DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 5891-98
23 April 2001

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 12 April 2001. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinion furnished by a designee of the Specialty Leader for Orthopedic Surgery, dated 23 February 2000, and the Director, Naval Council of Personnel Boards dated 18 December 2000, a copy of which is attached.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the advisory opinion provided by the Director, Naval Council of Personnel Boards. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official

Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

DEPARTMENT OF THE NAVY
NAVAL COUNCIL OF PERSONNEL BOARDS
WASHINGTON NAVY YARD
720 KENNON STREET SE RM 309
WASHINGTON, DC 20374-5023

IN REPLY REFER TO

5420
Ser: 00-27
18 Dec 00

From: Director, Naval Council of Personnel Boards
To: Executive Director, Board of Correction for Naval Records

Subj: REQUEST FOR COMMENTS AND RECOMMENDATION IN THE CASE OF FORMER [redacted]

Ref: (a) Chairman, BCNR JRE: jdh DN: 5891-98 ltr of 4 Oct 00
(b) SECNAVINST 1850.4D

1. This letter responds to reference (a) which requested comments and a recommendation regarding petitioner's request for correction of his records to show he was unfit at the time of his discharge from the naval service. He was discharged on 15 May 1998 for failing to meet the required weight standards. We have determined the evidence in this case does not support the petitioner's request for a change of records.

2. The petitioner's case history, contained in reference (a), was thoroughly reviewed in accordance with reference (b) and is returned. The following comments and recommendations are provided:

a. On 24 September 1994, the member suffered an anterior cruciate ligament tear. He was never able to gain complete extension of his right knee despite vigorous physical therapy and arthroscopy.

b. The service member suffered from the troublesome residuals of his knee injury. In contrast to the BCNR application, the member did have one MEB following his first surgical intervention in September of 1994 that recommended a one-year period of limited duty.

c. The arthroscopic repair of the member's ACL Deficiency left him with a persistent, frustrating, but relatively mild flexion contracture.

d. The most recent surgical attempt of record to correct the injury occurred on 28 October 1997 and appears to have resulted in mild improvement. The most recent health record entries list a contracture in the 5-8 degree range. This range is below the minimum threshold for compensability under VASRD Code 5261.

e. The service member's right knee injury may have contributed to this member's weight control problems, but was not of sufficient severity to classify him as unfit.

3. In summary, the record in this case suggests a frustrating injury that likely contributed to a more sedentary life style, but did not result in significant decrement, for disability purposes, in his ability to perform his duties. The record in this case does not support a correction of the petitioner's records to reflect he was unfit at the time of his discharge. Accordingly, the petitioner's request should be denied.

Subj: REQUEST FOR COMMENTS AND RECOMMENDATION IN THE CASE OF FORMER

[redacted]K

Acting Director

NAVAL MEDICAL CENTER
SAN DIEGO, CALIFORNIA 92134-5000

23 FEB 00

FROM: [redacted] CAPT MC USN
ORTHOPEDIC DEPARTMENT
NAVAL MEDICAL CENTER, SAN DIEGO

TO: CHAIRMAN
BOARD FOR CORRECTION OF NAVAL RECORDS

SUBJECT: REQUEST FOR COMMENTS AND RECOMMENDATIONS IN THE CASE OF FORMER [redacted]

REFERENCES:
A. Letter from the Chairman, Board of Correction of Naval Records, docket #5891-98, dated 1/5/00.
B. Letter from [redacted] to the Director of Board of Correction of Naval Records, dated 7/1/98.
C. Letter from [redacted] to the Honorable Norm Dix, dated 5/21/98.
D. The medical records of [redacted]

This letter is in response to Reference A, which requested comments and recommendations in the case of [redacted] References B, C, and D have been reviewed and the following summarization and recommendations are submitted.

References B and C were reviewed and numerous false statements were noted, which require clarification. The patient states, "I spent a year on limited duty and was cleared for full duty by his wife, a practicing Podiatrist." This statement is incorrect. The patient was returned to full duty by an Orthopedic Surgeon, [redacted]

The patient states, "I have been forced to maintain the same standard as a perfectly healthy sailor." This also is incorrect. There is documentation in the record that the patient was not required, nor did he complete the physical readiness test at any time after his surgery. This test requires the individual to run 1-1/2 miles in addition to other activities, two times per year.

The patient states, "I did not receive the medical support I should have for an injury of this magnitude." His record documents good care from the time of his injury to the time of his discharge, with appropriate referral to Physical Therapy, appropriate surgery, followed by physical therapy, and overall appropriate treatment for his injury.

PATIENT: [redacted]
SSN:



Physician Copy

The patient states that "I was the first person to undergo a notchplasty at the Bremerton Naval Hospital." This statement is also false. A notchplasty is a very common procedure performed during nearly every anterior cruciate ligament reconstruction. In addition, it is a surgery that is frequently performed in the event of graft impingement after anterior cruciate ligament reconstruction, when a patient fails to return to full extension, as in this case.

A medical record review reveals that Mr. [redacted] sustained an injury to his knee while playing basketball on 2/21/93. He was referred to Orthopedic Surgery the following day, and a diagnosis of anterior cruciate ligament injury was made. The patient was placed on crutches and referred to Physical Therapy for range of motion activities. On 3/29, he was seen back by Orthopedic Surgery; his examination confirmed anterior cruciate ligament laxity with a positive Lachman's test; however, a good endpoint was noted and it was elected to proceed with continued rehabilitation. The patient was placed on light duty and quadriceps strengthening exercises were begun. At followup on 8/20, a LIDO test, which measures strength and endurance of the muscles, revealed nearly symmetric strength of both the quadriceps and the hamstrings. Because of the perception of instability, a brace was ordered. Approximately one year later, the patient was referred again to Physical Therapy on 6/6/94, with a complaint of multiple giving-way episodes. As a result, he was scheduled for anterior cruciate ligament reconstruction. On 9/20, the patient underwent the procedure, a right knee anterior cruciate ligament reconstruction with bone-patellar tendon-bone autograft. During the procedure, a meniscal tear was found and this was debrided. After the procedure, the patient was placed on 30 days of convalescent leave. In addition, he was placed on a Limited Duty Board for a period of 12 months. He was protected postoperatively in a Bledsoe-type brace. At his first followup on 9/28/94, the patient was referred to Physical Therapy. His motion at that time was 0-100 degrees of flexion. This is considered good motion one week postoperatively. On 9/30, his sutures were removed; range of motion at that time was noted to be 0-95 degrees. Physical therapy was continued.

On 10/25, approximately one month postoperatively, the patient was noted to be improving with the therapy. His pain had decreased to 2/10; however, his motion, specifically full extension, had decreased. His motion was measured at 5 degrees to 115 degrees. This indicates that the patient lacked 5 degrees of full extension. He was continued in therapy and his motion improved. On 11/2, motion was noted to be 2 degrees to 100 degrees of flexion. At that time, a DonJoy anterior cruciate ligament functional brace was ordered. At further followup on 11/8 and then again on 2/7/95, a 5-degree flexion contracture was

again noted. Maximum flexion had increased to 130 degrees, as expected.

On 5/5/95, the patient had a reinjury when he slipped and injured his knee. He was seen in Orthopedics on 5/9/95; range of motion at that time was 15 degrees to 135 degrees of flexion. No instability was noted. X-rays and a Dyna splint were ordered. A Dyna splint is a dynamic splint which will aid a patient in returning to full extension of the knee. In addition, poor patellar mobility was noted. A diagnosis of "arthrofibrosis" was made. The patient was referred back to the original Surgeon, with a recommended debridement procedure. At followup in the Orthopedic Clinic, it was decided to continue with therapy as recommended, and on 11/2, the patient was seen by [redacted] the Surgeon's wife, who is also an Orthopedic Surgeon. She noted that the patient was still unable to run greater than one-quarter mile; however, recommended return to full duty at that time. At this point, the patient had been on limited duty for over one year.

The patient was transferred to Bremerton, Washington on 5/9/96. He was referred to Orthopedic Surgery there, complaining of popping, pain, and swelling. An examination revealed a 1+ Lachman test and a 10-degree flexion contracture. The patient was again referred to Physical Therapy for range of motion exercises.

Approximately one year later, on 4/24/97, the patient had still not run the physical readiness test. He was referred to Orthopedics for evaluation and was found to have a 12-degree flexion contracture, and at that time he was scheduled for arthroscopic surgery.

On 5/10/97, he underwent arthroscopic surgery with debridement of soft tissues and a bony notchplasty. This is a procedure which creates more room for the anterior cruciate ligament graft and prevents impingement anteriorly when the leg is brought into full extension. Postoperatively, the patient was treated with serial casting to attempt to stretch the soft tissues and bring the patient into full extension. At his first visit nine days postoperatively, range of motion was noted to be 16 degrees to 138 degrees. Slowly over time, his extension improved to 9 degrees; this was documented on 7/23/97. At that time, the casting was discontinued and dynamic stretching with prone hangs was recommended. Because the extension did not significantly improve over time, the patient was referred to Dr. Covey, a Sports Medicine Specialist. He felt that the problem was anterior placement of the graft on the tibial side. After discussion with the patient, it was recommended that the graft be excised and motion be regained, and then consider reconstructing the ligament at a later date.

On 10/21/97, the patient underwent a graft excision, as well as soft tissue debridement from the anterior portion of the joint. Again noted was the partial meniscectomy of the medial meniscus during that arthroscopy. Again, serial casting was attempted, and the patient's motion improved with time. On 1/23/98, extension had improved to 8 degrees, and on 3/11/98, which appears to be his last orthopedic visit prior to discharge, range of motion was noted to be 3 degrees to 143 degrees of flexion. There was a positive Lachman's test. In addition, the patient was noted to have patellofemoral findings consistent with the chondromalacia of the patella, which had been noticed at previous arthroscopy. The patient ultimately underwent Administrative Separation from the Navy, because he failed to maintain weight standards. Surgery was discussed at that final visit. The Surgeons recommended reconstruction with hamstring autograft, and the patient refused further surgery.

It is my opinion that the patient was treated appropriately. The most likely reason for failure to regain full extension after his first surgery was that the tibial channel was created more anteriorly than desired. This statement is based solely on review of the records, as I have no x-rays to review and no patient to examine. Heroic attempts were made to return motion to normal and nearly normal motion was documented at the patient's final visit. It is difficult to say at this point, what disability the patient has. However, it would be expected that the patient currently may have patellofemoral pain secondary to chondromalacia of the patellofemoral joint, which was noted at arthroscopy. He may have instability because of the resection of the anterior cruciate ligament graft. Motion has been returned to a functional level. It is my opinion that it would have been reasonable to refer this patient to the Physical Evaluation Board for a disposition, because of his lack of function; however, Administration Separation was performed prior to this becoming an issue. Because it is likely that the patient continues to have some disability, it is recommended that his records be amended to reflect that he left the Navy with this disability, and a physical examination of the patient would be beneficial in determining the extent of his disability.

[redacted]CAPT MC USN,

CC: [redacted]S CAPT MC USN
ORTHOPEDIC DEPARTMENT

PML:EDiX11045
D: 02/23/00 11:00 T: 02/24/00 07:23 DOCUMENT: 200002230799800400

PATIENT: [redacted]
SSN:



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**Physician Copy**