Patient Name ***DOB: MM/DD/YYYY***

Medical Chronology/Summary

Confidential and privileged information

Usage guideline/Instructions

***Verbatim summary:** All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

***Case synopsis/Flow of events:** For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

***Injury report:** Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments:** We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: "*Comments***".

Indecipherable notes/date:** Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes" in heading reference.

***Patient's History:** Pre-existing history of the patient has been included in the history section.

***Snapshot inclusion:** If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

***De-Duplication:** Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on the **Biocompatibility of the implant placed during total right knee arthroplasty on MM/DD/YYYY**, the resultant clinical condition of **XXXX** due to this surgery, treatments rendered and progress of the condition.*
- *Initial and final therapy evaluation has been summarized in detail. Interim visits have been presented cumulatively to avoid repetition and for ease of reference.*
- *Prior visits for other medical conditions have been included in brief for reference.*

Flow of events

↓

01/31/YYYY- XXXX Associates, XXXX, MD

Complaints of pain in both knee- Left knee is worse- Diagnosed with Complex tear of medial meniscus, current injury, left knee, Unilateral primary osteoarthritis, right knee- Recommend Short physical therapy and return in one moth

↓

02/12/YYYY- XXXX, MD, XXXX, MD

Xray of left knee - Pain after a fall - No acute osseous abnormality, left knee - MRI of left knee without contrast- Left knee pain after injury- Reviewed

↓

02/13/YYYY- XXXX Associates, XXXX, DO

Left knee pain - Unilateral primary osteoarthritis, left knee, Complex tear of medial meniscus, current injury, left knee, Complex tear of lateral meniscus, current injury, left knee - Conservative and surgical options were discussed - follow-up with Dr. XXXX.

↓

02/20/YYYY- Florida Orthopaedic Associates, XXXX, MD

Has been to physical therapy and states that his symptoms have dissipated - failed conservative measures - candidate for a left total knee arthroplasty - discussed that the pain may be better or worse than before surgery - patient will consider surgery and schedule preoperative medical assessment

↓

03/28/YYYY- XXXX, MD

Xray of left knee - Tricompartment osteoarthrosis with moderate to severe medial compartment Joint space narrowing - Reviewed

↓

04/03/YYYY- XXXX, MD

Left knee osteoarthritis- Left total knee arthroplasty done- Tolerated the procedure well- No complications

↓

04/03/YYYY- 05/06/YYYY- XXXX, PT

Physical therapy initiated- Three times weekly – 8 weeks duration

↓

07/08/YYYY- Florida Orthopaedic Associates, XXXX, PA-C

Right knee pain - increasing pain and disability of the right knee secondary to severe osteoarthritis – Diagnosed with Unilateral primary osteoarthritis, right knee, Pain in right knee - Severe osteoarthritis of the right knee unresponsive to conservative treatment - Patient does wish to proceed with right total knee arthroplasty and is tentatively scheduled for July 23rd

↓

07/16/YYYY- XXXX, MD

Xray of right knee - Advanced degenerative arthritis most severe medial compartment of knee where severe joint space narrowing with marginal osteophyte formation is present – Reviewed

↓

07/23/YYYY- XXXX, MD

Right knee osteoarthritis- Right total knee arthroplasty, posterior stabilized. Depuy Attune press fit done- Tolerated the procedure well- No immediate complications after surgery

↓

07/23/YYYY- XXXX, MD

Pathology report- Right knee bone shavings collected - Grossly examined and consistent with osteoarthritis (degenerative joint disease)

↓

07/30/YYYY- Florida Orthopaedic Associates, XXXX, MD

Status post right TKA performed on 07/23/YYYY - 1 week post op - complaining of increased pain in the right knee - complaints of swelling in the lower right leg and some redness around the incision site – X rays of right knee ordered- concerned about a possibility of a mismatch with the femoral component – Concluded Right TKA with some swelling and mismatch of the polyethylene - discussed this with the knee team at Depuy. There is a slight asymmetry between the cruciate retaining femoral component and the posterior stabilized tibial insert- planned to change the femoral component

↓

08/05/YYYY- XXXX, MD

Right knee femoral mismatch following total knee arthroplasty- Revision femoral component with polyethylene exchange right knee carried out - Postoperative radiographs showed a Press-Fit cruciate retaining femoral component matched with a posterior stabilized insert - discussed urgent exchange to avoid any ingrowth of the porous-coated femur - The 8 mm posterior stabilized insert was then placed rotating platform and the knee relocated - Explants sent to CSR to clean - stable condition tolerated procedure well

↓

08/05/YYYY- XXXX, MD

Postop medical management - Patient be continued on current therapy - Patient be ambulated

↓

08/05/YYYY- XXXX, MD

Xray of right knee - Postop – Postsurgical changes of total knee arthroplasty, without periprosthetic lucency or fracture - without complicating features – Reviewed

↓

08/07/YYYY- XXXX, PA-C

Discharge summary - Status post right total knee arthroplasty with mismatch components -On exam, a healing total knee scar with some swelling and blister at the distal portion, but otherwise moderate swelling and looks well. Neurovascular intact distally - Range of motion 0 to about 50 degrees - Postop course was uneventful - Arranged for home care services for 3 weeks for rehab and nursing care - Use Percocet and ibuprofen as needed for pain management - Follow up in the office in 2 weeks

Patient History

Past Medical History: History of sleep apnea and hypertension. *(Pdf ref: 1)*

Surgical History: History of surgery in left elbow. *(Pdf ref: 1)*

Family History: Father has history of osteoporosis and cancer. Mother has history of osteoporosis and cancer. *(Pdf ref: 2)*

Social History: Patient reports the use of alcohol and caffeine. Patient does not use illicit drugs or tobacco. *(Pdf ref: 2)*

Allergy: No known drug allergy

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/31/YYYY	Hospital/Provider Name	**Office Visit:** **Chief Complaint:** Presents with complaints of pain in both knees. **History of Present Illness:** The patient is a 55 year old male who presents with complaints of pain in both knees. Left knee is worse. The onset was sudden without injury about one month ago for the left knee. States the right knee has aggravated him for about 2 years. Denies any injury. The patient's symptoms are aggravated by going downstairs, going up stairs, kneeling and walking. The patient's symptoms are revealed by Ibuprofen. The symptoms are worse at rest. He walks with a limp. The patient denies any injections or surgery. The patient comes in for treatment options**.** **Review of Systems** **Constitutional:** Patient has history of weight loss or gain **Eyes:** Patient has history of glasses or contacts **Cardiovascular:** Patient has history of High Blood Pressure**.** **Musculoskeletal:** Patient has history of Joint Pain, stiffness and muscular pain. **Skin:** Patient has history of sores. **Physical exam:** **Neurologic:** Patient is alert, oriented x 3, cooperative, responsive to questions. There is normal tone and strength of both upper extremities. Normal ROM and no instability noted in either UE. Normal reflexes and normal sensory response. **Knee Exam:** **Gait:** Antalgic	1-4

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF

Posture: Shoulders are level

Inspection	Right	Left
Alignment	Normal	Neutral
Swelling	Negative	Negative
Ecchymosis	Negative	Negative
Effusion	None	None
Atrophy	Absent	Absent
Palpation: Tenderness:	Right knee joint line	Left knee medial joint line

ROM Active	Right	Left
Flexion	135	135
Extension	0	0

Description:
Right Knee Normal pain-free active range of motion**.**
Left Knee Normal painful active range of motion.

ROM Passive	Right	Left
Flexion	135	135
Extension	0	0

Description:
Left knee: Normal painful range of motion.
Right knee: Normal pain-free passive range of motion**.**

Muscle Testing	Right	Left
Quadriceps		5/5
Hamstrings		5/5
Patella Reflex	2/4	2/4

Neurological: The peripheral reflexes are normal with normal distal sensation.
Sensation: L2 left is normal, L3 Left is normal, L4 Left is normal, L5 Left is normal, L3 Right is normal, L5 Right is normal, L4 Right is normal, and S2 Right is normal

Stability	Right	Left
Valgus Stress	Negative	Negative
Varus stress	Moderate (4-10 mm)	Negative

Special Testing	Right	Left
McMurray		Positive

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Medial	
		Exam Notes: They are alert and oriented x3. There is appropriate affect and mood today. Coordination is normal. There are no palpable abnormalities and a full range of motion with no instability of both upper extremities. There is no weakness of either upper extremity noted**.** **Imaging:** Right Knee**:** X-ray of Knees-Bilateral **Left knee**- No acute abnormalities. Moderate lateral joint space narrowing. **Right Knee:** Standing AP, lateral and sunrise views are reviewed. Marked tricompartmental degenerative changes with Varus deformity, osteophytes, and subchondral sclerosis. **Reviewers comment: The above mentioned original reports of imaging studies are unavailable for review** **Impression:** • Pain in left knee • Pain in right knee • Complex tear of medial meniscus, current injury, left knee, initial encounter • Unilateral primary osteoarthritis, right knee **Plan:** **Knee:** I have explained the pathology to the patient. I explained that about 90% of meniscal tears will not heal because of the blood supply and the tear pattern. I went over the treatment options including observation, physical therapy, arthroscopic partial meniscectomy, and arthroscopic meniscal repair. At this time I recommend a short course of physical therapy for the left knee. The patient will return in one month to check their progress. Further alternatives could be discussed if there is no relief at that time. *Related records: Patient information: Pdf ref: 5-19*	
02/12/YYYY	Hospital/Provider Name	**X-Ray of left knee:** **Indication:** Pain after a fall **Comparison:** None **Findings:** **Bone Density:** Normal**.** **Joint Spaces:** Tricompartmental hypertrophic degenerative change with moderate narrowing of the lateral and patellofemoral compartments. No significant joint effusion. Corticated 2.6 x 1.6 cm density is noted posterior to the proximal lower leg on the lateral view which could reflect intra-articular	20-21

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		loose body. **Fracture:** None. **Dislocation:** None. **Soft Tissues:** No mass. **Impression:** No acute osseous abnormality, left knee.	
02/12/YYYY	Hospital/Provider Name	**MRI of left knee without contrast:** **Indication:** Left knee pain after injury. **Comparison:** Left knee x-ray dated 2/12/YYYY. **Findings:** **Menisci:** Degeneration medial meniscus with questionable minimal inferior surface degenerative tearing posterior horn medial meniscus centrally series 6 image 10 series 4 image 12. There is extensive degeneration with complex tearing involving the lateral meniscus most prominently the body and posterior horn **ACL:** No tear. Suspect ACL degeneration distally **PCL:** Normal. **MCL:** Normal. **LCL:** Normal. **Posterolateral Corner:** Soft tissue edema **Femur, Tibia, Fibula, Patella:** No acute fracture or dislocation. No significant marrow contusion. **Medial Compartment:** Primarily grade II chondromalacia. Small marginal osteophyte formation **Lateral Compartment:** Extensive grade Ill to IV chondromalacia, Moderate marginal osteophyte formation with mild subchondral marrow edema **Patellofemoral Joint:** Small areas of low-grade chondromalacia **Proximal Tibiofibular Joint:** Well preserved. **Tendons:** Normal. **Joint Effusion:** Small **Other Soft Tissues:** There is a dominant approximately 2.2 x 1.3 x 1.9 cm bony density in the posterolateral soft tissues about the knee proximal tibia level. This is in the posterior pericapsular area. No significant associated marrow edema. There is adjacent but separate appearing moderate to large bony spur projecting from the posterior aspect of the proximal tibia laterally series 5 image 27 series 4 image 27. This area of bony spurring measures approximately 1.7 x 0.9 cm. There is soft tissue edema surrounding the Ununited bony density **Impression:** 1. Large ununited bony density in the posterolateral soft tissues about the knee with adjacent surrounding soft tissue edema. There is an adjacent bony projection from the posterior aspect of the proximal tibia laterally. This bony	22-23

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		density may have arisen from prior fracture of the adjacent bony excrescence of indeterminate age. The presence of surrounding moderate soft tissue edema suggests potential recent injury in this region or ongoing mechanical irritation. 2. Tricompartmental osteoarthritis most severe in the lateral compartment of the knee where there is extensive high-grade cartilage loss with small reactive subchondral marrow edema and moderate marginal osteophyte formation. 3. Extensive degeneration lateral meniscus with complex tearing body and posterior horn lateral meniscus primarily. 4. Degeneration medial meniscus with equivocal minimal inferior surface degenerative tearing posterior horn. 5. No AGL or PCL tear 6. Intact MCL and LCL	
02/13/YYYY	Hospital/Provider Name	**Follow-up Visit:** **Chief Complaint:** Left knee pain **History of Present Illness:** 55-year-old male presents today for new evaluation of his left knee pain. He states that on 2/11/YYYY he stepped out of his truck onto gravel and slipped, causing the knee to twist and pop. He complains of pain lateral posterior, worse with overuse and walking. He does report some improvement since the initial injury. He takes Ibuprofen as needed. He denies any previous issues with the knee. Patient has had an MRI and is following up with his primary care provider. Patient has also seen Dr. XXXX for treatment of the knee as well. I was called by Dr. XXXX to see if we could evaluate his knee MRI and see if further treatment is necessary more urgently. He is brought in today for initial evaluation with plan to follow up with Dr. XXXX after this evaluation. **Review of Systems** **Constitutional:** Patient has history of weight loss or gain **Eyes:** Patient has history of glasses or contacts **Cardiovascular:** Patient has history of High Blood Pressure. **Musculoskeletal:** Patient has history of Joint Pain, stiffness and muscular pain. **Skin:** Patient has history of sores. **Physical exam:** **Neurologic:** Motor and sensory intact in the bilateral upper extremities. Motor and sensory intact in the right lower extremity. Stable mood and normal affect. Normal tone and coordination. **Musculoskeletal**: Full range of motion of the bilateral shoulder, elbows, wrists, and fingers with no tenderness to palpation or instability. Full range of motion of the right hip, knee, ankle, and toes with no tenderness to palpation or instability except for	24-28

<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>
crepitation about the medial joint line of the right knee

Knee Exam:
Gait: The gait is compensated.
Posture: Shoulders are level

<table>
<tr><th>Inspection</th><th>Left</th></tr>
<tr><td>Alignment</td><td>Mild</td></tr>
<tr><td>Swelling</td><td>Negative</td></tr>
<tr><td>Ecchymosis</td><td>Negative</td></tr>
<tr><td>Effusion</td><td>Mild</td></tr>
<tr><td>Atrophy</td><td>Quadriceps femoris</td></tr>
<tr><td>Palpation: Tenderness:</td><td>Left knee medial and lateral joint</td></tr>
</table>
<table>
<tr><th>ROM Active</th><th>Left</th></tr>
<tr><td>Flexion</td><td>130</td></tr>
<tr><td>Extension</td><td>0</td></tr>
</table>
Description:
Right Knee Normal pain-free active range of motion.
Left Knee Normal painful active range of motion.

<table>
<tr><th>ROM Passive</th><th>Left</th></tr>
<tr><td>Flexion</td><td>130</td></tr>
<tr><td>Extension</td><td>-5</td></tr>
</table>
Description:
Left knee: Normal painful range of motion.

<table>
<tr><th>Muscle Testing</th><th>Left</th></tr>
<tr><td>Quadriceps</td><td>4/5</td></tr>
<tr><td>Hamstrings</td><td>5/5</td></tr>
<tr><td>Semimembranosus</td><td>5/5</td></tr>
<tr><td>Semitendinosus</td><td>5/5</td></tr>
<tr><td>Patella Reflex</td><td>2/4</td></tr>
</table>
Neurological: Normal reflexes and distal sensation.
Sensation: L4 through S2 intact

Ankle/ Hip: Evaluation of the patient's left hip reveals no tenderness to palpation on manual examination, no limitations in range of motion, and no evidence of impingement.
Evaluation of the patient's left ankle reveals no tenderness palpation on manual examination, no limitations in range of motion, and no evidence of instability.

Imaging:
Left Knee: XRAY Knee -4 view or more- I personally reviewed the images, evidence of severe degenerative changes of the lateral compartment knee, no
</td><td></td></tr>
</table>

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		fracture or dislocation, and no osseous or soft tissue lesions. (Outside) **Left Knee: MRI of Lt Knee W/o Contrast**- Personally reviewed the images report indicating evidence of severe osteoarthritis lateral compartment knee with prior meniscectomy and complex tearing lateral meniscus and cleavage-type tear of the medial meniscus without displacement. Patient also has a large osseous body behind the fibular head likely an osteophyte that is fractured off from the lateral compartment osteoarthritis. There is no acuity to this pathology. The demand on the soft tissue appears to be secondary to sprain without instability ligaments. (Outside) **Impression:** • Pain in left knee • Unilateral primary osteoarthritis, left knee • Complex tear of medial meniscus, current injury, left knee, initial encounter • Complex tear of lateral meniscus, current injury, left knee, initial encounter **Plan:** **Knee:** 55-year-old male presents with complaint of pain in the left knee secondary to severe lateral compartment osteoarthritis, complex tearing of the lateral meniscus, complex tearing of the medial meniscus without displacement. There is an area of ossification posterior to the fibular head which is a fractured osteophyte posteriorly. There are well circumscribed borders which indicate there is no acuity to this fracture. Patient's symptoms are likely due to exacerbation of severe osteoarthritis. I have explained the pathology and treatment options, including the benefits and complications of each of the options. Conservative and surgical options were discussed, including activity modification, NSAIDs, physical therapy, bracing, injections, and surgery. I have reviewed the results of the x-rays with the patient and answered any questions that they had. After discussion, the patient wishes to activity modification, weight loss management as discussed, follow-up with Dr. XXXX for discussion about arthroscopy versus knee replacement surgery. Continue to be weightbearing as tolerated. NSAIDs are encouraged if needed. Patient will follow-up with Dr. XXXX for further evaluation and treatment recommendations for his left knee	
02/20/YYYY	Hospital/Provider Name	**Follow-up Visit:**	29-31

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chief Complaint: Knee **History of Present Illness:** **Knee:** XXXX presents today for a follow-up of his left knee pain. He has been to physical therapy and states that his symptoms have dissipated. He subsequently had an injury when he fell from loose gravel. The patient saw Dr. XXXX at the request of his PCP, Dr. XXXX. Dr. XXXX ordered an MRI and had some concerns. Dr. XXXX has referred him to me for further treatment options **Exam:** The patient is alert and oriented times three. There is a slight antalgic gait. There is mild pain over the medial joint line. There is no gross instability. There is a negative Lachman's. There are no skin or vascular changes bilaterally and symmetric. There is a normal motor and sensory examination. There is good distal capillary refill of both lower extremities. There is no pain at the hip or ankle. Otherwise the knee examination is unchanged from the previous visit. **Imaging:** **Left Knee: XRAY Knee 3 view-** X-Rays reveals no acute osseous abnormality, left knee. Tricompartmental left knee DJD with moderate narrowing of the lateral and patellofemoral compartments. (Outside) **Left Knee: MRI of Left Knee W/o Contrast-** MRI demonstrates large ununited bony density in the posterolateral soft tissues about the knee with adjacent surrounding soft tissue edema. There is an adjacent bony projection from the posterior aspect of the proximal tibia laterally. This bony density may have arisen from prior fracture of the adjacent bony excrescence of indeterminate age. The presence of surrounding moderate soft tissue edema suggests potential recent injury in this region or ongoing mechanical irritation. Tricompartmental osteoarthritis most severe in the lateral compartment of the knee where there is extensive high-grade cartilage loss with small reactive subchondral marrow edema and moderate marginal osteophyte formation. Extensive degeneration lateral meniscus with complex tearing body and posterior horn lateral meniscus primarily. Degeneration medial meniscus with equivocal minimal inferior surface degenerative tearing posterior horn. No ACL or PCL tear. Intact MCL and LCL. (Outside) **Impression:** • Pain in left knee • Unilateral primary osteoarthritis, left knee • Complex tear of medial meniscus, current injury, left knee, initial encounter • Complex tear of lateral meniscus, current injury, left knee, initial encounter	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Plan: **Knee:** We have had a lengthy discussion regarding the treatment options. The patient has failed conservative measures and is having pain that limits activities of daily living. At this point I feel they are candidate for a left total knee arthroplasty. We have discussed the risks, benefits and indications. The risks include but are not limited to infection, pain, stiffness and need for future surgical intervention. We have also discussed that the pain may be better or worse than before surgery. We also discussed the risk of deep vein thrombosis and the necessity of blood thinners. The patient understands the importance of therapy and that failure to perform the therapy as instructed will potentially adversely affect the outcome. The patient will consider surgery and schedule preoperative medical assessment if they wish to proceed.	
02/25/YYYY	Hospital/Provider Name	**Follow-up Visit:** **Chief Complaint:** Left knee pain **History of Present Illness:** Patient is a 55-year-old gentleman with a many year history of increasing pain and disability of his left knee secondary to severe osteoarthritis. The pain has become so significant over last 6 months or so that it is now interfering with his activities of daily living. He does have pain every day and can only ambulate short distances does with a limp. He has pain at night as well. Attempts at conservative treatment over the years to include nonsteroidal anti-inflammatories, analgesics, intra-articular cortisone and physical therapy have all failed to adequately control his symptoms. Because of this painful disabling symptoms interfering with his activities of daily living, he now wishes to discuss surgical treatment options to include left total knee arthroplasty**.** **Review of Systems** **Constitutional:** Patient has history of weight loss or gain **Eyes:** Patient has history of glasses or contacts **Cardiovascular:** Patient has history of High Blood Pressure**.** **Musculoskeletal:** Patient has history of Joint Pain, stiffness and muscular pain. **Skin:** Patient has history of sores. **Knee Exam:** **Gait**: The patient walks with a normal, non-antalgic heel to toe gait. **Posture**: Shoulders are level, iliac crests are level, normal thoracic kyphosis, normal lumbar lordosis, no lateral curvature.	32-36

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF

Inspection	Right	Left
Alignment	Normal	5-degree Varus
Swelling	Negative	Mild
Ecchymosis	Negative	Negative
Effusion	None	Mild
Atrophy	Absent	Absent
Palpation: Tenderness:	Right knee non tender	Left knee medial joint line

ROM Active	Right	Left
Flexion	135	120
Extension	0	0

Description:
Right Knee Normal pain-free active range of motion**.**
Left Knee Range of motion restricted due to pain

ROM Passive	Right	Left
Flexion	135	120
Extension	0	0

Description:
Left knee: Range of motion restricted due to pain.
Right knee: Normal pain-free passive range of motion**.**

Muscle Testing	Right	Left
Quadriceps	5/5	5/5
Hamstrings	5/5	5/5
Patella Reflex	5/5	5/5

Neurological: Normal reflexes and distal sensation.
Sensation: Intact

Exam Notes: Painful periarticular osteophytes.

Imaging:
Left Knee: Xray Knee 1-2 view- Marked tricompartmental degenerative changes. Patient has complete loss of the joint space medially and in the patellofemoral compartment. There is subchondral cysts bony sclerosis.

Impression:
Pain in left knee
Unilateral primary osteoarthritis, left knee

Impression: Severe osteoarthritis of the left knee unresponsive to conservative treatment. His medical history has been reviewed knee was examined today and does appear to be in stable optimized medical condition without any absolute contraindication to surgery. He is a candidate for left

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		total knee arthroplasty. **Plan:** The patient has significant acute pain secondary to Surgery which is not adequately controlled by alternative modalities. A prescription was written for 7-day supply of medication to address this acute pain after consulting the E-FORCSE system. The risks, benefits and side effects of the medication were discussed with the patient. An acute pain exemption is justified for this individual due to Surgery and the lack of alternative treatment options available at this time to adequately control the symptoms. I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. The options included activity modifications, use of assistive devices, glucosamine and chondroitin, NSAIDs, pain medicines, injections, bracing, and surgery. At this time, the patient is interested in a Left Total Knee Arthroplasty. We went over the surgery, post-operative care, benefits, complications, and the recovery. The risks include, but are not limited to, infection, pain, stiffness, and the need for future surgical intervention. We have also discussed that their pain may be better or worse than before surgery. We also discussed the risk of deep vein thrombosis and the necessity of blood thinners. They understand the importance of therapy and that failure to perform the therapy as instructed will potentially adversely affect the outcome. He does wish to proceed with left total knee arthroplasty and is tentatively scheduled for April 3 anticipate a 1-night hospital stay with a discharge home with home care services. We will use aspirin for DVT prophylaxis. He will be enrolled in the Depuy Press fit study.	
03/28/YYYY	Hospital/Provider Name	**X-Ray of left knee:** **Indication:** Preoperative evaluation for left total knee arthroplasty **Comparison:** 2/12/YYYY **Findings**: **Bone Density**: Normal. **Joint Spaces**: Tricompartment degenerative spurring at the articular margins. Moderate to severe medial compartment joint space narrowing. No erosion. No effusion. **Fracture**: None. **Dislocation**: None. **Soft Tissues**: No mass. **Impression**: Tricompartment osteoarthrosis with moderate to severe medial compartment Joint space narrowing.	37-38

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
04/03/YYYY	Hospital/Provider Name	**Operative Report of left total knee arthroplasty:** **Preoperative Diagnosis:** Left knee osteoarthritis**.** **Postoperative Diagnosis:** Left knee osteoarthritis**.** **Procedure Performed** Left total knee arthroplasty, posterior stabilized. Depuy Attune press fit **Type of anaesthesia:** Spinal with regional and local **Indications:** The patient has been followed for a left knee osteoarthritis which has been unresponsive to conservative, nonoperative measures. The patient is admitted for total knee arthroplasty. We have discussed at length the risks, benefits and indications of this with the risks including but not limited to infection, subsidence, stiffness, possible need for reoperation as well as medical complications including deep vein thrombosis, pulmonary embolism and death. He has stated understanding and wishes to proceed. He has consented to the Press-Fit study. **Surgeon:** XXXX, MD **Assistants:** Henry Samsoe, PA-C **Unanticipated Events/Complication:** None **Technique/Description of Procedure:** The patient was taken to the operating room and placed under successful spinal anesthesia. The patient did receive prophylactic antibiotics. At this time, a preoperative timeout was called, and appropriate side and site was identified. The left lower extremity was scrubbed with 2% iodine-alcohol scrub, draped with impervious stockinette, impervious U-sheet, an extremity sheet and a loban surgical drape over the proposed incision site. All surgeons and assistants were gowned in body exhaust suits. Outer gloves were changed after draping. The previously placed pneumatic tourniquet was inflated to 325 pounds per square inch. The anterior incision was made. This was carried down through the skin and subcutaneous tissue, dissected medially and laterally. A median parapatellar incision was made. The fat pad was removed. The soft tissues were dissected over the medial and lateral aspect of the tibia and the anterior aspect of the femur. The intramedullary guidewire was placed in the femur. The distal femur was cut at 9 mm and 5 degrees of valgus, based on the preoperative radiographs. The medial and lateral menisci were sharply removed. The anterior cruciate ligament was sectioned. The tibia was subluxed forward. The extramedullary guidewire was placed, and the tibial block pinned. This was verified with the extramedullary guide rod. The tibia was cut at 9 mm at 5 degrees posterior	39-40

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		slope at neutral Varus-valgus. At this time the extension gap was identified with the spacer block and full extension was obtained. The femur was then sized with the femoral sizer and was sized to 7. A posterior cut was made, and flex ion extension balance was obtained at this time. Anterior and chamfer cuts were then made. A femoral box cut was also made at this time. At this time the tibia was subluxed again forward and was sized to 8. The tibia was broached and punched. The 6 mm insert was placed. The femoral trial was placed, and the knee showed good stability to Varus and valgus stress in both flexion and extension. The patella was grasped with the patellar clamp and cut at 9 mm. This was sized to a 38 mm trial. This was drilled and tracked nicely in the midline. The patellar height was recreated. Trial components were removed. The knee was copiously irrigated with antibiotic irrigation and Pulsavac lavage system. Posterior capsule injected with local anesthesia. The tibia was subluxed forward and the knee copiously irrigated. Using bone slurry, the tibia was Press-Fit. In a similar fashion the femur was also Press-Fit. The 6 mm insert was placed. The patella was cemented at this time. Once the patella had been cemented, the tourniquet was let down. Total tourniquet time was 29 minutes. Bleeding was controlled by electrocauterization. Once the cement had cured, the knee was once again taken through range of motion with good stability to Varus and valgus stress in both flex ion and extension. The patella tracked nicely in the midline. The retinaculum was closed with #1 Vicryl. The subcutaneous tissue was closed with interrupted 2-0 Vicryl. The skin was stapled shut. The wound was dressed with Aqua gel dressing, Protouch and Ace wrap from the toes to the tourniquet. **Estimated Blood Loss:** 20 cc **Patient Condition/Disposition:** The patient was taken to the recovery room in stable condition. The patient tolerated the procedure well. All counts were reported to the surgeon as being correct. The patient had good distal capillary refill on arrival to recovery. *Related records: Flow sheets: Pdf ref: 41-60*	
04/03/YYYY	Hospital/Provider Name	**Pathology report:** **Specimen (&) Received:** Left knee bone shavings **Clinical Information:** Unilateral Primary Osteoarthritis, Left Knee **Gross Description:** Labeled "XXXX, left knee bone shavings". Received in formalin, and consists of an 11.0 x 10.0 x 6.0 cm aggregate of tan-yellow, firm granular bone fragments and soft tissue including probable synovium and meniscus. The boney resection margins are flat, firm, and granular consistent with surgical resection. The articular surfaces are white-tan, ranging from smooth to finely granular. There is extensive eburnation and extensive peripheral osteophyte	61-62

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		formation. The specimen is submitted for gross examination only per the surgeon's request. No sections are submitted. **Final Diagnosis:** • Left knee bone shavings, arthroplasty: Grossly examined and consistent with osteoarthritis (degenerative joint disease).	
04/03/YYYY	Hospital/Provider Name	**Consultation Report:** **Reason For Consultation:** Assistance in the medical management **Subjective/History of Present Illness** This is a 55-year-ald gentleman who has failed conservative management for the treatment of the osteoarthritis involving the left knee. Patient was brought to the hospital by Orthopedic surgery and had the left total knee arthroplasty done. Patient is admitted the hospital for further workup. He denies having any fever chills, dizziness cough congestion diaphoresis nausea vomiting. **Physical exam:** **Musculoskeletal:** Limited range of motion in the left knee wrapped in the Ace wrap with positive distal pulses **Clinical Impression and Recommendation:** Severe osteoarthritis involving the left knee Status post left total knee arthroplasty **Plan:** • Postoperative care • DVT and GI prophylaxis • Pain control • Correct electrolytes • Discharge planning	63-65
04/25/YYYY	Hospital/Provider Name	**Initial physical therapy visit:** **Diagnosis:** • Unilateral primary osteoarthritis left knee • Aftercare following joint replacement surgery • Pain in left knee **Subjective Comments:** Patient reports to physical therapy status post Left TKA on April 3rd of YYYY secondary to severe knee OA and meniscus pathology per patient. Patient had about 2 weeks of HH rehabilitation (Dr. XXXX). Patient continues to perform exercises that were prescribed by HH physical therapist without complaint. Patient would like to improve overall function of left knee by improving his walking tolerance without AD (currently uses single point cane R) improves his ability to negotiate uneven terrain and ascend/ descend stairs and curbs. Patient plans to have right TKA	66-71

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		after rehabilitation on left in 3-4 months **Prior Functional Status:** Independent with no pain or limitation in ambulation. IADL's. work or recreation **Rehabilitative Prognosis:** Good rehab potential to reach the established goals **Reason for Referral:** Decreased functional ability **Specific joints: Initial evaluation level** **Hip: Right, left- Strength** Flexion: 4, 4+ Extension: 4-, 4- Abduction: 3+, 3+ **Knee: Right, left- Strength** Flexion: 4, 4 Extension: 4, 4+ **Knee: Right, left- Active ROM** Flexion: 110, 84 degree Extension: 0, -14 degree **Knee: Right, left- Passive ROM** Flexion: 115, 95 degree Extension: 0, -11 degree **Knee Comments: LEFS: 18/80** **Observations/Posture:** Incision site clean and healing well, surgical tare 111 place distal incision. Slight erythema noted peri-incision. Knee Varus R>L **Girth measurement:** R knee at joint line: 46 cm, knee at joint line 49cm **Sensation:** Slightly reduced sensation to Light touch on lateral knee structures as compared to c/l R side **Palpation:** TTP distal quadriceps. popliteal fossa L **MMTs:** Pain in R knee with knee extension and flexion **MLT/Flexibility:** Gastrocs/hamstrings/hip external rotators and quadriceps moderate restrictions Left mild-moderate R **Patellar mobility:** Normalized with no pain **Gail analysis:** Slight gait antalgia with reduced stance time on lower left extremity using Single point cane on R Showing good cane advancement and technique. **Functional tests:** Sit to stand increased WS to Right Iowa extremity, excess forward trunk lean. Use of upper extremity assist **Impairment Observations:** The patient's presentation is consistent with the referring diagnosis and displays signs and symptoms of I. TKA on April 3rd	

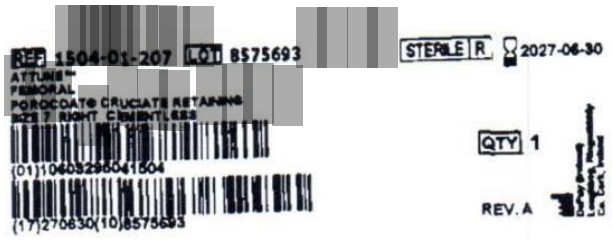
DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		of YYYY secondary to knee pain from severe OA and meniscal pathology. The patient also demonstrates knee joint mobility restrictions, Posterior chain tightness, Lower extremity weakness, slight knee joint swelling postural deficits, and impaired movement/gait mechanics evident during range of motion/mobility assessment. MLTs, MMTs, observation and functional movement/gait assessment. The patient also displays limitations or R knee that were evident during in initial exam and arc outlined in objective measures/physical lindi1tgs. The patient is currently presenting at a low complexity level based off the number of comorbidities, number of elements, to address as well as the stable state of diagnosis. Due to the impairments listed above skilled physical therapy medically necessary. utilizing the therapeutic contents outlined in the plan of care in order to restore the patients independent function and improve overall quality of life **Interventions**: • Physical therapy evaluation- moderate complexity • Balance and coordination • Dynamic activity • Electrical stimulation • Gait training • Hot or cold packs • Manual therapy • Self/home training • Therapeutic exercises **Frequency of PT**: Three times weekly **Durations**: 8 weeks	
04/26/YYYY-05/03/YYYY	Hospital/Provider Name	**Summary of interim physical therapy:** *(Illegible notes)* **Dates of visits available:** *04/26/YYYY, 04/27/YYYY, 05/01/019, 05/03/YYYY* Rec___, HS, ___ Heel sides, Quad, QS, SLR, therapeutic exercises	72-73
05/06/YYYY	Hospital/Provider Name	**Final physical therapy visit:** *(Illegible notes)* **Pain score**: 0/10 Rec___, HS, ___ Heel sides, Quad, QS, SLR, therapeutic exercises	73
07/08/YYYY	Hospital/Provider Name	**Follow-up Visit:** **Chief Complaint:** Right knee pain**.** **History of Present Illness:** Patient is a 55-year-old male with a many year history of increasing pain and disability of the right knee secondary to severe osteoarthritis. The pain has become so significant over last 6 months or so that it is now interfering with activities of daily living. Patient does have pain every day and can only ambulate short distances and does with a limp. Patient	74-77

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		has pain at night as well. Attempts at conservative treatment over the years to include nonsteroidal anti-inflammatories, analgesics, intra-articular cortisone and physical therapy have all failed to adequately control their symptoms. Because of the painful disabling symptoms interfering with activities of daily living patient now wishes to discuss surgical treatment options to include right total knee arthroplasty. Patient is status post successful left total knee arthroplasty 3 months ago. **Review of system:** **Musculoskeletal:** Muscular pain, joint pain and stiffness. The patient denies any arthritis, muscular weakness, stiffness or muscular pain. **Physical exam**: **Right Knee Examination** **Inspection:** 5-degree Varus deformity, no atrophy or ecchymosis, no swelling **Palpation:** there is evidence of crepitus, no effusion there is medial tenderness. **Range of Motion:** Range of motion Oto 115 degrees with pain. Strength: Strength testing is 5/5 in all muscle groups tested. Sensation: Sensations are intact. **Reflexes:** Reflexes are normal and symmetrical**.** **Special Tests:** McMurray, Apley, Anterior drawer, Lachman, Pivot shift, Valgus stress, Varus stress, Posterior sag, **Gait:** Gait is antalgic favouring the affected side**.** **Additional Exams:** **Left Lower Extremity:** Examination of the left lower extremity does not show any tenderness, deformity or injury. Range of motion is unremarkable. There is no gross instability. Well-healed left total knee scar **Right Upper Extremity:** Examination of the right upper extremity does not show any tenderness, deformity or injury. Range of motion is unremarkable. There is no gross instability. **Left Upper Extremity:** Examination of the left upper extremity does not show any tenderness, deformity or injury. Range of motion is unremarkable. There is no gross instability**.** **Outside Imaging Findings:** 5-degree Varus deformity. Bony sclerosis and osteophytes. Tricompartmental degenerative changes. **Reviewers comment: The above mentioned original reports of imaging studies are unavailable for review** **Diagnosis Codes:** Unilateral primary osteoarthritis, right knee,	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Pain in right knee **Impression:** Severe osteoarthritis of the right knee unresponsive to conservative treatment. Patient's medical history has been reviewed and patient was examined today, and patient does appear to be in stable optimize medical condition without any absolute contraindications for surgery. Patient is a candidate for right total knee arthroplasty. **Treatment Plan:** Patient screened for tobacco use and identified as a non-user of tobacco (1036F) The patient has significant acute pain secondary to Surgery which is not adequately controlled by alternative modalities. We did discuss alternative modalities for pain control. A prescription was written for 7-day supply of medication to address this acute pain after consulting the E-FORCSE system. The risks, benefits and side effects of the medication were discussed with the patient. An acute pain exemption is justified for this individual due to Surgery and the lack of alternative treatment options available at this time to adequately control the symptoms. I explained the pathology and its natural history of progression. I also explained the treatment options, including the benefits and complications of each of the options. The options included activity modifications, use of assistive devices, glucosamine and chondroitin, NSAIDs, pain medicines, injections, bracing, and surgery. At this time, the patient is interested in a Right Total Knee Arthroplasty. We went over the surgery, post-operative care, benefits, complications, and the recovery. The risks include, but are not limited to, infection, pain, stiffness and the need for future surgical intervention. We have also discussed that their pain may be better or worse than before surgery. We also discussed the risk of deep vein thrombosis and the necessity of blood thinners. They understand the importance of therapy and that failure to perform the therapy as instructed will potentially adversely affect the outcome. Patient does wish to proceed with right total knee arthroplasty and is tentatively scheduled for July 23rd. We will use Depuy press fit system to match his other knee. We will use aspirin for DVT prophylaxis. I anticipate a 1-night hospital stay. Because of intolerance to oxycodone we will use hydrocodone. The patient was prescribed Norco 7.5 mg-325 mg.	
07/16/YYYY	Hospital/Provider Name	**X-Ray of right knee:** **Indication:** Right knee pain. Arthritis. Preop **Comparison:** None **Findings:** **Bone Density:** Normal. **Joint Spaces:** Tricompartmental osteophytosis. Advanced medial	78-81

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		compartment joint space narrowing. **Fracture:** None. **Dislocation:** None. **Soft Tissues:** Unremarkable. **Impression:** 1. Advanced degenerative arthritis most severe medial compartment of knee where severe joint space narrowing with marginal osteophyte formation is present. 2. No significant effusion. 3. No acute fracture or dislocation	
07/23/YYYY	Hospital/Provider Name	**Operative Report of right total knee arthroplasty:** **Preoperative Diagnosis:** Right knee osteoarthritis. **Postoperative Diagnosis:** Right knee osteoarthritis. **Procedure Performed** Right total knee arthroplasty, posterior stabilized. Depuy Attune press fit **Type of anaesthesia:** Spinal with regional and local **Indications:** The patient has been followed for a right knee osteoarthritis which has been unresponsive to conservative, nonoperative measures. The patient is admitted for total knee arthroplasty. We have discussed at length the risks, benefits and indications of this with the risks including but not limited to infection, subsidence, stiffness, possible need for reoperation as well as medical complications including deep vein thrombosis, pulmonary embolism and death. He has stated understanding and wishes to proceed. He has consented to the Press-Fit study. **Surgeon:** XXXX, MD **Assistants:** XXXX, PA-C **Unanticipated Events/Complication:** None **Technique/Description of Procedure:** The patient was taken to the operating room and placed under successful spinal anesthesia. The patient did receive prophylactic antibiotics. At this time, a preoperative timeout was called, and appropriate side and site was identified. The right lower extremity was scrubbed with 2% iodine-alcohol scrub, draped with impervious stockinette, impervious U-sheet, an extremity sheet and a loban surgical drape over the proposed incision site. All surgeons and assistants were gowned in body exhaust suits. Outer gloves were changed after draping. The previously placed pneumatic tourniquet was inflated to 325 pounds per square inch. The anterior incision was made. This was carried down through the skin and subcutaneous	82-89

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		tissue, dissected medially and laterally. A median parapatellar incision was made. The fat pad was removed. The soft tissues were dissected over the medial and lateral aspect of the tibia and the anterior aspect of the femur. The intramedullary guidewire was placed in the femur. The distal femur was cut at 10 mm and 5 degrees of valgus, based on the preoperative radiographs. The medial and lateral menisci were sharply removed. The anterior cruciate ligament was sectioned. The tibia was subluxed forward. The extramedullary guidewire was placed, and the tibial block pinned. This was verified with the extramedullary guide rod. The tibia was cut at 10 mm at 5 degrees posterior slope at neutral Varus-valgus. At this time the extension gap was identified with the spacer block and full extension was obtained. The femur was then sized with the femoral sizer and was sized to 7. A posterior cut was made, and flexion extension balance was obtained at this time. Anterior and chamfer cuts were then made. A femoral box cut was also made at this time. At this time the tibia was subluxed again forward and was sized to 8. The tibia was broached and punched. The 7 mm insert was placed. The femoral trial was placed, and the knee showed good stability to Varus and valgus stress in both flexion and extension. The patella was grasped with the patellar clamp and cut at 9 mm. This was sized to a 38 mm trial. This was drilled and tracked nicely in the midline. The patellar height was recreated. Trial components were removed. The knee was copiously irrigated with antibiotic irrigation and Pulsavac lavage system. Posterior capsule injected with local anesthesia. The tibia was subluxed forward and the knee copiously irrigated using bone slurry. The tibia was Press-Fit in a similar fashion the femur was also Press-Fit. The 7 mm insert was placed. The patella was cemented at this time. Once the patella had been cemented, the tourniquet was let down. Total tourniquet time was 25 minutes. Bleeding was controlled by electrocauterization. Once the cement had cured, the knee was once again taken through range of motion with good stability to Varus and valgus stress in both flexion and extension. The patella tracked nicely in the midline. The retinaculum was closed with #1 Strata Fix. The subcutaneous tissue was closed with interrupted 2-0 Monocryl and running 3-0 Monocryl Strata fix. The skin was closed with Prineo **Implant details:** **Description:** Implant Knee Tier 19 **Free text:** Femoral component **CatLog number:** 1504-01-207 **Lot number:** 8575693 **Manufacturer:** Depuy **Size:** 7 right **Expiration date:** 06/30/2027 **Site:** Right knee **Quantity:** 1 **Implant label:** *(Pdf ref: 155)*	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		 **Estimated Blood Loss:** 20 cc **Patient Condition/Disposition:** The patient was taken to the recovery room in stable condition. The patient tolerated the procedure well. All counts were reported to the surgeon as being correct. The patient had good distal capillary refill on arrival to recovery. *Related records: Flow sheets, anesthesia records, discharge instructions, Patient information, labs: Pdf ref: 90-152*	
07/23/YYYY	Hospital/Provider Name	**Pathology report:** **Specimen (&) Received:** Right knee bone shavings **Clinical Information:** Right Knee Osteoarthritis **Gross Description:** Labeled "XXXX, right knee bone shavings". Received in formalin, and consists of multiple irregular pieces of bone, fibrous fatty cartilaginous tissue consistent with knee components. The articular surface display marked eburnation, fibrillation and focal osteophytic lipping. The tissue has an aggregate size of 14.0 x 9.0 x 4.0 cm. The specimen is submitted for gross examination only. No sections are submitted. **Final Diagnosis:** • Right knee bone shavings, arthroplasty: Grossly examined and consistent with osteoarthritis (degenerative joint disease).	153
07/30/YYYY	Hospital/Provider Name	**Follow-up Visit:** **Subjective:** The patient returns status post right TKA performed on 07 /23/YYYY. He is approximately 1 week post op. He is complaining of increased pain in the right knee. He has complaints of swelling in the lower right leg. There is some redness around the incision site. The patient is concerned about a reaction to the dressing. He ambulates with a cane. He is here for further evaluation and treatment options. **Date of Surgery:** 7/23/YYYY **Surgical Procedure:** Right TKA	154-155

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Right Knee Examination Patient has a satisfactory gait with ambulatory aid. There is mild medial and lateral joint line tenderness. Alignment is normal. Effusion is mild. Incisions show no drainage and healing well. Range of motion is: 0° to 90° active. Stability testing is good. Neurovascular exam is normal. Calf is soft, non-tender and supple; skin is without erythema. **Imaging Orders**: 3 views of the Right knee were ordered, obtained and interpreted from an orthopedic standpoint. **Knee X rays:** Standing AP/Lateral and sunrise x-ray reveals components to be intact with good alignment. There is no evidence of loosening or abnormal wear. There is no osteolysis. I am concerned about a possibility of a mismatch with the femoral component. **Reviewer comment: The original report of above mentioned X-ray is unavailable for review** **Diagnosis Codes:** • Unilateral primary osteoarthritis, right knee • Presence of right artificial knee joint • Aftercare following joint replacement surgery **Impression:** Right TKA with some swelling and mismatch of the polyethylene. **Treatment Plan:** After reviewing his x-rays I was concerned about a possible mismatch. I did have the operative stickers reviewed. There was a posterior stabilized polyethylene with a cruciate retaining femur. I have discussed with he and his wife that the polyethylene insert does not match his femoral component. I discussed this with the knee team at Depuy. There is a slight asymmetry between the cruciate retaining femoral component and the posterior stabilized tibial insert. Given his relatively young age I do not feel comfortable observing this. We discussed changing the polyethylene versus changing the femoral component. We will make this decision intraoperatively. I think most likely we will change the femoral component. We have scheduled him for next Monday. He will see Henry preoperatively at the hospital.	
08/05/YYYY	Hospital/Provider Name	**Operative Report of Revision femoral component with polyethylene exchange right knee:** **Date of Surgery:** 08/05/YYYY. **Preoperative Diagnosis:** Right knee femoral mismatch following total knee arthroplasty.	156-161

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Postoperative Diagnosis: Same **Procedure Performed:** Revision femoral component with polyethylene exchange right knee **Type of Anesthesia:** Spinal-regional **Indications:** XXXX is a healthy gentleman who underwent a total knee arthroplasty less than 2 weeks ago. Postoperative radiographs showed a Press-Fit cruciate retaining femoral component matched with a posterior stabilized insert. We have discussed at length with he and his wife that I do not feel this is a construct that would work well in the long-term. We discussed urgent exchange to avoid any ingrowth of the porous-coated femur. His wound has been healing nicely. He is admitted today for a femoral change and possible polyethylene revision. We discussed at length the risks, benefits and indications with the risk including but not limited to infection pain, stiffness and need for future surgical intervention. He stated understanding with this and wishes to proceed. **Specimen(s):** Femoral component and polyethylene **Technique/Description of Procedure:** He was taken operating placed under spinal anesthesia. He had received prophylactic antibiotics. The right lower extremity was scrubbed 2% iodine and alcohol scrub. This was followed by draping with impervious stockinette and extremity sheet and I band surgical drape. The previously placed incision was marked. Preoperative time-out was called, and appropriate site and side identified. The tourniquet was inflated, and the anterior incision was made. The suture in the subcutaneous tissue was removed. Likewise the deep suture in the retinacular was removed. A lateral release was also performed for exposure. At this time the patella everted, and the femoral component was removed without significant difficulty. Polyethylene was removed 1st. At this time the wound was copiously irrigated the cuts did appear to be pristine and the 7 posterior stabilized femoral trial was placed. The 6 mm insert was placed. However this did seem to be somewhat loose throughout an arc of motion the 7 and the 8 were then placed with the 8 showing good stability to Varus and valgus stress in both flexion extension. At this time the trial components were removed, and the knee copiously irrigated with antibiotic irrigation pulse lavage system. The posterior capsule injected with local anesthesia and the femoral component was cemented. The 8 mm posterior stabilized insert was then placed rotating platform and the knee relocated. The knee was taken through range of motion with good stability in Varus and valgus stress throughout arc of motion and the patella tracked nicely. The tourniquet was let down with total tourniquet time of 32 minutes. At this time the knee was copiously irrigated with antibiotic irrigation and the right ankle closed with 1. Stay fix. The subcutaneous tissue was closed with 2 0 Vicryl and skin stapled shut. The	

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		wound was dressed with Aqua gel dressing and patient taken recovery in stable condition tolerated procedure well. **Implant details:** **Description:** Implant Knee Tier 19 **Free text:** Femoral component **CatLog number:** 1504-10-207 **Lot number:** 9045651 **Manufacturer:** Depuy **Size:** 7 right **Expiration date:** 01/31/2029 **Site:** Right knee **Quantity:** 1 **Comments**: Explants sent to CSR to clean before giving them to the patient/wife **Implant label:** (*Pdf ref:109)*  **Estimated Blood Loss:** 20cc *Related records: Labs, flow sheets, PACU records: Pdf ref: 162-190*	
08/05/YYYY	Hospital/Provider Name	**Consultation Report:** **Reason for Consultation:** Postop medical management **Subjective/history of present illness:** Patient is a 55 years old white male who has past medical history significant for history of her *(Should be his)* recent hospitalization at this facility for the reason of total knee arthroplasty. Patient is undergoing surgical treatment at that time with total knee arthroplasty on after which he was discharged home in a stable condition. He did have uncontrolled hypertension at that time and his medications were adjusted. Patient since then has been discharged and has been doing okay except that his knee pain has continued for which reason, he was recommended a revision of arthroplasty and patient was admitted to the hospital again for the same. He denies any chest pain or shortness of breath. He denies any fevers or chills. He has undergone surgical treatment and now I was called for postop medical management again. He denies any radiation of pain or relieving or aggravating factors except that he continues to have right	191-195

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		knee pain postoperatively. He denies any chest pain or shortness of breath or nausea vomiting or diarrhea or any headache or dizziness or diplopia or blurring of vision. **Clinical Impression and Recommendation** • Severe osteoarthritis of bilateral knees s/p L TKA 4/YYYY • S/p right TKA • History of anxiety • History of hypertension • Sinus Bradycardia - 40-50's Patient be continued on current therapy GI DVT prophylaxis will be initiated Patient be ambulated Hemoglobin and hematocrit will be followed upon Further decisions after the above	
08/06/YYYY	Hospital/Provider Name	**X-Ray of right knee:** **Indication:** Postop **Comparison:** Right knee radiograph from 7/16/YYYY **Findings:** **Bone Density:** Demineralized**.** **Joint Spaces:** Postsurgical changes of total knee arthroplasty, without periprosthetic lucency or fracture**.** **Fracture:** None**.** **Dislocation:** None**.** **Soft Tissues:** Soft tissue swelling about the knee with subcutaneous emphysema and skin staples in pace, consistent with recent surgery**.** **Impression:** **1.** Postsurgical changes of total knee arthroplasty, without complicating features.	196-199
08/07/YYYY	Hospital/Provider Name	**Discharge Summary:** **Date of admission:** 08/05/YYYY **Date of discharge:** 08/07/YYYY **Reason For Hospitalization:** Status post right total knee arthroplasty with mismatch components, history of hypertension, anxiety. There were no additional postop diagnosis. **Significant Findings From History And Exam:** The 55-year-old male, 2 weeks status post total knee arthroplasty, presented in the office for wound	200

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		issues and appeared to be a mismatch to the femoral component and polyethylene. He was recommended to go under revision of the femoral component. He presents now for that**.** With the exam on admission, a healing total knee scar with some swelling and blister at the distal portion, but otherwise moderate swelling and looks well. Neurovascular intact distally. Range of motion 0 to about 50 degrees. **Hospital Course:** Admitted electively on 08/05/YYYY, underwent revision of right total knee arthroplasty. Postop course consisted of prophylactic intravenous antibiotics, analgesics, pain control, DVT prophylaxis with aspirin, rehab for weightbearing as tolerated, range of motion. Postop course was uneventful. He was discharged home on 08/07/YYYY. We will arrange for home care services for 3 weeks for rehab and nursing care. Follow up in the office in 2 weeks. We will continue the aspirin 325 b.i.d. for DVT prophylaxis. We will use Percocet and ibuprofen as needed for pain management.	

Other records *(PDF REF)**:***

Medical bills: *201-205.*

Others: *206-235.*

Orders: *236.*

Labs: *237-238.*

Reviewer's Comments: All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence not elaborated.