

'Ambulatory Progress Notes**Max Fabrizio Conserva** [REDACTED]**Ambulatory Progress Notes Info**

| Author | Note Status | Last Update User | Last Update Date/Time |
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| Michael D Ries | Signed | Transcription Conversion Edi | 10/5/2011 4:09 PM |

Ambulatory Progress Notes

UCSF ARTHRITIS AND JOINT REPLACEMENT CENTER

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RE: Conserva, Max Fabrizio
U#: 41998318
DATE OF SERVICE: 09/28/2011

HISTORY: The patient is a 30-year-old man who has undergone considerable trauma to his right leg previously associated with loss of lateral femoral condyle and tibial plateau requiring surgical reconstruction and soft tissue grafting procedures, who presents as a new patient in our practice for evaluation of knee instability and stiffness. The patient was seen today with Dr. Carol Lin and full details of the patient's clinic note will be dictated separately by Dr. Lin. The patient is also using a knee-ankle foot orthosis with drop locks which appears to be fitting well but this 3 years old and worn in areas requiring modification and repair.

PHYSICAL EXAMINATION: There is a marked atrophy of the entire lower extremity and peroneal nerve palsy with weakness in dorsiflexion and eversion of the foot present. Multiple skin grafts are present over the lateral knee which is held in a position of 30 degrees of valgus and motion of 0 to 90 degrees is present but with a 10-degree extensor lag. The knee is relatively lax to varus stress.

IMAGING: X-rays demonstrate complete loss of the lateral femoral condyle and tibial plateau with an irregularity of the articular surface of the medial compartments of the knee in the presence of the patella consistent with traumatic loss of bone to the lateral aspects of the distal femur and proximal tibia.

RECOMMENDATION: I have reviewed treatment options with the patient including continued use of bracing and activity modifications as he has done. Currently he has no knee pain and was advised that the most appropriate treatment in my opinion would be repair and modification of his brace and otherwise continuing his current activities but if symptoms worsen either in terms or instability, then reconstructive surgery would be appropriate. If surgery were undertaken to stabilize the knee and improve function, I would favor either fusion or hinged knee replacement. I have discussed both options including the functional differences between the 2 and the patient is opposed to fusion as an option given the limitation of losing knee flexion. I would consider hinged knee arthroplasty a reasonable option likely with trabecular metal augmentation which may require custom augments to be made and have cautioned the patient in no uncertain terms that this is a fully constrained implant which would be intended to improvement alignment and knee function but over time mechanical failure would like occur necessitating multiple revision surgeries in the future. At this

point he will plan to followup with the orthotics group to have the brace modified and continue his current activity and exercise and return on a p.r.n. basis.

MICHAEL D. RIES, M.D.
PROFESSOR AND CHIEF, ARTHROPLASTY SERVICE
DEPARTMENT OF ORTHOPAEDIC SURGERY

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Dictated by: Michael D. Ries, MD 31325

Attending Physician: Michael D. Ries, MD 31325

Electronically Signed by
Michael D. Ries, MD 10/04/2011 08:03 A

D: 09/28/2011 04:47 P
T: 09/28/2011 08:25 P d57 CS#: 2826781

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