this time. The examination of x-rays shows a deficient lateral femoral condyle and lateral tibial plateau, and he appears squared off with a flat distal femur, which probably does not have much chondral cover. The mechanism of this injury was hyperflexion, and a snowboarding, and a fall, which was associated with the pop. About the only way we can tell new from old problems is doing an MRI and see if there is fresh medial collateral injury or fresh ACL injury, and we can tell from bone bruises, etc. what is going on. This patient might be a candidate for medial collateral ligament suturing to try to spare what soft tissue stability around the knee that he has, but this should be a difficult call. We will try to talk to his surgeons in Los Angeles. He originally saw Dr. Vernon Tolo and was followed recently by Dr. Richard Reynolds. He will try to obtain his most recent notes of 1 or 2 years ago from LA, which might indicate for us what the real range of motion was, what the stability of the medial collateral and ACL were. A difficult case overall, I discussed some of the problems with the patient.

Frederic W. Bost, M.D.

FWB:mtpinoy.com/cmo::iba/+

D: 01/21/05 T: 01/24/05

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F Conserva M 20050121 bost1978

JAN 28 2005

January 28, 2005

Patient: CONSERVA, MAX

I reviewed his MRI, which shows a sling instead of a medial collateral ligament and it appears that there is no frank tearing in it, although there is some increased signal. His patellofemoral joint seems to be relatively nonfunctional with a very jagged undersurface to the patella and to the anterior trochlea. It appears that there are no bone bruises posteriorly, but he is very squared off at the posterior femoral condylar region indicating that he cannot really roll back his femur. The patellar ligament looks perfectly all right. He is tender medially and anteriorly at the patellar ligament. He seems unstable to valgus stress because he goes into valgus during flexion to gain flexion. He seems to be fairly sure that the stability is about the same. His discomfort is improving anteriorly. We will see him in about 2 weeks to 3 weeks to see what his progress with physical therapy and a brace was ordered.

Frederic W. Bost, M.D.

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D: 01/28/05 T: 01/31/05

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FEB 18 2005

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MRI CONSULTATION REPORT

DOB: 02/02/1981

MR#: 06317098

Name: CONSERVA, MAX

Report Status: Final

Location: PREOUW

ACCT#: 04579472

Exam Code: M65009

Order#: CPM0501002

MR: 06317098

Patient: CONSERVA, MAX

Exam Date: 01/26/2005

Exam: R MRI Lower Ext 3 Sequence Joint

Indication: RT KNEE DX: MAJOR BONE
LOSS AGED LATERAL
FEMORAL, ? MCL OR ACL
INJURY

CLINICAL INFORMATION: RT KNEE DX: MAJOR BONE
LOSS AGED LATERAL
FEMORAL, ? MCL OR ACL
INJURY

TECHNIQUE: T1 weighted coronal images, fat suppressed FSE coronal
images, gradient echo sagittal images, fat suppressed FSE sagittal
images, T1 weighted axial images, fat suppressed FSE axial images.

FINDINGS:

There is marked deformity and abnormal anatomy of the right knee.
The patella articulates with the patient's lateral femoral condyle as
seen on axial image number 7. The lateral femoral condyle has lost
its normal anatomy. The findings are compatible with a history of
trauma at the age of 8 with reconstruction surgery.

In the medial compartment, the MCL is intact without evidence of
tearing. There is radial tearing of the posterior horn medial
meniscus as seen on sagittal image number 6. There is chondromalacia
involving medial compartment with thinning and fibrillation with
perhaps some areas of erosion of bone as seen on sagittal image
number 10.

No identifiable lateral meniscal tissue is seen. The patient's
lateral tibial plateau has essentially been previously resected or
absent from prior trauma. The biceps femoris insertion upon the
fibular head is seen.

The ACL and PCL are intact as seen on sagittal images 8 through 11.

Again, the patella has a pseudoarticulation with the lateral aspects
of the femoral condyles. There is marked deformity of the patella.
There is chondromalacia and subcortical irregularity.

There is a large geode noted in the medial femoral condyle. Distal

T: 01/27/2005 DS

Physician(s): Bost, Frederic

Ord. MD: Bost, Frederic

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MRI CONSULTATION REPORT

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DOB: 02/02/1981

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Report Status: Final

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portion of the quadriceps tendon and patellar tendons are normal in appearance.

IMPRESSION:

1. Marked deformity and deviation from normal knee anatomy is compatible with the history of trauma at the age of 8 with reconstructive surgery of the knee.
2. The ACL and MCL are intact.
3. There is posterior horn medial meniscus radial tearing.
4. No discernible lateral meniscal tissue visualized.

Dictated By:

Christopher Govea MD with David Stoller MD

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D:01/27/2005

Electronically Signed
01/28/2005 10:22

T: 01/27/2005 DS
Physician(s): Bost, Frederic

Ord. MD:Bost, Frederic

July 26, 2005

Patient: CONCERVA, MAX

Max has been seen here before his recent injury of the first of the year. He seems to have improved. The strength is gradually improving. He does not feel any less stable than he did before. He is looking for a new brace and refurbishing of this. I referred him to Paul _____. His ability to extend with the brace on is good, he cannot with the brace off, so he needs the alignment of the brace and I told him heavy duty was probably what he would have to have because he is so dependent upon it. He once had an athletic-type brace, which was somewhat helpful, but it would not stay fixed to the front of his knee. He could not lash it tightly enough. I asked him to see Paul _____, brace maker, with my prescription for fabrication of a new brace. He probably will need steel uprights because the plaster would give out too much since he has got so much valgus stress. Plan is to see him in supportive brace making if he needs it. He has a totally unstable knee with a totally unstable collateral ligaments and malalignment and loss of bone, etc.

Frederic W. Bost, M.D.

FWB:mtpinoy.com/mmr::mmc/+

D: 07/26/05 T: 07/28/05

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