VA Notes

Source:	VA
Last Updated:	22 Oct 2017 @ 1114
Sorted By:	Date/Time (Descending)

VA Notes from January 1, 2013 forward are available 3 calendar days after they have been completed and signed by all required members of your VA health care team. If you have any questions about your information please visit the FAQs or contact your VA health care team.

Date/Time:	
Note Title:	
Location:	
Signed By:	
Co-signed By:	
Date/Time Signed:	

Note

LOCAL TITLE: C&P EXAM
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: JUL 14, 2017@10:58 ENTRY DATE: JUL 14, 2017@10:58:07
AUTHOR: EXP COSIGNER:
URGENCY: STATUS: COMPLETED

C&P for knees disability questionaire completed pending results of left knee

radiograph and right knee MRI. She has long standing hx of right knee recurrent subluxation since 1995.

PCP: Veteran had CT Scan 2012 lumbar spine indicating L4-L5 vacuum phenoma, DJD with recurrent chronic back pain/right radiculopathy s/s. She is requesting consideration for a MRI of lumbar spine.

Veteran has positive history of MST but "does not want to deal with it at this
time".

Receipt Acknowledged By:
07/18/2017 09:20

MEDICAL CONFIDENTIAL

Date/Time:	14 Jul 2017 @ 1000
Note Title:	C&P EXAM
Location:	
Signed By:	
Co-signed By:	
Date/Time Signed:	20 Jul 2017 @ 0703

Note

LOCAL TITLE: C&P EXAM
STANDARD TITLE: C & P EXAMINATION NOTE
DATE OF NOTE: JUL 14, 2017@10:00 ENTRY DATE: JUL 20, 2017@07:03:03
[redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Knee and Lower Leg Conditions
Disability Benefits Questionnaire

Name of patient/Veteran:

Is this DBQ being completed in conjunction with a VA 21-2507, C&P Examination
Request?
[X] Yes [ ] No

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)
[X] CPRS

1. Diagnosis
---
a. List the claimed condition(s) that pertain to this DBQ:
right knee condition

b. Select diagnoses associated with the claimed condition(s) (Check all that apply):

MEDICAL CONFIDENTIAL

[X] Knee joint osteoarthritis
Side affected: [ ] Right [ ] Left [X] Both
ICD Code: ?
Date of diagnosis: Right 2017

[X] Recurrent subluxation
Side affected: [X] Right [ ] Left [ ] Both
ICD Code: ?
Date of diagnosis: Right 1970

c. Comments (if any): RIGHT KNEE OTHER DIAGNOSIS CURRENT:

1. Very mild lateral subluxation of the patella.
2. Degenerative change involving the patellofemoral joint.
3. Very mild degenerative change involving the knee joint.
4. Very small knee joint effusion.
5. Small popliteal cyst.
6. Degenerative change involving the lateral meniscus.
7. Degenerative change involving the medial meniscus and a tear involving the posterior horn of the medial meniscus cannot be excluded.

d. Was an opinion requested about this condition (internal VA only)?
[X] Yes [ ] No [ ] N/A

2. Medical history
---
a. Describe the history (including onset and course) of the Veteran's knee
and/or lower leg condition (brief summary):
Military Service Marine Corp:
2/24/1975 - 7/23/1975 and 5/3/1974 - 9/5/1974

Veteran is requesting consideration for direct SC for a right knee SUBLUXATION, RECURRENT residuals.

STRS, Medical Board evaluation documented 16 June 1975 summarized:
...initial injury 5 years prior to enlistment running on track and experienced giving way of right knee. She was asymptomatic for a long time.
By the 10 week of basic training she began to experience several episodes of right knee giving way during physical fitness training events.. Surgical
option discussed and declined. Physical therapy for strengthening conducted.
She was found unfit for duty with a 10% disability rating for SUBLUXATION PATELLA RIGHT, RECURRENT.

RIGHT KNEE: Per Veteran reporting shortly after leaving medical separation from military service, she went to a VAMC in California. She was placed in a long leg cast x 6 months. The cast was extrememly heavy and finally her boyfriend at the time removed it using a hachet. She had some calf atrophy

MEDICAL CONFIDENTIAL

right side at that time. She was hired by Southern Pacific Railroad and she was on the job training for engineer position. She had recurrent subluxations right knee. Around 1995 she developed an internet system for the Farmington, MO region. Internet systems changing to satellites from hard wire. She and her associate was required to climb a variety of towers to set up satellites and cables. She once incident in which she was 80 feet above ground moving cable. Her right knee gave way, and luckily she was saved by her safety harness. In 2006 her knee gave way and fell down a few stairs landing on right shoulder.

Review of CPRS indicates she had long hx of using NSAIDS.
LEFT KNEE: no trauma, intermittent discomfort, crepitus and stiffness.

b. Does the Veteran report flare-ups of the knee and/or lower leg?
[X] Yes [ ] No

If yes, document the Veteran's description of the flare-ups in his or her own words:
RIGHT KNEE: Recurrent instability at random, pain variable but constant, intermittent edema, chronic crepitus, chronic stiffness. She is not in flare up today. Pain mostly lateral aspect, and slight posterior. She has wore instability brace in past but not comfortable. Treatment is NSAIDS, hot or cold packs. No prior surgery, arthroscopy, steroid or Synvisc injections.

LEFT KNEE: no treatment

c. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this DBQ, including but not limited to repeated use over time?
[X] Yes [ ] No

If yes, document the Veteran's description of functional loss or functional impairment in his or her own words:
pain, less endurance, instability

3. Range of motion (ROM) and functional limitation
---

a. Initial range of motion

Right Knee

[ ] All normal
[X] Abnormal or outside of normal range
[ ] Unable to test (please explain)
[ ] Not indicated (please explain)

Flexion (0 to 140): 5 to 110 degrees

MEDICAL CONFIDENTIAL

Extension (140 to 0): 110 to 5 degrees

If abnormal, does the range of motion itself contribute to functional loss? [X] Yes (please explain) [ ] No
If yes, please explain:
less flexion and lacks full extension

Description of pain (select best response):
Pain noted on exam and causes functional loss

If noted on exam, which ROM exhibited pain (select all that apply)?
Flexion, Extension

Is there evidence of pain with weight bearing? [X] Yes [ ] No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? [X] Yes [ ] No

If yes, describe including location, severity and relationship to condition(s):
entire lateral, anterior and superior, slight posterior

Is there objective evidence of crepitus? [X] Yes [ ] No

Left Knee

[ ] All normal
[X] Abnormal or outside of normal range
[ ] Unable to test (please explain)
[ ] Not indicated (please explain)

Flexion (0 to 140): 0 to 115 degrees
Extension (140 to 0): 115 to 0 degrees

If abnormal, does the range of motion itself contribute to functional loss? [X] Yes (please explain) [ ] No
If yes, please explain:
less flexion

Description of pain (select best response):
Pain noted on exam and causes functional loss

If noted on exam, which ROM exhibited pain (select all that apply)?
Flexion

Is there evidence of pain with weight bearing? [ ] Yes [X] No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? [ ] Yes [X] No

MEDICAL CONFIDENTIAL

Is there objective evidence of crepitus? [X] Yes [ ] No

b. Observed repetitive use

Right Knee

Is the Veteran able to perform repetitive use testing with at least three repe
titions? [X] Yes [ ] No
Is there additional functional loss or range of motion after three repetitions? [X] Yes [ ] No
Select all factors that cause this functional loss:
Pain

ROM after three repetitions:
Flexion (0 to 140): 5 to 110 degrees
Extension (140 to 0): 110 to 5 degrees

Left Knee

Is the Veteran able to perform repetitive use testing with at least three repetitions? [X] Yes [ ] No
Is there additional functional loss or range of motion after three repetitions? [ ] Yes [X] No

c. Repeated use over time

Right Knee

Is the Veteran being examined immediately after repetitive use over time? [X] Yes [ ] No

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?
[X] Yes [ ] No [ ] Unable to say w/o mere speculation
Select all factors that cause this functional loss:
Pain, Weakness, Lack of endurance

Able to describe in terms of range of motion: [ ] Yes [X] No
If no, please describe:
not observed over a period of time

Left Knee

Is the Veteran being examined immediately after repetitive use over time? [X] Yes [ ] No

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

MEDICAL CONFIDENTIAL

[X] Yes [ ] No [ ] Unable to say w/o mere speculation
Select all factors that cause this functional loss:
Pain

Able to describe in terms of range of motion: [ ] Yes [X] No
If no, please describe:
not observed over a period of time

d. Flare-ups

Right Knee

Is the exam being conducted during a flare-up? [ ] Yes [X] No

If the examination is not being conducted during a flare-up:
[X] The examination is medically consistent with the Veteran's statements describing functional loss during flare-ups.
[ ] The examination is medically inconsistent with the Veteran's statements describing functional loss during flare-ups. Please explain.
[ ] The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare-ups.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare-ups?
[X] Yes [ ] No [ ] Unable to say w/o mere speculation
Select all factors that cause this functional loss:
Pain, Fatigue, Weakness, Lack of endurance

Able to describe in terms of range of motion: [ ] Yes [X] No
If no, please describe:
not observed in acute flare up

Left Knee

Is the exam being conducted during a flare-up? [ ] Yes [X] No

If the examination is not being conducted during a flare-up:
[ ] The examination is medically consistent with the Veteran's statements describing functional loss during flare-ups.
[ ] The examination is medically inconsistent with the Veteran's statements describing functional loss during flare-ups. Please explain.
[X] The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during

MEDICAL CONFIDENTIAL

flare-ups.

Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare-ups?
[ ] Yes [X] No [ ] Unable to say w/o mere speculation

e. Additional factors contributing to disability

Right Knee

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:
Less movement than normal due to ankylosis, adhesions, etc., Swelling, Instability of station, Disturbance of locomotion, Interference with standing

Please describe additional contributing factors of disability:
interference with climbing, kneeling or squatting

Left Knee

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe: None

4. Muscle strength testing
---
a. Muscle strength - Rate strength according to the following scale:

0/5 No muscle movement
1/5 Palpable or visible muscle contraction, but no joint movement
2/5 Active movement with gravity eliminated
3/5 Active movement against gravity
4/5 Active movement against some resistance
5/5 Normal strength

Right Knee: Rate Strength:
Flexion: 5/5
Extension: 4/5
Is there a reduction in muscle strength? [X] Yes [ ] No

Left Knee: Rate Strength:
Flexion: 5/5
Extension: 5/5
Is there a reduction in muscle strength? [ ] Yes [X] No

b. Does the Veteran have muscle atrophy?
[ ] Yes [X] No

c. Comments, if any:
No response provided

MEDICAL CONFIDENTIAL

5. Ankylosis

Complete this section if the Veteran has ankylosis of the knee and/or lower leg.

a. Indicate severity of ankylosis and side affected (check all that apply):

Right Side:
[ ] Favorable angle in full extension or in slight flexion between 0 and 10 degrees
[ ] In flexion between 10 and 20 degrees
[ ] In flexion between 20 and 45 degrees
[ ] Extremely unfavorable, in flexion at an angle of 45 degrees or more
[X] No ankylosis

Left Side:
[ ] Favorable angle in full extension or in slight flexion between 0 and 10 degrees
[ ] In flexion between 10 and 20 degrees
[ ] In flexion between 20 and 45 degrees
[ ] Extremely unfavorable, in flexion at an angle of 45 degrees or more
[X] No ankylosis

b. Indicate angle of ankylosis in degrees:
No response provided

c. Comments, if any:
No response provided

6. Joint stability tests
---
a. Is there a history of recurrent subluxation?

Right: [ ] None [ ] Slight [ ] Moderate [X] Severe

Left: [X] None [ ] Slight [ ] Moderate [ ] Severe

b. Is there a history of lateral instability?

Right: [ ] None [ ] Slight [ ] Moderate [X] Severe

Left: [X] None [ ] Slight [ ] Moderate [ ] Severe

c. Is there a history of recurrent effusion?

[X] Yes [ ] No

If yes, describe: right only

d. Performance of joint stability testing

MEDICAL CONFIDENTIAL

Right Knee:

Was joint stability testing performed?
[X] Yes
[ ] No
[ ] Not indicated
[ ] Indicated, but not able to perform

If joint stability testing was performed is there joint instability?
[X] Yes [ ] No

If yes (joint stability testing was performed), complete the section below:

- Anterior instability (Lachman test)

  [ ] Normal
  [X] 1+ (0-5 millimeters)
  [ ] 2+ (5-10 millimeters)
  [ ] 3+ (10-15 millimeters)
- Posterior instability (Posterior drawer test)
  [X] Normal
  [ ] 1+ (0-5 millimeters)
  [ ] 2+ (5-10 millimeters)
  [ ] 3+ (10-15 millimeters)
- Medial instability (Apply valgus pressure to knee in extension and with 30 degrees of flexion)
  [X] Normal
  [ ] 1+ (0-5 millimeters)
  [ ] 2+ (5-10 millimeters)
  [ ] 3+ (10-15 millimeters)
- Lateral instability (Apply varus pressure to knee in extension and with 30 degrees of flexion)
  [ ] Normal
  [X] 1+ (0-5 millimeters)
  [ ] 2+ (5-10 millimeters)
  [ ] 3+ (10-15 millimeters)

Left Knee:

Was joint stability testing performed?
[ ] Yes
[X] No
[ ] Not indicated
[ ] Indicated, but not able to perform

e. Comments, if any:
No response provided

7. Additional conditions

MEDICAL CONFIDENTIAL

---

a. Does the Veteran now have or has he or she ever had recurrent patellar dislocation, "shin splints" (medial tibial stress syndrome), stress fractures, chronic exertional compartment syndrome or any other tibial and/or fibular impairment?
[ ] Yes [X] No

b. Comments, if any:
No response provided

8. Meniscal conditions
---

a. Does the Veteran now have or has he or she ever had a meniscus (semilunar cartilage) condition?
[X] Yes [ ] No

If yes, indicate severity and frequency of symptoms, and side affected:

Right Side:
[X] Frequent episodes of joint "locking"
[X] Frequent episodes of joint pain
[X] Frequent episodes of joint effusion

b. For all checked boxes above, describe:
CURRENT MRI: indicates right knee small effusion 7/2017

9. Surgical procedures

No response provided

10. Other pertinent physical findings, complications, conditions, signs, symptoms and scars
---

a. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to any conditions listed in the Diagnosis Section above?
[X] Yes [ ] No

If yes, describe (brief summary): Crepitus bilaterally with right more pronounced than left. Atalgic gait with increased weight bearing to the left extremity. No edema or erythema to knees.

b. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any conditions listed in the Diagnosis Section above?
[ ] Yes [X] No

c. Comments, if any:

MEDICAL CONFIDENTIAL

No response provided

11. Assistive devices
---
a. Does the Veteran use any assistive device(s) as a normal mode of locomotion,
although occasional locomotion by other methods may be possible?
[ ] Yes [X] No

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each condition:
No response provided

12. Remaining effective function of the extremities

Due to the Veteran's knee and/or lower leg condition(s), is there functional
impairment of an extremity such that no effective function remains other than that which would be equally well served by an amputation with prosthesis?
(Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.)

[ ] Yes, functioning is so diminished that amputation with prosthesis would equally serve the Veteran.
[X] No

13. Diagnostic testing
---
a. Have imaging studies of the knee been performed and are the results available?
[X] Yes [ ] No

If yes, is degenerative or traumatic arthritis documented?
[X] Yes [ ] No

If yes, indicate knee: [X] Right [ ] Left [ ] Both

b. Are there any other significant diagnostic test findings and/or results?
[X] Yes [ ] No

If yes, provide type of test or procedure, date and results (brief summary):

(Case 4392 COMPLETE) KNEE,RIGHT,1 OR 2 VIEWS (RAD Detailed)
CPT:73560

Report Status: Verified Date Reported: MAY 18, 2017

MEDICAL CONFIDENTIAL

Report:
Right knee 2 views. There are degenerative changes present. No fracture or dislocation. No bony destruction.

Impression:
Mild degenerative arthritis
****
(Case 5017 COMPLETE) KNEE,LEFT 1 OR 2 VIEWS (RAD Detailed)
CPT:73560

Report Status: Verified Date Reported: JUL 14, 2017

Report:
Two views of the left knee reveal mild degenerative skeletal change with no acute osseous or adjacent soft tissue abnormality.

Impression:
No acute process

c. If any test results are other than normal, indicate relationship of abnormal
findings to diagnosed conditions:
No response provided

14. Functional impact

Regardless of the Veteran's current employment status, do the condition(s)
listed in the Diagnosis Section impact his or her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?
[X] Yes [ ] No

If yes, describe the functional impact of each condition, providing one or more examples:
RIGHT KNEE: Must be afforded opportunity to walk on smooth even surfaces. Must avoid repetitive walking inclines/declines, stairs, and use of ladders. Unable to tolerate prolonged standing or walking. Unable to participate in moderate to high impact aerobics. Unable to tolerate kneeling or squatting.

MEDICAL CONFIDENTIAL

15. Remarks, if any:

SUBLUXATION RIGHT KNEE, RECURRENT etiology onset five years prior to enlistment. Recurrent within the tenth week of active duty physical fitness training. Refer to MO.

Offset weight bearing shifting toward the left lower extremity. Refer to MO.

****

Medical Opinion
Disability Benefits Questionnaire

Name of patient/Veteran: Proffer, Victoria

ACE and Evidence Review

Indicate method used to obtain medical information to complete this document:

[X] In-person examination

Evidence Review

Evidence reviewed (check all that apply):

[X] VA e-folder (VBMS or Virtual VA)
[X] CPRS

MEDICAL OPINION SUMMARY

RESTATEMENT OF REQUESTED OPINION:

a. Opinion from general remarks: Does the Veteran have a knee injury for direct SC for a right knee injury residuals.

b. Indicate type of exam for which opinion has been requested: knee
TYPE OF MEDICAL OPINION PROVIDED: [MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE]

a. The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service event, injury or illness.

MEDICAL CONFIDENTIAL

c. Rationale: STRS, Medical Board evaluation documented 16 June 1975 summarized: ...initial injury 5 years prior to enlistment running on track and experienced giving way of right knee. She was asymptomatic for a long time. By the 10th week of basic training she began to experience several episodes of right knee giving way during physical fitness training events... Surgical option discussed and declined. Physical therapy for strengthening conducted. She was found unfit for duty with a 10% disability rating for SUBLUXATION PATELLA RIGHT, RECURRENT.

****

RESTATEMENT OF REQUESTED OPINION:

a. Opinion from general remarks: Veteran is claiming left knee arthritis as secondary to offset weight bearing of SC right knee condition.

b. Indicate type of exam for which opinion has been requested: knee

TYPE OF MEDICAL OPINION PROVIDED: [MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION]

a. The condition claimed is at least as likely as not (50% or greater probability) proximately due to or the result of the Veteran's service connected condition.

c. Rationale: Chronic pain, less endurance, instability of SC right knee patella subluxation issues has lead to the osteoarthritis left knee.

RATIONALE:
It is well documented in the medical literature that alteration in gait imposed by the RIGHT knee condition precipitates the development of osteoarthritis in the contralateral LEFT knee.
Minor compensations can increase stress on a contralateral limp and predispose the patient to premature degenerative arthritis. Journal of Rehabilitation Research and Development January 2008.

Harrison's Principles of Internal Medicine, 18th Edition, Copyright 2012,
page 2830-2831. (ISBN 978-0-07174889-6, MHID 0-07-174889-X)
Joint vulnerability and joint loading are the two major factors contributing to the development of Osteoarthritis. On the one hand, a vulnerable joint whose protectors are dysfunctional can develop OA with minimal levels of loading, perhaps even levels encountered during every day activities. On the other hand, in a young joint with competent protectors, a major acute injury or long-term overloading is necessary to precipitate disease. Risk factors for OA can be understood in terms of their effect either on joint vulnerability or on loading. Risk factors for osteoarthritis either contribute to the susceptibility of the joint (systemic factors or factors in
the local joint environment) or increase risk by the load they put on the joint. Usually a combination of loading and susceptibility factors is

MEDICAL CONFIDENTIAL

required to cause disease or its progression.
Systemic factors affecting joint vulnerability: increased age, female gender,
racial/ethnic factors, genetic susceptibility, nutritional factors.
Intrinsic joint vulnerability (local environment): previous damage (e.g.
meniscetomy) bridging muscle weakness increasing bone density, mal-alignment,
proprioceptive deficiencies.
Use (loading) factors acting on joints: obesity injurious physical
activities.

****

MEDICAL CONFIDENTIAL