August 29, 2019

To: Boston VA Regional Office

This is a claim for CUE, Clear and Unmistakable Error, under provisions of 38 CFR 5109A for violation of 38 U.S.C. 1111 and 38 CFR 4.6.

Veteran respectfully request the VA call a clear and unmistakable error on part of the October 4, 1999 rating decision from the Boston VA Regional Office **(Exhibit A)** and to correct it. The laws in effect at that time were not properly applied nor was all of the relevant evidence available in support of veteran's claim considered. The result was a denial for service-connection for right knee disorder and left knee disorder. Had the laws and regulations been properly applied, and the preponderance of supporting evidence considered, it would have manifestly changed the outcome of the decision.

38 U.S.C 1111 – Presumption of sound condition states "every veteran shall be taken to have been in sound condition when examined, accepted, and enrolled for service, except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed before acceptance and enrollment and was not aggravated by such service."

In the decision letter dated October 4, 1999 **(Exhibit A)**, veteran was denied right knee disorder. The decision stated "since this condition neither occurred in nor was caused by service". The left knee disorder was denied stating that it was a pre-existing condition". 38 U.S.C 1111 was not properly applied in light of three separate physical exams on record at the time of the decision which did not note any pre-existing conditions **(Exhibits B, C, D)**.

- Entrance Exam for Florida Army National Guard dated September 16, 1985 **(Exhibit B)**
- Entrance Exam for U.S. Army dated April 29, 1987 **(Exhibit C)**
- Airborne Medical Exam dated March 13, 1989 **(Exhibit D)**

38 CFR 4.6 – Evaluation of evidence states "Every element in any way affecting the probative value to be assigned to the evidence in each individual claim must be thoroughly and conscientiously studied by each member of the rating board in the light of the established policies of the Department of Veterans Affairs to the end that decisions will be equitable and just as contemplated by the requirements of the law. "

In the decision letter dated October 4, 1999 **(Exhibit A)**, the decision was based on inaccurate and incomplete information and failed to properly apply 38 CFR 4.6 requiring the consideration of all evidence available at that time.

In item 1. Service connection for right knee disorder, FACTS - "The service records show the veteran had a strain of the right knee playing softball. There was no further treatment in service."

Strained right MCL was diagnosed on May 27, 1990 **(Exhibit E).** Veteran was playing for the company softball team during a company sanctioned game. Veteran was put on a 7-day profile and given a brace to wear due to severe swelling and pain. Veteran injured his back a few months later and spent an extended time in the hospital and subsequently he was discharged from the service on July 3, 1991.

In item 2 for service connection left knee disorder, FACTS: "Evidence shows that the veteran had a left knee problem prior to entry onto active duty. There is no medical evidence of any injury or treatment in the military service."

June 5, 1992 VA Rating Decision **(Exhibit F)**, item 23 Narrative "F" states: "Unable to do deep knee bends due to pain"

There are no medical treatment records in veteran's service treatment record or private medical records that diagnose or treat any knee problem prior to military service. On page 3 of C&P exam dated October 1, 1991 **(Exhibit G)**, the report noted "Both knees injured in service from training at Airborne and jumped out of plane caused damage. Never reported it, never got treatment for it." Veteran did not want to get recycled and have to start training all over. In medical treatment record dated August 4, 1987 (**Exhibit H)**, it documents sharp lower leg pain in left leg.

During the same C&P exam, veteran was asked about any injuries playing sports prior to service. Veteran informed examiner that in 1983 he tried out for high school football team and during the first day of tryouts he was tackled from the left side and experienced pain in left leg. He left the field, changed clothes and went home. Veteran did NOT go to the doctor, take any medications nor have any residual issues from that experience. Veteran went to school the next day and did not experience any further issues relating to that day. The reason that memory stood out was because veteran DID NOT go back to football tryouts. The examiner made a note that veteran had left knee injury prior to service, but also annotated "ligament injury" at the bottom of the note without any medical evidence to support his statement.

The operation report dated August 23, 1996, from Dr. Robert Foster **(Exhibit I)**, Chief of Orthopedic Surgery at Mount Auburn Hospital stated "This is a 29-year-old white male who injured his knee in the military." Dr. Foster also noted that the left knee was injury as a result of being a paratrooper on surgery/procedure short form dated August 23, 1996 **(Exhibit J)**.

C&P exam dated September 8, 1999 **(Exhibit K)**, noted on page 2 "He injured both knees while in the military. He injured the left knee in a parachute jump in 1989, after which it swelled and suddenly popped out of place. He was not able to move the knee for some time after that. He injured his right knee in 1990 when he twisted it, he was seen at sick call." Diagnosis status postop meniscectomies of both knees with osteoarthritis of the left knee.

Had 38 U.S.C 1111 and 38 CFR 4.6 been properly applied during the adjudication of veteran's claim, with due consideration to the presumption of sound condition and the preponderance of relevant evidence supporting veteran's claim for bilateral knee condition, the result would have been manifestly affected.

This CUE review request is based on the laws in effect and information available at the time of the adjudication on October 5, 1999.

EXHIBIT A

RATING DECISION
DATED OCTOBER 4, 1999

File Copy

DEPARTMENT OF VETERANS AFFAIRS
REGIONAL OFFICE
JFK FEDERAL BUILDING
BOSTON, MA 02203

RANDY C. BROGEN

VA File Number
[redacted]

Represented by:
Disabled American Veterans

Rating Decision

October 4, 1999

INTRODUCTION

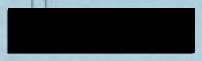
Mr. Randy C. Brogen, a veteran who served honorably in the US Army from 06-16-87 to 07-03-91, filed a claim for an increased evaluation which was received on 04-19-99.

ISSUE/DECISION

Based on a review of the evidence of record, and for the reasons outlined below, we have made the following decision(s):

1. Service connection for right knee disorder is denied.
2. Service connection for left knee disorder is denied.
3. Evaluation of low back syndrome, which is currently 20 percent disabling, is continued.

MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION



EVIDENCE CONSIDERED

The evidence received and considered includes:

- VA examination dated 09-08-99
- Report from Mount Auburn Hospital dated 07-31-96 to 04-30-97
- Service medical records.

REASONS FOR DECISION

1. Service connection for right knee disorder:

FACTS: The service medical records show the veteran had a strain of the right knee playing softball. There was no further treatment in service. The Mt. Auburn records show right knee surgery in 1997.

ANALYSIS: Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. Service connection for right knee disorder is denied since this condition neither occurred in nor was caused by service. (See 38 CFR 3.303)

No chronic disability subject to service connection was shown in the service medical records or any other evidence reviewed. Treatment on one occasion in service does not demonstrate a chronic disability for which service connection can be granted.

2. Service connection for left knee disorder:

FACTS: Evidence shows that the veteran had a left knee problem prior to entry onto active duty. There is no evidence of any injury or treatment in the military service. Mt. Auburn records show left knee surgery in 1996, with no reference to in service etiology. VA exam notes the reported history of injury in service and makes a diagnosis of status post meniscectomy with osteoarthritis. Examiner does not comment on etiology of the left knee.

ANALYSIS: The evidence shows that left knee disorder existed prior to service. There must be objective evidence of worsening of a pre-existing condition in order to establish service connection by aggravation. There is no evidence that the condition permanently worsened as a result of service. (See 38 CFR 3.306)

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[redacted]

3. Evaluation of low back syndrome currently evaluated as 20 percent disabling:

FACTS: VA exam notes the veteran's complaints of a constant ache in the low back and pain. Physical examination reveals tenderness across the pelvis, no sciatic notch tenderness and no tenderness in the lumbar spine. Flexion is to 60 degrees, right and left lateral bending is to 10 degrees. There is abnormal muscular spasm associated with motions and neck pain is reported on lateral bending. An x-ray shows narrowing indicative of degenerative disk disease. Evidence does not indicate additional functional loss due to pain on prolonged activity or during flareups. (See 38 CFR 4.40)

ANALYSIS: The evaluation of low back syndrome is continued as 20 percent disabling. An evaluation of 20 percent is assigned for muscle spasm on extreme forward bending and unilateral loss of lateral spine motion in a standing position. A higher evaluation of 40 percent is not warranted unless the record shows lumbosacral strain with listing of the whole spine to the opposite side, positive Goldthwait's sign, marked limitation of forward bending in standing position, loss of lateral motion with osteoarthritic changes, or narrowing or irregularity of joint space, or some of the above with abnormal mobility on forced motion. (See 38 CFR 4.71, Diag. Code 5295)

Evidence of muscle spasm on forward bending and some limitation of motion is consistent with the assigned evaluation.

Referral to the Director, Compensation and Pension Service, for consideration of an extraschedular evaluation is not warranted because the record does not show frequent periods of hospitalizations or a marked interference with employment. The veteran's disability does not pose such an unusual disability picture as to render impractical the application of the regular schedular standards. (See 38 CFR 3.321(b)(2))

For additional information regarding applicable laws and regulations, please consult your Service Officer or local library, or visit us at our web site, www.va.gov.

MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

ACTIVE DUTY *(Month/Day/Year)*				ADDITIONAL SERVICE CODE	COMBAT STATUS	SPECIAL PROVISION CODE	FUTURE EXAM *(Month/Year)*
EOD	RAD	EOD	RAD				None

COPY TO:		EFFECTIVE DATE	BASIC	HOSPITAL	LOSS OF USE	ANAT. LOSS	OTHER LOSS
	S						
	M						
	C						

JURISDICTION: 020;3 Claim for increase received 04-19-99

1. SC (PTE)

5295 LOW BACK SYNDROME
20% from 07-04-91

8. NSC (PTE GW)
5299 RIGHT KNEE DISORDER
5299 LEFT KNEE DISORDER
6600 CHRONIC BRONCHITIS
5299 COSTOCHONDRITIS

F.X.Sullivan, Rating Specialist

[redacted]

[redacted] MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

NOTICE

The attached decision on your claim for VA benefits is in a format which is being tested by the Department of Veterans Affairs (VA). This format has been developed for the purpose of providing you with a decision which is clear and understandable and which meets all the requirements of the laws governing the processing of claims. As part of this test, you will soon receive a questionnaire asking for your opinion of this format. A self-addressed, stamped envelope will be enclosed for your use. Your response to this questionnaire will be greatly appreciated as it will assist us in developing a better product.

MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

EXHIBIT B

ENTRANCE EXAM
DATED SEPTEMBER 16, 1985

BEST COPY

Standard Form 88
Revised 10-75
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

88-119

1. LAST NAME—FIRST NAME—MIDDLE NAME	2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO.
BROGEN, R[redacted]Y CLARENCE	PFC	[redacted]
4. HOME ADDRESS (*Number, street or RFD, city or town, State and ZIP Code*)	**5. PURPOSE OF EXAMINATION**	**6. DATE OF EXAMINATION**
4073 Bay Ave, Highland City, Fl. 33846	Enlistement	16 Sep 1985

7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE		10. AGENCY	11. ORGANIZATION UNIT
M	CAU	MILITARY 00 00	CIVILIAN 00 00	NG	Btry A 2/116th FA, Bartow

12. DATE OF BIRTH	13. PLACE OF BIRTH	14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN
8 Mar 1967	West Palm Beach, Fl	315 Armor Rd, Bartow Fl 33830 James O. BROGEN SR, Father

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS	16. OTHER INFORMATION
	NONE

17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (*Total*)	LAST SIX MONTHS
DMOS: 13B10	NA	NA

CLINICAL EVALUATION

NORMAL	(*Check each item in appropriate column; enter "NE" if not evaluated.*)	ABNORMAL
✓	18. HEAD, FACE, NECK, AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (*Int. & ext. canals*) (*Auditory acuity under items 70 and 71*)	
✓	23. DRUMS (*Perforation*)	
✓	24. EYES—GENERAL (*Visual acuity and refraction under items 59, 60 and 67*)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (*Equality and reaction*)	
✓	27. OCULAR MOTILITY (*Associated parallel movements, nystagmus*)	
✓	28. LUNGS AND CHEST (*Include breasts*)	
✓	29. HEART (*Thrust, size, rhythm, sounds*)	
✓	30. VASCULAR SYSTEM (*Varicosities, etc.*)	
	31. ABDOMEN AND VISCERA (*Include hernia*)	
✓	32. ANUS AND RECTUM (*Hemorrhoids, fistulae*) (*Prostate, if indicated*)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (*Strength, range of motion*)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (*Except feet*) (*Strength, range of motion*)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	X
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (*Equilibrium tests under item 72*)	
✓	42. PSYCHIATRIC (*Specify any personality deviation*)	
	43. PELVIC (*Females only*) (*Check how done*) ☐ VAGINAL ☐ RECTAL	

NOTES. (*Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.*)

A368
B62

39: Left shoulder, AT of C
Mole: R-CB. & Flower.

(*Continue in item 73*)

44. DENTAL (*Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.*)

Restorable teeth: 1 (0) 2 (0) 3 (0) / 32 31 30
Non-restorable teeth: 1 (/) 2 (/) 3 (/) / 32 31 30
Missing teeth: 1 (x) 2 (x) 3 (x) / 32 31 30
Replaced by dentures: x x x / 1 2 3 / 32 31 30 / x x x
Fixed Partial dentures: (x) / 1 2 3 / 32 31 30 / (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

W.N.L.

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.005		46. CHEST X-RAY (*Place, date, film number and result*)
B. ALBUMIN Trace	D. MICROSCOPIC —	#A8377 9-16-85 W.N.L.
C. SUGAR neg		
47. SEROLOGY (*Specify test used and result*) RPR	**48. EKG** —	**49. BLOOD TYPE AND RH FACTOR** —
50. OTHER TESTS		

COPY MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

EXHIBIT C

ENTRANCE EXAM
DATED APRIL 29, 1987

BEST COPY

Standard Form 88
Revised 10/75
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41 CFR) 201-45.505

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME: Brogen Randy Clarence

2. GRADE AND COMPONENT OR POSITION: ~~CIVILIAN~~ SP/4 Army National Guard

3. IDENTIFICATION NO.: [redacted]

4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code): 2729 Main Ave, Eaton Pk., FL. 33840.

5. PURPOSE OF EXAMINATION: ~~ENLISTMENT~~ COMMISSION; ARMY NAVY AIR FORCE MARINE CORPS; COAST GUARD RESERVE NATIONAL GUARD

6. DATE OF EXAMINATION: APR 29 1987

7. SEX: MALE

8. RACE: CAU NEG IND (AMERICAN) MON MAL

9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY 8 mon; CIVILIAN 0

10. AGENCY: DA

11. ORGANIZATION UNIT: 7/ONE

12. DATE OF BIRTH: 08 MAR 67 AGE: 20

13. PLACE OF BIRTH: W. PALM BEACH

14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: James A. Brogen Sr. Father, 315 Armour Rd., Bartow Fl. 33830

15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS: Miami MEPS, 8395 Executive Dr. Miami, FL 33166-4611

16. OTHER INFORMATION

17. RATING OR SPECIALTY

TIME IN THIS CAPACITY (Total)

LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
—	18. HEAD, FACE, NECK AND SCALP	
—	19. NOSE	
—	20. SINUSES	
—	21. MOUTH AND THROAT	
—	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
—	23. DRUMS (Perforation)	
—	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
—	25. OPHTHALMOSCOPIC	
—	26. PUPILS (Equality and reaction)	
—	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
—	28. LUNGS AND CHEST (Include breasts)	
—	29. HEART (Thrust, size, rhythm, sounds)	
—	30. VASCULAR SYSTEM (Varicosities, etc.)	
—	31. ABDOMEN AND VISCERA (Include hernia)	
—	32. ANUS AND RECTUM (Hemorrhoids, fistulae) Prostate, if indicated)	
—	33. ENDOCRINE SYSTEM	
—	34. G-U SYSTEM	
—	35. UPPER EXTREMITIES (Strength, range of motion)	
—	36. FEET	
—	37. LOWER EXTREMITIES (Except feet)(Strength, range of motion)	
—	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	—
—	40. SKIN, LYMPHATICS	
—	41. NEUROLOGIC (Equilibrium tests under item 72)	
—	42. PSYCHIATRIC (Specify any personality deviation)	
	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

(39) Tat/2 ~~left~~ upper arm
2 rt upper arm.

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and low

23 M111744-9

RIGHT																	LEFT
	1 2 3 / 32 31 30	0	Restorable teeth	1 2 3 / 32 31 30	Non-restorable teeth		1 2 3 x / 32 31 30 x	Missing teeth	x x x / 1 2 3 / 32 31 30 x x		by dentures	32 31 30 (x)	dentures		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

ACCEPTABLE

NOT ACCEPTABLE

(DENTAL EXAMINATION NOT DONE BY DENTAL OFFICER)

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY

B. ALBUMIN-REAGENT STRIP: NEGATIVE

C. SUGAR-REAGENT STRIP: NEGATIVE

D. MICROSCOPIC

46. CHEST X-RAY (Place, date, film number and result)

PLACE AS IN ITEM 15: FILM NO. ____

DATE ____ RESULT ____

47. SEROLOGY (Specify test used and result)

RPR ____

48. EKG

49. BLOOD TYPE AND RH FACTOR

50. OTHER TESTS

ELISA NEGATIVE W'BLOT ____

URINE HCG ____

USMEPCOM OVERPRINT 88, 1 Sep 85

PREVIOUS EDITIONS WILL BE USED

COPY MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

EXHIBIT D

ENTRANCE EXAM
DATED MARCH 13, 1989

BEST COPY

Standard Form 88
Revised 10/75
General Services Administration
Interagency Comm. on Medical Records
FPMR 101-11.806-8

REPORT OF MEDICAL EXAMINATION

1. LAST NAME—FIRST NAME—MIDDLE NAME: Brogen, Randy C	2. GRADE AND COMPONENT OR POSITION: E-4	3. IDENTIFICATION NO.: [redacted]
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code): 459 Pinebrook, Eatontown NJ 07724	5. PURPOSE OF EXAMINATION: Airborne	6. DATE OF EXAMINATION: 13 MAR 89
7. SEX: M / 8. RACE: W / 9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY 3, CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT: HHC 513th MI BDE
12. DATE OF BIRTH: 08 MAR 67 / 13. PLACE OF BIRTH: W. Palm Beach, FL.		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN: MATTIE S Brogen (MOTHER) 109 Minick ST Warner Robins, GA 31093
15. EXAMINING FACILITY OR EXAMINER AND ADDRESS: US PATTERSON ARMY HOSPITAL, MEDICAL EXAMINATION SECTION, FORT MONMOUTH, NEW JERSEY 07703		16. OTHER INFORMATION
17. RATING OR SPECIALTY	TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	(Check each item in appropriate column; enter "NE" if not evaluated.)	ABNORMAL
✓	18. HEAD, FACE, NECK AND SCALP	
✓	19. NOSE	
✓	20. SINUSES	
✓	21. MOUTH AND THROAT	
✓	22. EARS—GENERAL (Int. & ext. canals) (Auditory acuity under items 70 and 71)	
✓	23. DRUMS (Perforation)	
✓	24. EYES—GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
✓	25. OPHTHALMOSCOPIC	
✓	26. PUPILS (Equality and reaction)	
✓	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
✓	28. LUNGS AND CHEST (Include breasts)	
✓	29. HEART (Thrust, size, rhythm, sounds)	
✓	30. VASCULAR SYSTEM (Varicosities, etc.)	
✓	31. ABDOMEN AND VISCERA (Include hernia)	
✓	32. ANUS AND RECTUM (Hemorrhoids, fistulae) (Prostate, if indicated)	
✓	33. ENDOCRINE SYSTEM	
✓	34. G-U SYSTEM	
✓	35. UPPER EXTREMITIES (Strength, range of motion)	
✓	36. FEET	
✓	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
✓	38. SPINE, OTHER MUSCULOSKELETAL	
✓	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
✓	40. SKIN, LYMPHATICS	
✓	41. NEUROLOGIC (Equilibrium tests under item 72)	
✓	42. PSYCHIATRIC (Specify any personality deviation)	
NP	43. PELVIC (Females only) (Check how done) ☐ VAGINAL ☐ RECTAL	

NOTES. (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)

Restorable teeth: 1/32 2/31 3/30 (0)
Non-restorable teeth: 1/32 2/31 3/30 (/)
Missing teeth: 1/32 2/31 3/30 (x)
Replaced by dentures: 1/32 2/31 3/30 (x x x / x x x)
Fixed Partial dentures: 1/32 2/31 3/30 (x) / (x)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY 1.030		46. CHEST X-RAY (Place, date, film number and result): nl study 13 Mar 89
B. ALBUMIN –	D. MICROSCOPIC 1-2 WBC, 1-2 RBC	
C. SUGAR –		
47. SEROLOGY (Specify test used and result): RPR-NR	48. EKG: nl study	49. BLOOD TYPE AND RH FACTOR
		50. OTHER TESTS: 13.7 / 42.2 / 6.07 Sickle –

50.2S 32.6L 8M 3.8E 1.8B 3.5ATL

88-118

COPY MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

EXHIBIT E

RIGHT KNEE MCL INJURY
(SICK CALL RECORD)
DATED MAY 29, 1990

BEST COPY

NSN 7540-00-634-4176 600-108

HEALTH RECORD — CHRONOLOGICAL RECORD OF MEDICAL CARE

Outpatient Clinic U.S. Army Hospital
Berlin APO NY 09742

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
29 MAY 1990	Time In 0852 T 98.6 P 84 BP 110/80 WT — LMP — Allergies NKDA Meds Motrin Sick Call APPOINTMENT 23 yo male who injured right knee while playing softball seen in ER on Sunday here for F/U. Pt c/o continued pain and edema. Maria A. Polanco S: as above, twisted (R) knee 2 days ago, still c/o pain + swelling O: (R) knee: some swelling medial to patella but less than 2 days ago, pain MCL area on varus stress A: MCL strain (R) knee P: (1) wear knee brace (2) phys ther consult given on 27.5.90 (3) elevate if swelling! (4) F/U no running, no PT x 7 (seven) days (5) F/U PRN S Kollmann

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

[redacted]

3193 AFF USA
BROGE RANDY C
B MAC CT AD USA
SPC USA ASC

RECORDS MAINTAINED AT:

PATIENT'S NAME (Last, First, Middle initial)		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

IVONA KOLLMANN
SPC USA
280-56-2591

CHRONOLOGICAL RECORD OF MEDICAL CARE — STANDARD FORM 600 (Rev. 5-84) Prescribed by GSA and ICMR FIRMR (41 CFR) 201-45.505

COPY MADE BY VARMC, ST. LOUIS FROM A RECORD IN VA'S POSSESSION

EXHIBIT F

RATING DECISION
DATED JUNE 5, 1992

VETERANS ADMINISTRATION — RATING DECISION

1.REGIONAL OFFICE NO.	2.TYPE OF RATING	3.ORIGINAL DISABILITY RATING?	4.VETERAN'S FILE NO.
309	DISABILITY	Yes	[redacted]

5.VETERAN'S INITIALS AND SURNAME	6.COPY TO	7.VETERAN'S SOCIAL SECURITY NO.
R. C. BROGEN		

8.DATE OF CLAIM	9.DATE OF THIS RATING	10. DATE OF BIRTH	11.DATE OF DEATH
08-14-91	6-5-92	03-08-67	

12.ACTIVE DUTY (Mo,day,yr.)				13.ADDL. SERVICE CODE
EOD	RAD	EOD	RAD	
06-16-87	07-03-91			

14.COMBAT STATUS	15.DATE OF LAST EXAMINATION	16.DATE OF FUTURE PHYSICAL EXAMINATION(Mo./yr.)	17.EMPLOYABLE (COMPENSATION only)
1	10-01-91	10-93	Yes

18.COMPETENT	19.SPECIAL PROVISION CODE	20.NO.OF ADDITIONAL DIAGNOSTICS	21.NO.OF ADDITIONAL S/C DIAGNOSTICS
Yes			

22.SPECIAL MONTHLY COMPENSATION

A.STATUS	B.BASIC SMC	C.HOSPITAL SMC	D.LOSS OF USE	E.ANAT LOSS	F.OTHER LOSS
CURRENT					
FUTURE					

23.NARRATIVE

J. Original claim.

I. Service connection for lower back condition, chronic bronchitis and costochondritis.

E. SMR's, VA examination of 10-01-91.

F. SMR's show the veteran was treated for low back pain on numerous occasions beginning on 11-24-87 when the diagnosis was strained with spasm. X-rays of the back done on 10-07-88 showed no significant abnormalities. CT scan done 04-24-90 showed wide based medial left accentuated disc prolapse on segment L5-S1 with definite displacement of fatty tissue with no significant alleviation of the nervous structure. On 05-23-90 the diagnosis was medial lateral nucleus prolapse L5-S1. The veteran was subsequently seen in 06-90, 08-90 and 11-90 for lower back pain. On 04-14-91 the veteran complained of low back pain and left leg pain. Diagnosis was low back pain. Spinal CT done 04-18-91 found moderate disc protusion L4-5 and L5-S1. Current VA examination found the veteran complaining of constant low back pain. The neurological examination found the veteran had slight difficulty walking on toes and heels. He was unable to do deep knee bends due to pain. There was spasm of the paravertebral muscles with left

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VETERANS ADMINISTRATION

RATING DECISION
CONTINUATION SHEET

NAME OF VETERAN
R. C. BROGEN

FILE NUMBER
[redacted]

Page 02 of Rating Dated:

sciatic notch tenderness. The orthopedic examination found the veteran walked on toes and heels and accomplished a deep bend with some difficulty. He stood erect and the spinal column exhibited a decrease in lumbar lordotic curvature. The range of motion of the trunk was flexion 50 degrees, extension 0 degrees, lateral bends to the left 20 degrees and to the right 15 degrees. There was marked pain on percussion over the lumbosacral spine. There was marked spasm of the lumbar paraspinal musculature. There was sciatic notched tenderness. SLR test was positive at 60 degrees. An X-ray showed very minimal changes L5-S1 with no other abnormalities found. Diagnosis was low back syndrome. The VA examination also diagnosed chronic bronchitis and costochondritis. SMR's are negative for treatment for either of these conditions.

D. The veteran's low back condition is service-connected and evaluated at 20% disabling effective day following discharge from service. Service connection is denied for chronic bronchitis and costochondritis as SMR's are negative for treatment of these conditions.

1. SC PTE

5295 Low back syndrome
20% from 07-04-91

8. NSC, PTE, PGW

6600 Chronic bronchitis
5299 Costochondritis

24.MEDICAL RATING SPECIALIST	25.RATING SPECIALIST	26.RATING SPECIALIST	27.P/A
J. AGRAMONTE, MD	T. OLIVARI/135/rac	C. M. KUCHTA	DAV
J. Agramonte, MD	T. O Livi	C M Kuchta	28.R.B.NO. B
CHP./ /	CHP./ /	CHP./ /	

VA FORM 21-6796b-1
SEP 1986
DD: 05/28/92 DT: 05/29/92 89350

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EXHIBIT G

C&P REPORT
DATED OCTOBER 1, 1991

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544-8943 3/8/67

Form Approved
OMB No. 2900-0052

Veterans Administration

REPORT OF MEDICAL EXAMINATION FOR DISABILITY EVALUATION

1A. FILE NO. C-

1B. VETERANS SOCIAL SECURITY NO. [redacted]

2. INSURANCE FILE NO. *(V.H.K., ect., if pertinent)*

INSTRUCTIONS TO THE VETERAN: Please complete all unshaded items on Page 1 of this form. Bring this form with you when reporting for the examination.

PRIVACY ACT INFORMATION - The information requested by this form is authorized by existing law (38 U.S.C. 210(C)(1)) and is considered relevant and necessary to determine entitlement to maximum benefits applied for under the law. Responses may be disclosed outside the VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register.

3. FIRST, MIDDLE, LAST NAME OF VETERAN *(Type or print)*: RANDY CLARENCE BROGEN

4. PURPOSE OF EXAMINATION: C&P EXAM

5. DATE OF EXAMINATION: 10-1-91

6. HOME ADDRESS *(Street or RFD Number, City, State, and ZIP Code)*: 459 Pinebrook Rd, Eatontown, NJ 07724

7. PLACE OF EXAMINATION: VAMC-EONJ 07019 OPC-KD

8. AGE: 24

SECTION A – OCCUPATIONAL HISTORY SINCE LATEST DISCHARGE FROM MILITARY SERVICE OR LATEST VA EXAMINATION

9. NAME AND ADDRESS OF EMPLOYER *(If unemployed enter "None")*	10. TYPE OF WORK	11. MONTHLY WAGES	12. DATES OF EMPLOYMENT FROM	TO	13. TIME LOST IN PAST 12 MONTHS

14. REASON FOR TIME LOST *(If any)*

SECTION B – MEDICAL HISTORY SINCE LATEST VA EXAMINATION AS RELATED BY PERSON EXAMINED

15. NARRATIVE HISTORY *(Include manner and date of origin)*

I was stationed in Berlin Germany and was moving boxes upstairs when I felt a sharp pain and heard a snap in my lower back. This was in MAY 90 when it first occurred

24 yr. white male (+) Hx of allergic reaction → Hives, generalized/anaphylaxis went to local ER treated etiology UNKNOWN (−) Hx of New meds or foods.

NAME AND ADDRESS OF DOCTOR OR HOSPITAL	CONDITION TREATED	FROM	TO
16A. Dr Selquich Berlin Germany 21S Army Hospital	Slipped Disc L5/S1		
16B. US Army Hospital Berlin Germany	Slipped Disc L5/S1		
16C. Patterson Army Hospital	Slipped Disc L5/S1		

17. PRESENT COMPLAINT *(Symptoms only, not diagnosis)*

Constant pain in lower back, tingling in left leg, periodically trip over left foot. Cannot sleep due to irritation and pain.

FHx: M alive Emphysema 60½ Lung cancer; F alive Lung CA 60½ Copd

EtoH: 6 pack per week Beer / few mixed drinks weekends x 6 years

Smoke: None x 3 years. Prior 1½ ppd x 12 years

No Hx of allergy to meds. (+) JAN 1986 PSHx surgery → merged Fx of lower spine

Hobbies: NONE

(+) Chronic disease: IS Asthma

(−) Illicit Drug Abuse

I HEREBY CERTIFY that the entries under Occupational and Medical History are complete and correct to the best of my knowledge.

18. DATE SIGNED: 10/1/91

19. SIGNATURE OF PERSON EXAMINED *(Do not print)*: Randy C. Brogen

PENALTY - The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

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SECTION C – EXAMINATION (Examinee must be stripped)

INSTRUCTIONS TO THE EXAMINING PHYSICIAN: This report must be completely executed. Describe the results of a general examination of every system and body parts including but not restricted to the systems and body parts involved in the history and present complaints. Wherever indicated specialists' examinations, X-rays, laboratory examinations, ect., should be recommended. If additional space is needed, comments may be continued in Item 44 or on separate sheets attached to this form.

20. HEIGHT	21. WEIGHT	22. MAX. WT. PAST YEAR	23. BUILD AND STATE OF NUTRITION	24. TEMPERATURE
5'5"	147 1/2 LBS.	LBS.	WDWN White male	AT AM PM
25. CARRIAGE	**26. POSTURE**	**27. GAIT**	**28. RIGHT-OR LEFT-HANDED-HOW DETERMINED**	

29. SKIN-INCLUDING APPENDAGES *(Describe type, area, and extent of lesions. Report injuries, including burns, under Item 41)*

tattoo (L) upper Arm
(L) [illegible] 2° to injury [illegible]
pt below mandible 2cm [illegible]

30. LYMPHATIC AND HEMIC SYSTEMS *(Describe local or generalized adenopathy, enlargement, tenderness, suppuration, blocking of lymphatic circulation, etc.)*

(+) [illegible] 1cm x 1cm pt posterior auricular area (Present NOD [illegible])

31. HEAD, FACE, AND NECK

Normal head & face
Neck good [illegible] (−) JVD (−) carotid Bruit thyroid NL size

32. NOSE, SINUSES, MOUTH, AND THROAT *(Include gross dental findings)*

Nose: Normal
NL sinuses, [illegible] (−) lesions

33A. EARS *(Describe canals, drums, perforations, discharge)*

[illegible] clear (−) [illegible]

33B. HEARING LOSS NOTED

☐ YES
☒ NO

34A. EYES *(Describe external eye, pupil reaction, movements and field of vision)*

Pupils equal & [illegible] to [illegible], [illegible]
fundi: Normal
Visual fields [illegible]

34B. DISTANT VISION

R 20/ CORRECTED TO 20/

L 20/ CORRECTED TO 20/

35A. CARDIOVASCULAR SYSTEM *(Describe thrust, size, rhythm, sounds, and condition of peripheral vessels)*

Reg. rate & rhythm (−) S_3 (−) S_4
Good pulses all over

Anterior chest wall (+) tenderness on palpation in lower ribs slightly above (L) nipple

c/o 2wks of chest pain
(L) chest pleuritic pain ant.
aggr on cough & on deep breath
on & off. [illegible] & 10 minutes
Prior very [illegible]
[illegible] pleuritic chest pain
(−) PND (−) [illegible]
reduction in position

	35B. PULSE	35C. BLOOD PRESSURE	35D. RESPIRATION	35E. IF NOT EXERCISED, GIVE REASON
SITTING	100	S 120 D 80 pt	120/78 (Lt)	RR 16
RECUMBENT		S D		
STANDING		S D		
SITTING AFTER EXERCISE		S D		
2 MIN. AFTER EXERCISE		S D		

36A. VARICOSE VEINS *(Describe location, size, extent, ulcers, scars, and competency of deep circulation)*

[illegible] Varicose Veins
(−) edema
(−) ulcer

36B. ARE ELASTIC STOCKINGS NECESSARY?

36C. IS OPERATION RECOMMENDED?

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Attach Continuation Sheets, Specialists' Reports, Laboratory Reports, etc., in this space.

12/90 → hospitalized for pneumonia x 1 wk

37A. RESPIRATORY SYSTEM *(Describe cough, expectoration, mobility, palpation, percussion, and auscultation and specify area)*

/x 3 months

⊕ SOB on min exertion in wheelchair

⊕ fatigue

⊕ cough ⊕ sputum yellow-green + years, daily

⊖ ⊕

lungs: ~~se~~ ↓ BS greenlight clear to A + P

37B. SHAPE OF CHEST

Not Known

37C. EXPIRATION

INCHES

37D. INSPIRATION

INCHES

38. DIGESTIVE SYSTEM *(Describe findings on inspection and palpation, enlargements, masses, tenderness, rigidity, hemorrhoids (internal or external), fissures, stricture, prolapse, etc.)*

soft, flat, BS ~~se~~ NOT tender

⊖ masses ⊖ liver or spleen palpable

⊖ ⊖ ⊖ ⊖

39. HERNIA *(Describe type, location, size, whether complete, reducible, recurrent, retained by truss, and whether operable)*

⊖ Inguinal Hernia

penis + testicles NL

40. GENITO-URINARY SYSTEM *(Describe kidneys, bladder, prostate, seminal vesicles, testes, cord, penis, and appendages; evidence of past or present veneral disease; in females report pelvic exam., if indicated)*

penis: Prostate NL / Brown Stool ⊖ gross

Good urine flow ⊖ burn ⊖ hematuria

41. MUSCULO-SKELETAL SYSTEM

(A-DISEASES and INJURIES, include effect of gunshot wounds and other injuries on skin and underlying structures.

B-SCARS, describe location, measurements, depression, type of tissue loss, adherence, disfigurement, and tenderness.

C-FUNCTIONAL EFFECTS, describe location, swelling, astrophy, tenderness, degree of limitation of flexion and extension, angle of fixation, fracture disease, fibrous or bony residual, and specify mechanical aid used and benefit.

D-FEET, describe objective evidence of pain at rest and on manipulation, rigidity, spasm, circulatory disturbance, swelling, callus, strength, mobility of ankles, feet, toes, and limitation in degrees and indicate whether right or left, acquired or congenital.

E-BURNS, degree and area in square inches.)

See attached C + P exam dated 10-1-91 Dr Klug

on P.E.

Hands, wrists, Ankles, Knees { ⊖ swelling ⊖ ~~[illegible]~~ ⊖ deformity ⊖ ~~[illegible]~~ tenderness, good ROM

In service was working out A.R. Bum + jumped out of plane caused damage. Never reported it. Never got treatment for it.

Both Knees swollen in Am get worse with movement; neg/stiff in Am. Thus, I have to get ready.

Hands + wrists → stiff + swollen Am gets worse with activity. occ. Ankles also stiff + swollen

(L) Knee injury playing Foot Ball (Before service)

↳ ligament injury

Constant Neck pain

Received Ultrasonic Physical therapy/Exercises No help

42. ENDOCRINE SYSTEM *(Describe disease of thyroid, pituitary, adrenals, pancreas, gonads, etc.)*

None

~~Apparent~~

Usual wt 150.

↓ Appetite → eating 1 meal a day

too much pain to eat

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6½ minutes 4:30 pm → 10 pm
Comfortable place CAN'T get to sleep due to C - Pile N/A.

43. NERVOUS SYSTEM (A-NEUROLOGICAL, describe motor status, coordination, reflexes, sensory status, equilibrium, and give exact location. B- PSYCHIATRIC and PERSONALITY, describe behavior, comprehension, coherence of response, emotional reaction, orientation, memory, signs of tension and status as to social and industrial capacity.)

(+) Bad dreams

Neurology: History of constant pain in lower back after heavy lifting in May 1990. Patient was admitted to an army Hospital in Germany. CT Scan allegedly showed HNP L5-S1. Radiation down posterior aspect of left leg. No medical records available at present. Aggravated by bending and lifting.

44. REMARKS (Cite number of item continued in this space)

Alert, well oriented (X3) RH. Motor status: slight difficulty walking on toes and heel to toes. Unable to accomplish a deep knee bend due to pain. No weakness (5/5). Spasm of paravertebral muscles noted. Left sciatic notch tenderness. Reflexes were bilat. equal and active (2+) no pathol. reflexes. Coordination: finger to nose and heel to knee tests were wnl. Cranial nerves (NII-NXII) were wnl.

45A. LABORATORY TESTS, X-RAYS, BMR, EKG, ETC.	45B. DATE MADE	45C. URINALYSIS		
~~CBC, Smear, UA, Cult, EKG~~		SPECIFIC GRAVITY	ALBUMIN	SUGAR
~~PPD~~, ESR, RF		EKG + PFT - 10-1-91		L. 61
titer 1:20		MICROSCOPIC		
CBC: WNL · UA: WNL		Smear: WNL Sugar ++6 = 3.25		

45D. OTHER TESTS RECOMMENDED, ETC. NSR, 75, NLAFIS

CXR: NO ABNormality

46. DIAGNOSIS Neurology: Low back pain r/o HNP L5-S1 (+) RF 1:20
1. chronic Bronchitis
2. Costochondritis
3. Elevated Triglycerides
ORTHO - see attached H & P exam dated → 10/1/91

47A. IS EXAMINEE BEDRIDDEN?	47B. IS HOSPITALIZATION NEEDED?	47C. WILL EXAMINEE ACCEPT HOSPITALIZATION?

48A. IS EXAMINEE ABLE TO TRAVEL?	47B. ALONE?	48C. WITH ATTENDANT?

49. SPECIALISTS EXAMINATIONS RECOMMENDED

50. SIGNATURE OF PHYSICIAN C.T. Liem M.D.	NAME AND SPECIALTY (Type or print) Chris T. LIEM M.D.	DATE SIGNED OCT 30 1991
51. SIGNATURE OF PHYSICIAN Antoinette D. Costa	NAME AND SPECIALTY (Type or print) Antoinette Costa MD	DATE SIGNED 10-31-91
52. SIGNATURE OF PHYSICIAN A J Krug MD	NAME AND SPECIALTY (Type or print) A J KRUG MD ORTHO	DATE SIGNED 10/16/91
53. SIGNATURE OF REVIEWING OFFICER	NAME AND TITLE (Type or print)	DATE SIGNED

54. ATTACHMENTS MADE A PART OF THIS EXAMINATION (List by number or describe)

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EXHIBIT H

LEG PAIN DIAGNOSIS
(SICK CALL RECORD)
DATED JUNE 5, 1992

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
	Rt CPR x 10 days E/a
[redacted]	DENNIS J. DADIG CWO, Physician Assis 904-[illegible]-2859
04 AUG 1987	USARMC, FT GORDON, GA [illegible] TMC #2 [illegible] 8824
	MEDICATIONS & NKA
	S: 20 yo WM c/o sharp lower leg pain while marching x 1 day. Pt denies recent hx of trauma to area. S: Numbness, Tingling to area. S: hx of surgical procedure
	O: T-96° palpable tenderness to (L) leg - Tibia. ~ mild Edema. S: Erythema, Ecchymosis. (A) Discomfort c̄ flexion, extension of Knee
	A: R/o Begining Stress Reaction
	P: (1) Recommend (1) c̄ PT for evaluation
	Sp4 [illegible]
	9 [illegible]
	Examined & Agree
	Cama T Bogid
	No Running / marching x 10 days
	RICE/PRN
	DENNIS J. DADIG CWO, Physician Assistant

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EXHIBIT I

LEFT KNEE SURGERY REPORT
DATED AUGUST 23, 1996

Mount Auburn Hospital
330 Mount Auburn Street
Cambridge, MA 02238
(617)492-3500

OPERATIVE REPORT

SURGEON: ROBERT FOSTER, M.D.

PROCEDURE: Comprehensive arthroscopy, medial and lateral meniscectomy and removal of multiple loose bodies left knee.

ANESTHESIA: General.

PREOPERATIVE DIAGNOSIS: Torn medial and lateral menisci.

POSTOPERATIVE DIAGNOSIS: Torn medial and lateral menisci, osteoarthritis lateral tibial condyle and multiple loose bodies left knee.

PATHOLOGY: This is a 29-year-old white male who injured his knee in the military. He has had recurrent catching, giving way, swelling, pain ever since. MRI showed torn medial and lateral menisci. At surgery he had a torn posterior horn of the medial meniscus undersurface type, unstable and a middle third tear of the lateral meniscus and chondromalacia of the lateral tibial condyle and multiple loose bodies which appeared to be fragments of lateral meniscus rather than chondral surface. He had a normal patella, only grade I chondromalacia of the medial femoral condyle. No chondromalacia of the lateral femoral condyle. Intact anterior cruciate ligament. We were able to saucerize the middle third of the lateral meniscus and left him with a stable rim, intact anterior horn and posterior horn. We were able to remove the posterior third of the medial meniscus until a stable rim achieved, the anterior two-thirds stable. We removed all the multiple loose bodies and shaved the lateral tibial condyle. At conclusion of the procedure he had a knee that was free of debris.

PROCEDURE: After adequate general anesthesia had been accomplished, the patient was positioned in the supine position on the operating table. The left knee was prepped with alcohol and Betadine solution and draped appropriately for a left knee operation. We used the tourniquet for 43 minutes and a leg holder and the Dyonics pump. When the above pathology was noted, we went ahead and removed the posterior horn of the medial meniscus with multiple instruments, Acufex basket and the razor cutter, the turbo whisker and then we did the same to the middle third of the lateral meniscus. We removed all the loose bodies, fragments of lateral meniscus. Then the knee was irrigated again copiously with antibiotic solution and Marcaine, 30 cc 0.25% was instilled in the knee. The patient was then awoke, placed in a Robert Jones

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Mount Auburn Hospital
330 Mount Auburn Street
Cambridge, MA 02238
(617)492-3500

OPERATIVE REPORT

CONTINUATION...

compression dressing and returned to the recovery room in good condition. There were no complications.

ROBERT FOSTER, M.D.

RF/17
SecrePhone
DD: 08/23/96
DT: 08/23/96
#1137

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EXHIBIT J

SURGERY/PROCEDURE SHORT FORM (LEFT KNEE)

DATED AUGUST 19, 1996

Alina [redacted] Gastly form

6J-31-1J TRANS
BROGEN,RANDY
Randy Brogen 03 03/08/67
FOSTER M.D., ROBERT
11399268

MOUNT AUBURN HOSPITAL

330 MOUNT AUBURN STREET
CAMBRIDGE, MASSACHUSETTS 02238

08/23/96

SURGERY/PROCEDURE SHORT FORM
HISTORY & PHYSICAL

STAMP PATIENT PLATE HERE

HISTORY: 29y/o computer programmer w/ (L) knee is hx playing FB. NOT seen. Parapatellar but no knee injury. Did have MVP in Lorain

PAST MEDICAL HISTORY: Op — Jaw Op (Fx)

MEDICATIONS: 0 — SH & cigs, snuff, EOA — Ben

PHYSICAL EXAMINATION

T ____ BP 122/72 P 60 R 16 HT ____ WT ____

EENT: clear

Chest: clear

Breast: ✓

Heart: RSR, 60

Abdomen: ✓

Rectal/Pelvis: ✓

Extremities: LJL. Tendium (L) Knee

Neurological: 2+ DP

Surgical Lesion: ____

REVIEW OF SYSTEMS

FH — Pt hung ✓ + CAD

CR — 0

GI — 0

GU —

ALLERGIES ASA → Dyspepsia, NKA, Cactus Dilaudid

MRI Torn Med Lat Meniscus & CAD LFC & MFC

3+ DP

IMPRESSION: Torn Med & Lat Meniscus (L) Knee ? Chondromalacia MFC LCK

Signature: [signature] Date: 8/19/96

Co-Signature by Attending Surgeon: " Date: "

(IF H & PE performed by another provider)

PRE-OPERATIVE NOTE AND PLAN BY SURGEON:

Arthroscopic Surg (L) Knee

Signature by Attending Surgeon: [signature] Date: 8/19/96

Form 1023-MR Rev. 7/91 MAH File 1550 (Available General Stores)

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EXHIBIT K

C&P EXAM REPORT
DATED SEPTEMBER 8, 1999

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Date: OCT 1,1999 Compensation and Pension Exam Report Page: 1

BOSTON VAMC

** FINAL **

Processing time: 45

For BRAIN AND SPINAL CORD Exam

==========

Name: BROGEN,RANDY

[redacted]

DOB: MAR 8,1967

Address: 9 WARD STREET

City,State,Zip+4: Res Phone: (781)229-6865

BURLINGTON MASSACHUSETTS 01803 Bus Phone:

Entered active service: JUN 16,1987 Last rating exam date: DEC 27,1993

Released active service: JUL 3,1991

Priority of exam: Increase

==========

Examining provider: Molloy

Examined on: SEP 8,1999

==========

Examination results:

See Joints

This exam has been reviewed and approved by the examining provider.

VA Form 2507

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Date: OCT 1,1999 Compensation and Pension Exam Report Page: 1
BOSTON VAMC
** FINAL **
Processing time: 45
For JOINTS (SHOULDER/ELBOW/WRIST/HIP/KNEE/ANKLE) Exam

==========

Name: BROGEN,RANDY

[redacted]
DOB: MAR 8,1967

Address: 9 WARD STREET

City,State,Zip+4:
BURLINGTON MASSACHUSETTS 01803

Res Phone: (781)229-6865
Bus Phone:

Entered active service: JUN 16,1987
Released active service: JUL 3,1991

Last rating exam date: DEC 27,1993

Priority of exam: Increase

==========

Examining provider: MOLLOY
Examined on: SEP 8,1999

==========

Examination results:

EXAM DATE: 09/08/99

This 32-year-old white male served in the United States Army between 1987 and 1991. He apparently is service connected for a low back problem and he did have an examination for a compensation and pension evaluation in New Jersey in 1993. The history is that he injured his low back in 1991 in Berlin while lifting some heavy boxes. He felt a "pop" and was unable to straighten up, he was placed on bedrest for five to six days, he eventually claims that he had an MRI while in the military which showed a herniated disk, but he declined surgery at that time .
He was discharged shortly afterwards. He has continued to have difficulty with his back ever since, and he had a second MRI on 05/07/97 which apparently showed some foraminal narrowing at L5-S1 on the left, but it did not show a herniated disk. The MRI report is not included in the file, although reference to it is made by Dr. Bowens, which is dated April 30, 1997.

His continued symptoms for his back are more or less constant ache, pain in the lower back which is across the back, it goes into his legs with any strenuous activity, the right more than the left, it is aggravated by sitting for long periods of time, standing for long periods of time, or walking long distances, and he finds it very difficult to bend or lift anything which weighs more than a few pounds. He also experiences a tingling in both toes. He is not currently taking any medication for his back or for any of the other complaints.

He states that over the past six months he has noted recurrent stiffness in his neck and a pop when he turns his neck. The pain is located between the shoulder blades, these episodes occur at least once per month and last for two to three days. He was told that he had a muscle strain and was treated with Motrin. He states that he did miss a few days from work because of this while he was in the military. Although it really has not become problematic until the last six months. When asked how he relates this to his back, he states that he thinks it

Continued on next page
VA Form 2507

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Exam Results Continued

is due to the positions he gets in when his back is bothering him. He has to turn his neck in an awkward angle.

He injured both knees while in the military. He injured the left knee in a parachute jump in 1989, after which it swelled and states suddenly popped out of place. He was not able to move the knee for some time after that.

He injured his right knee in 1990 when he twisted it, he was seen at sick call and he was told that he had a "sprain." He continued to have difficulty after his discharge from the military and eventually he underwent an arthroscopy to both knees, the left knee on 08/23/96, at which time medial and lateral meniscectomies were carried out, as well as removal of multiple loose bodies. Osteoarthritis of the lateral femoral condyle was found at the time of arthroscopy.

The second arthroscopy on his right knee was done on 02/07/97, at which time a lateral meniscectomy was done and there was a cyst on the lateral meniscus.

He has continued to have difficulty with both knees, they give out on him at times, particularly going down stairs, he does have pain in both knees.

PHYSICAL EXAMINATION: He is 5 feet 5 inches tall, 155 pound, 32-year-old white male.

Examination of his neck reveals decreased range of motion of approximately 20% in all directions with pain at the extremes of all motions. He states that he is having a "spasm" today and that this is one of the days when he does experience a great deal of difficulty with his neck. He does grimace at the extreme of all motions of the neck.

Examination of his back reveals some tenderness across the pelvis posteriorly, but no sciatic notch tenderness, no tenderness in the lumbar spine. Flexion is restricted to 60 degrees, right and left lateral bending are restricted to 10 degrees each, there is abnormal muscular spasm associated with these limitations of motion, as well as pain. On lateral bending of his lumbar spine he complains of pain in the neck.

Examination of the knees reveals a well-healed arthroscopy wound, the range of motion is full in both knees, McMurray's test is negative, however, motion on th e
left knee is accompanied by crepitus and a moderate amount of cracking and snapping.

X-rays of the cervical spine, lumbosacral spine, and both knees are ordered.

DIAGNOSES:
1. Cervical arthrosis.
2. Chronic lumbosacral syndrome with probable degenerative disk disease.

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Name: BROGEN,RANDY [redacted]
For JOINTS (SHOULDER/ELBOW/WRIST/HIP/KNEE/ANKLE) Exam
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Exam Results Continued

3. Status postop meniscectomies of both knees with osteoarthritis of the left knee.

John Molloy, M.D.

JM:ESA:amr
d/d: 09/08/99
d/t: 09/08/99
J5649

This exam has been reviewed and approved by the examining provider.

VA Form 2507

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