REHAB ORTHOPEDIC MEDICINE
1452 Church Street Decatur, Georgia 30030
(404) 378-8002 (404) 378-6226
Ralph D'Auria, M.D.

PatientID:
Patient Name:
Date of Birth:

Date of Service:

COMPREHENSIVE EXAMINATION

REASON FOR VISIT: patient seen in this office today for a nexus evaluation. I have been asked to write a statement in support of his claim. I have personally reviewed his medical history and have noted the circumstances and events of his military service. I performed a full orthopedic and neurologic examination of the results of which are below, and have provided my opinion regarding causation (nexus statement) and rationale at the end of this report.

CHIEF COMPLAINT: The patient presents with complaints of right shoulder pain, right wrist pain, bilateral hip pain, and bilateral knee pain.

INITIATING EVENT: The patient states he sustained injuries to his right shoulder, right wrist, and right knee while serving in the U.S. Army from July 27, 1976 to July 21, 1977. He states he developed right shoulder and right wrist pain while stationed in Germany in 1977, after repetitively unloading boxes of metal reels from a truck. He states his right knee was also injured while he was stationed in Germany. He states he was practicing take downs and his legs got crossed, causing him to fall, landing on his right knee on concrete. He states his left knee pain began in 2007 due to overcompensation for his longstanding right knee problems. He states his bilateral hip pain began due to altered gait and limping due to the knee problems.

HISTORY OF TREATMENT: On February 22, 1977, the patient was seen at Edwards Dispensary 45th Med Bn due to complaints of right shoulder and wrist pain after lifting heavy equipment. He was evaluated and x-rays of the shoulder were ordered. He was given a prescription for Tylenol. He returned on February 24, 1977, at which time it was noted that the x-ray report was not yet ready. He was given a prescription for Indocin and was placed on profile with no heavy lifting over 15 pounds for two days. The patient followed up again on March 02, 1977, complaining of continued right anterior shoulder pain. It was noted that his x-rays were normal by report. Physical examination revealed full range of motion in the shoulder and no tenderness. He was diagnosed with a muscular strain and was instructed to apply heat to the shoulder. He was also placed on profile with no heavy lifting and no overhead work through March 08, 1977. He returned on March 07, 1977 due to continued right shoulder pain. He was given a prescription for Robaxin and was placed on limited duty with no heavy lifting over 20 pounds. He was next seen on March 14, 1977, complaining of continued right shoulder pain. Examination of the shoulder revealed tenderness over the bicipital tendon, therefore he was diagnosed with bicipital tendinitis. He was placed in a sling for one week and was given a prescription for Indocin, with follow up in one week. He was seen again on March 22, 1977, at which time he was placed on profile with no overhead work, no physical training involving the arms, and no heavy lifting over 15 pounds for 30 days.

On March 21, 1977, the patient was seen at 97th General Hospital emergency room due to right knee pain after bumping his right knee on concrete. X-rays were taken of the knee, which were negative. He was diagnosed with an anterior knee contusion, and was advised to use an Ace bandage and ice. On March 23, 1977, he was seen at Edwards Dispensary 45th Med Bn 97 regarding his right knee pain after falling onto his right knee on concrete. X-rays were taken of the knee, which were negative. He was diagnosed with a moderate knee contusion, and was

advised to use an Ace bandage, ice, and crutches for three days.

The patient states after being discharged from the Armv in 1977, he had no treatment until 1992. On October 21, 1992, he was seen by] at ' regarding lumbar spine and left hip complaints. impression was that of fibromyalgia or fibrositis and minimal osteoarthritis in the thoracic and lumbar spine and left hip. He was started on Elavil 10 mg and Voltaren 75 mg and was instructed to follow up in six weeks. The patient continued to follow up with every 4 months. During subsequent visits, he complained of hip, shoulder, and knee pain. In 1996, he was placed on work restrictions. X-rays of the knee were taken on January 06, 2000, which were negative for fracture or dislocation. On April 13, 2000, he was diagnosed with osteoarthritis of the hips and fibromyalgia syndrome. He was given prescriptions for Vioxx, Flexeril, and Darvocet.

On March 03, 2002, the patient was seen by Orthopaedic complaining of a several month history of right knee pain with popping and swelling about the knee. Her reported multiple episodes of popping, especially with squatting or twisting the knee. He stated that once he experienced a loud pop, the knee would be swollen for several weeks. Examination of the knee revealed medial and lateral joint line tenderness, negative McMurray's sign, minimal effusion, ROM 0-120 degrees, good stability to varus stress, and pain at the extremes of flexion or with attempting a deep squat. X-rays were taken of the right knee, which showed very minimal degenerative changes in the lateral tibial plateau. The patient was diagnosed with a meniscal injury of the right knee. Treatment options were discussed, including continued conservative treatment with anti-inflammatories and physical therapy vs right knee arthroscopy. Since the patient was getting ready to potentially move to another job in Chicago, and was concerned about his persistent symptoms, he chose to proceed with arthroscopy.

Surgery was performed by on March 11, 2002, consisting of arthroscopy with partial lateral meniscectomy and debridement chondromalacia. Post-operative diagnoses were large split bucket handle tear of the lateral meniscus, as well as grade 2 to 3 chondromalacia of the lateral femoral condyle and lateral tibial plateau. The patient followed up with on March 14, 2002 for recheck, 4 days status post surgery. At that time, he complained of lateral popping in the contralateral knee. Examination of the right knee revealed a well-healing incision and ROM 10-90 degrees. Examination of the left knee revealed mild crepitus on ROM and mild joint line tenderness laterally. The patient was fitted for a Neoprene knee sleeve for the left knee, and was instructed to continue his range of motion exercises. He returned on March 22, 2002 for suture removal. Physical examination on that date showed ROM 0-100 degrees, with a soft and nontender calf. He was instructed to transition off crutches to weight bearing as tolerated and continue his home exercise program, with follow up in one month for recheck. The patient also continued to follow up with his rheumatologist.

He returned to Orthopaedic on February 19, 2004, reporting that he had fallen one week earlier, landing on his right knee and right elbow. Examination of the right knee revealed full ROM with minimal effusion, no joint line tenderness, and no ligamentous instability. X-rays were taken of the right knee, which showed some mild lateral joint space narrowing, but no acute findings. The patient was advised to continue his

conservative care, with quadriceps strengthening program, and follow up as needed. He was seen again on December 01, 2004, reporting that his right knee pain had progressively increased after the fall in February 2004, however it had significantly worsened over the past month. Physical examination revealed soreness at the medial and lateral joint lines, but no effusion. Range of motion was full, and the calf was soft and nontender. Due to the new trauma, an MRI scan of the right knee was ordered, which was performed on December 03, 2004. The scan showed soft tissue thickening of the lateral collateral ligament complex suggestive of an old injury, allowing lateral displacement of the lateral meniscus; scattered internal signal of the lateral meniscus suggestive of degenerative changes; a spur in the lateral compartment with joint space narrowing; and areas of cartilage thinning in the articular surface of the lateral femoral condyle, as well as cartilage thinning along the medial articular facet of the patella.

The patient followed up at Orthopaedic on February 19, 2008 due to complaints of left elbow and bilateral knee pain. He reported that he had to do a lot of walking up steps in his job, as there was no elevator, and continued to have intermittent discomfort in both knees. It was noted that he had had progressive discomfort with swelling in the right knee and difficulty going up and down stairs because of the left knee. Examination of both lower extremities revealed 2+ effusion of the right knee, diffuse tenderness about the knee that was worse on the inferior aspect of the patella, no significant McMurray's, ligamentous stability, and preserved sensation to light touch in all dermatomes. X-rays were taken of the right knee, which showed moderate tricompartmental degenerative changes. X-rays of the left knee were essentially normal. The impression was that of bilateral knee internal derangement. He was given an injection to the right knee, and an MRI scan of the left knee was ordered for further evaluation. The MRI of the left knee was performed on February 21, 2008. The scan showed no definite abnormality.

On March 03, 2008, the patient was seen by at Orthopaedic complaining of continued significant pain about both knees. It was noted that he had a long history of right knee problems that were treated arthroscopically by and that arthroscopic debridement of the meniscus was done and he was found to have significant arthrosis at that time. Physical examination of both knees revealed mild diffuse tenderness, boggy effusions, no gross ligamentous instability, and preserved sensation to light touch in all dermatomes. The impression was that of bilateral knee internal derangement. It was noted that in his current job he had to walk up and down a fair amount of stairs and that seemed to aggravate his pain. He felt like the previous degenerative change in the knees had been aggravated by the significant climbing of stairs that he was doing. He also seemed to be straining the left knee because he had been favoring the right. opined that the patient would benefit from arthroscopic debridement of the right knee as he continued to feel significantly unstable in that knee. Surgery was performed by on May 14, 2008, consisting of right lateral partial meniscectomy and medial femoral chondroplasty second compartment.

The patient followed up with on May 29, 2008, reporting that he had much less discomfort that he had from his previous surgery, however he did not feel that he could return to work at that time since he would have to climb steps. Examination of the knee revealed full ROM with mild tenderness. He was kept off work until June 09, 2008, at which time he would be returned to full duty work with limited stair climbing. The patient was seen

again on July 03, 2008, reporting that his right knee was doing much better, however he complained of intermittent discomfort of the left knee with clicking and popping on flexion. Examination of the right knee revealed minimal tenderness over the medial joint line, good ROM, and no swelling. Examination of the left knee revealed mild crepitation on ROM, most specifically at the patellofemoral joint, but no deficits in sensation and no instability. The impression was that of bilateral knee internal derangement. The patient was returned to full duty work, but was advised to limit his stair climbing. He was also given an Orthovisc injection to the right knee, which was repeated on July 15, 2008 and July 31, 2008. X-rays of the right knee performed on July 31, 2008 showed degenerative changes, as had been documented arthroscopically. The patient was given a hinged knee brace, and it was noted that the type of work he was doing, with repetitive stair climbing, was going to aggravate his arthritic knee no matter how it was treated.

On September 04, 2008, at Orthopaedic issued a letter stating that the patient had underlying arthritis in both knees, as well as lumbar degenerative disk disease, and that these problems were chronic and could progress over time. He opined that his back, hip, and knee pain were most likely aggravated by limping due to his knees. It was noted that, at present, the right knee was more problematic that the left knee, and that his knee condition significantly limited his ability to kneel, squat, and climb, particularly stairs. also opined that the repetitive stair climbing was likely to continue aggravating his knee condition, including progression, and that all of these factors together made it difficult for him to work and were most likely disabling long term. He noted that knee replacement would be an option, but that would not likely guarantee his ability to ambulate up stairs. He again stated that he felt the previous degenerative changes in the knees had been aggravated by the significant climbing of stairs on his job, and that he also seemed to be straining the left knee due to the fact he had to favor the right knee.

On October 21, 2008, issued a statement indicating that the patient was totally and permanently disabled form any employment due to fibromyalgia and osteoarthritis of the hands, knees, thoracic spine, and lumbar spine, as well as a herniated disk in the cervical spine.

On December 30, 2008, the patient was seen by orthopedic surgeon MD for evaluation of his multiple problems relating to fibromyalgia and arthritis, including neck pain, back pain, hip pain, elbow pain, and bilateral knee pain. It was noted that he had had an automobile accident in 1980 and a work injury in 2001. Concerning his knees, he had arthritis in the right knee and had had two arthroscopic surgeries, in 2002 and 2008, however he continued to have pain, swelling, and giving out of that knee. He has wearing a knee brace all the time for stability, and also used a walking stick. He was taking Percocet, Roxicodone, Nexium, and Zanaflex. It was noted that the patient had worked as a computer repair person at Talladega College, but had to stop in July 2008 because the job involved walking up and down a significant amount of stairs and he was unable to do this. The patient was examined and was diagnosed with diffuse osteoarthritis involving the hips and knees, as well as status post two arthroscopic surgeries on the right knee. opined that the patient would have significant limitations in walking, lifting, standing, and travel limitations.

A bone scan was performed on January 30, 2009 at Medical Center, at the request of . The

scan showed degenerative change about the knees, ankles, wrists, and shoulder girdles, as well as a small focus of mild asymmetric uptake about the superior right acetabular region most likely degenerative in etiology.

A letter dated from dated October 28, 2010 states that the patient was dealing with degenerative joint disease of both knees, which had become progressively worse both by x-rays and symptomatically. He also noted that the repetitive stair climbing he did on a daily basis from December 2007 until September 2008 aggravated his problem and reduced his capacity to work, and that the repetitive loading of the knee in this fashion had accelerated the symptoms of his degenerative joint disease. Another letter from dated January 29, 2009 indicates that the patient's advanced arthritis of both knees would become progressively worse and would eventually warrant knee replacement. He also opined that, even with a good result from knee replacement, he would have significant limitations as far as ability to ambulate for long periods of time and climb.

An office note from dated January 11, 2013 indicates that the patient's left knee was doing worse and the pain was keeping him up at night. It was noted that he was very tender along the medial joint line, medial tibial plateau, and medial femur, and the knee and calf were swollen. He had full extension and 120 degrees of flexion. He walked with a limp. An MRI of the left knee was ordered to evaluate for meniscus tear or bony injury not apparent on plain x-rays, since he was not progressing.

On October 13, 2015, the patient was seen by to inquire about viscosupplementation for the right knee, mainly Orthovisc injections. Examination of the knee revealed valgus alignment, no effusion, patellofemoral crepitus, and lateral compartment crepitus. The patient stated non-steroidals were not really working anymore. He did not want to do a total knee until at least a year away. He was considered to be an excellent candidate for Monovisc injections.

The patient was seen by again on September 26, 2016, complaining of the right knee giving way. On physical examination, the right knee was in valgus; there was crepitus of the patellofemoral compartment, medial compartment, and lateral compartment; and range of motion was 5 degrees to 110 degrees. Examination of the left knee revealed small effusion, varus alignment, and crepitus of the medial compartment and patellofemoral compartment. Standing x-rays of the right knee were taken, which revealed advanced osteoarthritis with valgus deformity. X-rays of the left knee standing showed moderate medial compartment arthritis and varus deformity. It was noted that the patient had failed all modalities for the right knee, including viscosupplementation, and was actually considering knee replacement at that time. He was given an injection to the right knee using Marcaine and Kenalog.

An office note from dated December 18, 2017 indicates that the patient presented with complaints of bilateral knee pain and bilateral shoulder pain, right worse than left in both. It was noted that the right knee was waking him up at nights; it was getting harder and harder to ambulate; injections weren't helping anymore; and he was again considering knee replacement. Examination of the right shoulder revealed tenderness over the cuff, pain with supraspinatus testing, and abduction and flexion of 180 degrees with pain. The left shoulder had

full range of motion, 5/5 cuff muscle strength, positive impingement sign, and negative Hawkins sign. Examination of the right knee revealed valgus deformity, flexion 110 degrees, moderate effusion, diffuse crepitus, and tenderness along the joint line. Examination of the left knee revealed 5 to 100 degrees range of motion, tenderness medially, and medial compartment and patellofemoral crepitus. Standing x-rays of the right knee revealed advanced tricompartmental arthritis with valgus deformity. Standing x-rays of the left knee revealed varus deformity with advanced tricompartmental arthritis. X-rays of the right shoulder revealed a type II acromion and glenohumeral joints well preserved. impression was that of bilateral shoulder impingement and bilateral knee osteoarthritis. Since the pain in the right knee had become intractable and he had failed all other modalities, total knee replacement was again recommended. For the right shoulder, he was given a subacromial injection using Marcaine and Kenalog. It was noted that some military records from 1977 had been reviewed, which had indicated a shoulder problem similar to what he is having at that time, and that the problem could be chronic and recurrent, or related to old injury.

An MRI scan of the right shoulder was performed no January 02, 2018 at the request of . The scan showed mild tendinopathy of the supraspinatus tendon without full thickness tear, as well as hypertrophic changes in the acromioclavicular joint. The patient followed up with on January 30, 2018 to review the MRI results, which were noted to be compatible with impingement. The patient reported that his shoulder was feeling better since the injection, however his knees weren't any better. He had been considering knee replacement later that year, but had some other medical issues going on that needed to be seen about before considering the surgery. Since his shoulder felt better after the injection, the recommendation was observation and cuff exercises. It was again noted that he had multiple orthopedic problems going back several years, even related to some of his military service and injuries while he was participating in that. He followed up on July 10, 2018, and was given an intraarticular injection into the right knee using Marcaine and Kenalog.

The patient returned to on December 19, 2018 for his right shoulder and bilateral knee pain. He reported that his right shoulder was hurting again and was waking him up at night, but he did not want to pursue anything surgical. He was given intraarticular injections in both knees using Marcaine and Kenalog, as well as a subacromial injection into the right shoulder using Marcaine and Kenalog.

An office note from dated October 29, 2019 indicates that the patient presented with complaints of bilateral knee and hip pain. X-rays were taken of the pelvis, which showed that the hip joints were well preserved, however there was sacroiliac arthritis. The impression was that of bilateral knee osteoarthritis and bilateral sacroiliitis. Intraarticular injections were given in both knees using Marcaine and Kenalog. The patient was seen again on July 09, 2020, at which time he was given a subacromial injection in the right shoulder and intraarticular injections in both knees.

A new MRI scan of the right shoulder was performed on December 10, 2020. The scan showed mild abnormal signal in the distal infraspinatus/supraspinatus tendons suggestive of tendinosis and/or partial-thickness tear with no definite full-thickness rotator cuff tear, as well as mild to moderate AC joint arthropathy. The patient continued to follow up with in 2021 for injections to the right shoulder and both knees.

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During a follow up visit on January 12, 2022, the patient reported that the pain in his right shoulder and both hips was waking him up at night. Examination the right shoulder revealed tenderness over the cuff, positive impingement sign, positive Hawkins sign, abduction and flexion of 160 degrees with pain, no weakness on abduction, subacromial crepitance, and no tenderness over the AC joint. Both hips were found to be tender over the trochanters, and there was pain on rotation and abduction of both hips. The impression was that of right shoulder impingement syndrome, bilateral hip trochanteric bursitis, and right knee osteoarthritis. For the right knee, total knee replacement was again recommended. The patient was given injections to the right shoulder and bilateral hip trochanters using Marcaine and Kenalog.

performed right total knee replacement surgery on March 14, 2022. Post-operative x-rays showed prosthesis in satisfactory alignment and positioning. A follow up office note dated April 04, 2022 indicates that the patient was getting around fairly well with a walker, and had only mild to moderate swelling. Physical therapy was ordered. An office note dated May 31, 2022 indicates that the right knee had full extension and 120 degrees flexion, with mild swelling ant no instability. Examination of the right shoulder revealed tenderness over the greater tuberosity in the cuff insertion, positive impingement sign, and positive Hawkins sign. A subacromial injection was given to the right shoulder, and the patient was encouraged to continue his daily walking program.

The patient was seen again on July 05, 2022, 3 months after surgery, reporting knee pain only at night, with no pain on walking. During an office visit on August 01, 2022, he reported that he was having some shoulder pain that was waking him up at night, and that he had been benefitting from physical therapy, but it had been stopped because the VA would not approve anymore. Another month to 6 weeks of physical therapy was strongly recommended for the right knee. For the right shoulder, he was given a subacromial injection using Marcaine and Kenalog.

The patient followed up regarding his right knee on September 07, 2022. Physical examination revealed full active extension and 90 degrees of flexion. It was noted that he had a little difficulty getting out of a chair because of this, however his overall result was considered to be reasonably good, and he had good pain relief. opined that his limited range of motion was probably permanent, in that a lot of it had to do with the pre-existing state of the knee before replacement.

The patient states he continues to follow up with every 3 months regarding both knees, both hips, and the right shoulder. He states he is also currently on pain management with Alabama Anesthesiology and Pain, where he follows up once a month. He states he has had no recent MRI scans.

SUBJECTIVE COMPLAINTS:

SHOULDER: The pain is localized to the lateral aspect of the right shoulder. The duration is constant. The quality is described as dull and achy. The pain radiates into the right upper arm. Numerical pain scale is subjectively graded 4 to 8 out of 10. The pain is aggravated by reaching overhead and reaching to the back. Associated symptoms include stiffness in the mornings. The patient denies any weakness, locking or popping.

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HAND & WRIST: The pain is localized to the palmar and dorsal aspects of the right wrist, with pain in the knuckles of the hand. The duration is intermittent. The quality is described as achy and burning. Numerical pain scale is subjectively graded 3 to 9 out of 10. The pain is aggravated by repetitive movements. Associated symptoms include stiffness of the fingers.

HIPS: The pain is localized to both anterior hips, left worse than right. The duration is intermittent in both. The quality is described as sharp and stabbing on the left, and dull on the right, depending on how much walking he does. Numerical pain scale is subjectively graded 5 to 6 out of 10 on the left, and 4 to 5 out of 10 on the right. The pain is aggravated by using stairs. Associated symptoms include stiffness of both hips, especially in the morning.

RIGHT KNEE: The pain is localized to the medial and lateral aspects of the right knee. The duration is constant in the medial aspect, and intermittent in the lateral aspect. The quality is described as burning in the medial aspect, and sharp in the lateral aspect. The pain radiates into the lateral aspect of the right thigh. Numerical pain scale is subjectively graded 5 to 6 out of 10. The pain is aggravated by prolonged walking. Associated symptoms include mild swelling in the medial aspect, popping, and "giving way" while walking.

LEFT KNEE: The pain is localized to the medial aspect of the left knee. The duration is constant. The quality is described as sharp and achy, and stabbing with walking. Numerical pain scale is subjectively graded 6 to 7 out of 10. The pain is aggravated by prolonged walking, squatting, and using stairs. There are no other associated symptoms.

HISTORY OF SIMILAR COMPLAINTS: The patient reports a previous history of right wrist pain due to a wrist fracture years ago before entering the Army. The fracture was treated with a splint, and he had no residual symptoms.

PAST MEDICAL HISTORY:

MEDICAL: Arthritis, depression, insulin dependent diabetes, hypertension, gastroesophageal reflux, prostatitis, history of skin cancer.

SURGICAL: Cervical diskectomy and fusion, right knee replacement, right knee arthroscopy x 2, removal of melanoma from face, treatment of urinary tract stricture.

PRESENT MEDICATIONS: Norco 10-2-325mg, Metformin ER 500mg, Lisinopril 5mg, Glimepiride 4mg, Alfuzosin HLC ER 10mg, Esomeprazole 40mg, HCTZ, Farxiga 10mg, Basaglar, inject 26-36 units, Novolog 22 units, Bydureon Bcise 2mg, Montelukast 10mg, Levocetirizine 5mg, Viagra 100mg, Azelastine HLC nasal spray, Diclofenac 50mg, Terazosin 2mg.

ALLERGIES: Avalox, sulfa, Omnicef, Trulicity.

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SOCIAL HISTORY:

MARITAL STATUS: Married, living with spouse.
WORK HISTORY: The patient is not currently working. He worked as a computer programmer & technician with College 2005 to October 2008; as a truck driver/warehouse worker 2004 to 2005; as an IT technician 1999 to 2004, and construction worker 1984 to 1986.
TOBACCO USE: Has no smoking history.
ALCOHOL: Does not give any significant history of alcohol usage.
SLEEP DEFICITS: The patient reports awakening during the night due to pain, losing up to 3 hours of sleep per night as a result.

REVIEW OF SYSTEMS:

GENERAL: No major weight gain, loss or fever.
EYES: No loss or change in vision.
EARS/NOSE/MOUTH/ THROAT: No hearing changes, hoarseness, or swallowing difficulties.
RESPIRATORY: No shortness of breath, cough, hemoptysis, or wheezing.
CARDIAC:No chest pain, palpitations, tachyarrhythmias, or edema.
GI: No abdominal pain or change in bowel habits.
GU: No urinary problems noted.
MUSCULOSKELETAL: See SUBJECTIVE COMPLAINTS.
NEUROLOGICAL: No recent focal neurologic symptoms or headaches.
SKIN: No rashes, sores, blisters, growths, changing moles, discolorations or non-healing lesions.
PSYCHIATRIC: No recent change in mood or behavior.
ENDOCRINE: No heat or cold intolerance, change in hair distribution, excessive thirst, hunger, or urination, change in energy level, or significant weight gain or loss.
HEMATOLOGIC/LYMPHATIC: No abnormal bruising or bleeding. No swollen or painful lymph nodes.
ALLERGIC/IMMUNOLOGIC: No latex allergies or recurrent infections.

FUNCTIONAL LIMITATIONS: Reported activity restrictions include using stairs, prolonged standing, stooping, prolonged walking, squatting, prolonged sitting, reaching overhead, reaching away from the body, pushing, pulling, lifting, kneeling, climbing, yard work, and repetitive movements.

HAND DOMINANCE: The patient is right hand dominant.

ORTHOPEDIC/NEUROLOGICAL EXAMINATION:

HEIGHT: 5ft9in
WEIGHT: 228lbs

NEUROLOGICAL/SENSORY EXAMINATION:

UPPER EXTREMITIES:

C4 Dermatome: Within normal limits.

C5 Dermatome: Within normal limits.
C6 Dermatome: Within normal limits.
C7 Dermatome: Within normal limits.
C8 Dermatome: Within normal limits.
T1 Dermatome: Within normal limits.
T2 Dermatome: Within normal limits.

LOWER EXTREMITIES

L2 Dermatome: Within normal limits.
L3 Dermatome: Within normal limits.
L4 Dermatome: Within normal limits.
L5 Dermatome: Within normal limits.
S1 Dermatome: Within normal limits.

MUSCLE STRETCH REFLEXES:

UPPER EXTREMITIES:

RIGHT C5: 2.
LEFT C5: 2.
RIGHT C6: 2.
LEFT C6: 2.
RIGHT C7: 2.
LEFT C7: 2.

LOWER EXTREMITIES

RIGHT L4: 0.
LEFT L4: 2.
RIGHT S1: 0.
LEFT S1: 0.

GAIT EXAMINATION:

SIT TO STAND: Positive for bilateral knee pain.
TRUNK ANTALGIA: Absent.
WEIGHT BEARING: Mostly on the right side, due instability on the left side.
TOE GAIT: Positive on the right for weakness. Positive on the left for pain.
HEEL GAIT: Within normal limits.
STANDARD GAIT: On standard gait, the patient walks with a limp, avoiding weight bearing on the left lower extremity due to left knee pain.

SHOULDER RANGE OF MOTION:

RIGHT ABDUCTION: Limited to 100 degrees, with pain.
LEFT ABDUCTION: Limited to 100 degrees, with pain.
RIGHT ADDUCTION: Full at 50 degrees, with pain.

LEFT ADDUCTION: Full at 50 degrees, negative for pain.
RIGHT FLEXION: Limited to 160 degrees, with pain.
LEFT FLEXION: Limited to 170 degrees, with pain.
RIGHT EXTENSION: Full at 50 degrees, negative for pain.
LEFT EXTENSION: Full at 50 degrees, negative for pain.
RIGHT INTERNAL ROTATION: Limited to 60 degrees, with pain.
LEFT INTERNAL ROTATION: Full at 90 degrees, negative for pain.
RIGHT EXTERNAL ROTATION: Limited to 60 degrees, with pain.
LEFT EXTERNAL ROTATION: Full at 90 degrees, negative for pain.

WRIST RANGE OF MOTION:
RIGHT EXTENSION: Full at 60 degrees, with pain.
LEFT EXTENSION: Full at 60 degrees, negative for pain.
RIGHT FLEXION: Full at 60 degrees, with pain.
LEFT FLEXION: Full at 60 degrees, negative for pain.
RIGHT RADIAL DEVIATION: Full at 20 degrees, negative for pain.
LEFT RADIAL DEVIATION: Full at 20 degrees, negative for pain.
RIGHT ULNAR DEVIATION: Full at 20 degrees, negative for pain.
LEFT ULNAR DEVIATION: Full at 20 degrees, negative for pain.

HIP RANGE OF MOTION
RIGHT FLEXION: Full at 100 degrees, with pain.
LEFT FLEXION: Full at 100 degrees, negative for pain.
RIGHT EXTENSION: Full at 30 degrees, negative for pain.
LEFT HIP EXTENSION: Full at 30 degrees, negative for pain.
RIGHT ABDUCTION: Full at 40 degrees, negative for pain.
LEFT ABDUCTION: Full at 40 degrees, negative for pain.
RIGHT ADDUCTION:
LEFT ADDUCTION: Full at 20 degrees, with pain.
RIGHT INTERNAL ROTATION: Full at 40 degrees, with pain.
LEFT INTERNAL ROTATION: Limited to 30 degrees, with pain.
RIGHT EXTERNAL ROTATION: Limited to 40 degrees, with pain.
LEFT EXTERNAL ROTATION: Full at 50 degrees, negative for pain.

KNEE RANGE OF MOTION:
RIGHT FLEXION: Limited to 100 degrees, with pain.
LEFT FLEXION: Limited to 120 degrees, negative for pain.
RIGHT EXTENSION: Full at 0 degrees, negative for pain.
LEFT EXTENSION: Full at 0 degrees, negative for pain.

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CIRCUMFERENCE OF UPPER EXTREMITIES:
At 12 cm Proximal to the Antecubital Fossa:
Right: 36cm
Left: 36cm
At 5 cm Distal to the Antecubital Fossa:
Right: 30cm
Left: 30cm

CIRCUMFERENCE OF LOWER EXTREMITIES:
At 12 cm Proximal to the Medial Knee Joint:
Right: 42cm
Left: 42cm
At 10 cm Distal to the Medial Knee Joint:
Right: 39cm
Left: 38cm

LEG LENGTH:
Right: 90 cm
Left: 90cm

Examination of the right knee revealed crepitus on mobilization of the patella. There is no pistoning. Stability is preserved. Examination of the left knee revealed positive McMurray test. The left knee is stable in all planes.

ASSESSMENT: was seen in this office today for a comprehensive evaluation/nexus evaluation. A complete history and physical examination were performed, and previous medical records were reviewed.

DIAGNOSES:

Right shoulder impingement syndrome (M75.41)
Bilateral trochanteric bursitis (M70.61, M70.62)
Bilateral hip arthritis (M16.0)
Right wrist chronic sprain (S63.501)
Right total knee replacement (Z96.651)
Advanced osteoarthritis of both knees (M17.0)

MEDICAL OPINION ON CAUSATION: After examining discussing his history, and reviewing his treatment records, it is my medical opinion that it is more likely than not that his right knee and right shoulder conditions are a direct result of his military service; that it is more likely than not that his left knee and bilateral hip conditions are a direct result of his military service by way of follow through from the right knee condition; and that it is at least as likely as not that the chronic wrist condition is a direct result of his military service.

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Ralph D'Auria, M.D.

PatientID:
Patient Name:
Date of Birth:

Date of Service:

RATIONALE:
RIGHT SHOULDER/RIGHT WRIST: The patient sustained an injury to the right wrist and right shoulder while lifting and unloading heavy equipment (metal reels) while stationed in Germany in 1977. The injuries are well documented in the service medical records, which also show that the patient continued to complain of pain and symptoms in several follow up visits. (On February 22, 1977, the patient was seen at Edwards Dispensary 45th Med Bn due to complaints of right shoulder and wrist pain after lifting heavy equipment. The documentation includes follow up visits on February 24, 1977, March 02, 1977, March 07, 1977, March 14, 1977, and March 22, 1977 due to continued pain.) These injuries were then further aggravated by his duties in the military. The patient was treated with only work restrictions and medications, therefore his condition never fully resolved and became chronic in nature, resulting in tendinosis and impingement syndrome of the right shoulder and a chronic sprain of the right wrist.

Shoulder impingement occurs when the top outer edge of the shoulder blade, called the acromion, rubs against or pinches the rotator cuff beneath it, causing pain and irritation. This can happen when there is an injury to the shoulder that causes swelling of the rotator cuff (such as the lifting injury sustained by the patient). The shoulder injury was then most likely aggravated by the patient's repetitive activities performed in his military service, including heavy lifting, lifting overhead, and intensive physical training over time. This type of heavy or chronic overuse will eventually lead to inflammation and irregular movements, resulting in accelerated wear and tear of the shoulder joint. Regarding the right wrist, the patient presents with a chronic right wrist sprain because his initial sprain was never properly rehabilitated and was aggravated by his military duties and work activities after leaving the military.

RIGHT KNEE/LEFT KNEE/HIPS: The patient sustained an injury to his right knee during physical training while stationed in Germany. He states he was practicing take downs when he fell, landing on his right knee on concrete. This injury is also documented in the service medical records. (On March 21, 1977, he was seen at 97th General Hospital emergency room due to right knee pain after bumping his right knee on concrete. He was diagnosed with an anterior knee contusion. On March 23, 1977, he was seen at Edwards Dispensary 45th Med Bn 97 regarding his right knee pain after falling onto his right knee on concrete. He was diagnosed with a moderate knee contusion. The knee was wrapped in an Ace bandage and he was given crutches for ambulation.) His left knee pain began later due to overcompensation for his longstanding right knee problems and treatment, including two arthroscopies. His right knee condition progressively worsened, as documented in the medical records, eventually requiring right total knee replacement. His bilateral hip pain began due to altered gait and limping due to his bilateral knee problems.

The patient developed right knee osteoarthritis after his injury during physical training in the military, when he fell and hit the knee on concrete. Meniscal tears and ligament injuries can cause instability and additional wear on the knee joint which, over time, can result in arthritis. In this case, the patient sustained a blunt trauma to the right knee against concrete, resulting in a tear of the lateral meniscus. This injury led to instability and thinning of the cartilage, with development of symptomatic arthritis. (The fact that he initially developed arthritis in only the right knee, as opposed to both knees, indicates that this was a post-traumatic arthritis that developed as a

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result of the injury.) The patient's military duties then aggravated the right knee condition, causing acceleration of the degenerative changes in the knee; as did the repetitive stair climbing performed on a daily basis at his job from December 2007 until September 2008. As the patient's right knee condition worsened over time, he had to progressively bear more and more weight on the left knee due to right knee pain and instability, causing him to develop progressively worsening arthritis in the left knee, as shown on serial x-rays, with worsening symptoms over time. The altered gait and distorted weight bearing due to the knee problems changed the body's center of gravity by shifting weight unevenly to one side, placing additional stress on the hips and leading to the development of osteoarthritis and trochanteric bursitis in both hips

QUALIFICATIONS: My name is Ralph D'Auria, M.D. I have been practicing medicine as an orthopedic physician for over 30 years, and have acquired expertise during completion of two full residency programs for a total of 10 years of post graduate medical training - first in Orthopedic Surgery, and later in Physical Medicine and Rehabilitation, with board certification. During my 30+ years of clinical practice, I have developed a particular expertise in the non-surgical treatment and rehabilitation of musculoskeletal injuries.

If there are any questions, please fell free to contact me. My phone number is 404-378-8002. My email address is rehabortho@comcast.net.

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