Reference Determination Content

Example document — fictitious patient. A suggested draft determination prepared by the Veterans Health Centre from the matching example Diagnostic Assessment, to show how a DVA delegate could determine the claim. Names, dates, service details and clinicians are invented. It is not a decision of the Department of Veterans' Affairs.

Bilateral Knees - Bursitis / Knee Pain

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- An outpatient health record and dermatology letter by the medical officer and dermatologist, dated 15 April 2008;
- A field injury report and physiotherapy notes by the medical officer, dated 11 June 2009;
- A rheumatology consultation by the rheumatologist, dated 5 March 2010;
- An X-ray left knee by the radiologist, dated 17 August 2011;
- A role 2 operation note by the surgeon, Afghanistan, dated 12 September 2012;
- A post-operational medical examination by the medical officer, dated 18 September 2012;
- An operation note by the surgeon, Garrison hospital, dated 26 September 2012;
- An admission record and microbiology report by the medical officer, dated 9 October 2012;
- Ultrasound both knees by the radiologist, dated 10 October 2012;
- An MRI left knee and sports medicine consultation by the sports physician, dated 5 November 2012;
- An operation note by the orthopaedic surgeon, dated 3 August 2016;
- An admission record and microbiology report by the medical officer, dated 12 August 2016;
- Ultrasound both knees and X-ray left knee by the radiologist, dated 15 August 2016;
- A discharge medical examination by the medical officer, dated 3 November 2021.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

20 January 1998 and 3 November 2021

Bilateral Knees - Bursitis / Knee Pain

You have stated that your condition was caused by:

- *for knee bursitis other than prepatellar and superficial infrapatellar bursitis, running or jogging an average of at least 60 kilometres per week for the four weeks before the clinical onset of knee bursitis*
- *for prepatellar bursitis or superficial infrapatellar bursitis only, working whilst kneeling, crawling or pressing the anterior knee against a hard vertical surface for a cumulative period of at least 60 hours within the two months before the clinical onset of knee bursitis*
- *for medial collateral ligament bursitis only, pressing the medial side of the knee against a hard surface for a cumulative period of at least 60 hours within the two months before the clinical onset of knee bursitis*
- *having trauma to the affected knee bursa in the 30 days before the clinical onset of knee bursitis*
- *having surgery to the knee of the affected side in the 30 days before the clinical onset of knee bursitis*
- *having a bacterial, fungal or algal infection of the affected knee bursa at the time of the clinical onset of knee bursitis*
- *for septic knee bursitis only, being in an immunocompromised state as specified at the time of the clinical onset of knee bursitis*
- *for prepatellar, superficial infrapatellar or pretibial bursitis only, having psoriasis, atopic dermatitis or other inflammatory skin disorder, where the skin disorder involves the skin of the extensor surface of the affected knee, at the time of the clinical onset of knee bursitis*
- *having a disease from the specified list of diseases at the time of the clinical onset of knee bursitis*

Diagnosis: Bursitis / Knee Pain

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by ultrasound both knees by the radiologist, dated 10 October 2012.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Knee Bursitis (Balance of Probabilities) (No. 66 of 2018)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *for knee bursitis other than prepatellar and superficial infrapatellar bursitis, running or jogging an average of at least 60 kilometres per week for the four weeks before the clinical onset of knee bursitis*
- *for prepatellar bursitis or superficial infrapatellar bursitis only, working whilst kneeling, crawling or pressing the anterior knee against a hard vertical surface for a cumulative period of at least 60 hours within the two months before the clinical onset of knee bursitis*
- *for medial collateral ligament bursitis only, pressing the medial side of the knee against a hard surface for a cumulative period of at least 60 hours within the two months before the clinical onset of knee bursitis*
- *having trauma to the affected knee bursa in the 30 days before the clinical onset of knee bursitis*
- *having surgery to the knee of the affected side in the 30 days before the clinical onset of knee bursitis*
- *having a bacterial, fungal or algal infection of the affected knee bursa at the time of the clinical onset of knee bursitis*
- *for septic knee bursitis only, being in an immunocompromised state as specified at the time of the clinical onset of knee bursitis*
- *for prepatellar, superficial infrapatellar or pretibial bursitis only, having psoriasis, atopic dermatitis or other inflammatory skin disorder, where the skin disorder involves the skin of the extensor surface of the affected knee, at the time of the clinical onset of knee bursitis*
- *having a disease from the specified list of diseases at the time of the clinical onset of knee bursitis*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with a hot, red, painful swelling over the front of the right knee with fever, and aching pain, tenderness and swelling on the inner side of the left knee just below the joint, worse with running, stairs and lying with the knees together on 9 October 2012.

The diagnosis was confirmed on the right by aspiration of the prepatellar bursa on 9 October 2012, which yielded turbid fluid growing Staphylococcus aureus, and by ultrasound on 10 October 2012 showing complex collections in the prepatellar and superficial infrapatellar bursae with hyperaemia. On the left, ultrasound and MRI of 5 November 2012 showed fluid distension of the pes anserine, medial collateral ligament and semimembranosus-tibial collateral ligament bursae. This meets the Statement of Principles definition of knee bursitis as inflammation or infection of a bursa around the knee joint, and the collections were not popliteal cysts.

This has then led to further investigations and the diagnosis of your condition of *Bursitis / Knee Pain*. I have accepted your condition of *Bursitis / Knee Pain*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that this condition is related to your peacetime service.

I have therefore accepted that this condition is related to your service with effect from 8 October 2012.

Bilateral Knees - Bursitis / Knee Pain (Worsening)

Evidence

The evidence that I have considered in making this decision includes:

- Formal Claim with supporting statements;
- A Statement of your Service from the Department of Defence;
- Copies of your Service Medical Records.
- A Diagnostic Assessment by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 18 June 2025;
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- An X-ray left knee by the radiologist, dated 17 August 2011;
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- A post-operational medical examination by the medical officer, dated 18 September 2012;
- An operation note by the surgeon, Garrison hospital, dated 26 September 2012;
- An admission record and microbiology report by the medical officer, dated 9 October 2012;
- Ultrasound both knees by the radiologist, dated 10 October 2012;
- An MRI left knee and sports medicine consultation by the sports physician, dated 5 November 2012;
- An operation note by the orthopaedic surgeon, dated 3 August 2016;
- An admission record and microbiology report by the medical officer, dated 12 August 2016;
- Ultrasound both knees and X-ray left knee by the radiologist, dated 15 August 2016;
- A discharge medical examination by the medical officer, dated 3 November 2021.

Your service

I have identified that you have the following service:
Australian Defence Force service between :

20 January 1998 and 3 November 2021

Bilateral Knees - Bursitis / Knee Pain (Worsening)

You have stated that the worsening of your condition was caused by:

- *for knee bursitis other than prepatellar and superficial infrapatellar bursitis, running or jogging an average of at least 60 kilometres per week for the four weeks before the clinical worsening of knee bursitis*
- *for prepatellar bursitis or superficial infrapatellar bursitis only, working whilst kneeling, crawling or pressing the anterior knee against a hard vertical surface for a cumulative period of at least 60 hours within the two months before the clinical worsening of knee bursitis*
- *for medial collateral ligament bursitis only, pressing the medial side of the knee against a hard surface for a cumulative period of at least 60 hours within the two months before the clinical worsening of knee bursitis*
- *having trauma to the affected knee bursa in the 30 days before the clinical worsening of knee bursitis*
- *having surgery to the knee of the affected side in the 30 days before the clinical worsening of knee bursitis*
- *having a bacterial, fungal or algal infection of the affected knee bursa at the time of the clinical worsening of knee bursitis*
- *for septic knee bursitis only, being in an immunocompromised state as specified at the time of the clinical worsening of knee bursitis*
- *for prepatellar, superficial infrapatellar or pretibial bursitis only, having psoriasis, atopic dermatitis or other inflammatory skin disorder, where the skin disorder involves the skin of the extensor surface of the affected knee, at the time of the clinical worsening of knee bursitis*
- *having a disease from the specified list of diseases at the time of the clinical worsening of knee bursitis*
- *inability to obtain appropriate clinical management for knee bursitis*

Diagnosis: Bursitis / Knee Pain (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 18 June 2025, and is supported by ultrasound both knees by the radiologist, dated 10 October 2012.

I am satisfied this is the appropriate diagnosis.
In determining your claim for this condition, I have applied the SOP:

Statement of Principles concerning Knee Bursitis (Balance of Probabilities) (No. 66 of 2018)

which sets out the factors that can connect the condition with service.

I am satisfied that you have met the following factor:

- *for knee bursitis other than prepatellar and superficial infrapatellar bursitis, running or jogging an average of at least 60 kilometres per week for the four weeks before the clinical worsening of knee bursitis*

- *for prepatellar bursitis or superficial infrapatellar bursitis only, working whilst kneeling, crawling or pressing the anterior knee against a hard vertical surface for a cumulative period of at least 60 hours within the two months before the clinical worsening of knee bursitis*
- *for medial collateral ligament bursitis only, pressing the medial side of the knee against a hard surface for a cumulative period of at least 60 hours within the two months before the clinical worsening of knee bursitis*
- *having trauma to the affected knee bursa in the 30 days before the clinical worsening of knee bursitis*
- *having surgery to the knee of the affected side in the 30 days before the clinical worsening of knee bursitis*
- *having a bacterial, fungal or algal infection of the affected knee bursa at the time of the clinical worsening of knee bursitis*
- *for septic knee bursitis only, being in an immunocompromised state as specified at the time of the clinical worsening of knee bursitis*
- *for prepatellar, superficial infrapatellar or pretibial bursitis only, having psoriasis, atopic dermatitis or other inflammatory skin disorder, where the skin disorder involves the skin of the extensor surface of the affected knee, at the time of the clinical worsening of knee bursitis*
- *having a disease from the specified list of diseases at the time of the clinical worsening of knee bursitis*
- *inability to obtain appropriate clinical management for knee bursitis*

I have noted your contention as to the cause of this condition. The available evidence indicates, I have noted your contention to the cause of your condition. Your service medical records indicate that you presented to the health facility with a hot, red, painful swelling over the front of the right knee with fever, and aching pain, tenderness and swelling on the inner side of the left knee just below the joint, worse with running, stairs and lying with the knees together on 9 October 2012.

The diagnosis was confirmed on the right by aspiration of the prepatellar bursa on 9 October 2012, which yielded turbid fluid growing Staphylococcus aureus, and by ultrasound on 10 October 2012 showing complex collections in the prepatellar and superficial infrapatellar bursae with hyperaemia. On the left, ultrasound and MRI of 5 November 2012 showed fluid distension of the pes anserine, medial collateral ligament and semimembranosus-tibial collateral ligament bursae. This meets the Statement of Principles definition of knee bursitis as inflammation or infection of a bursa around the knee joint, and the collections were not popliteal cysts.

After the condition arose, it was worsened during your service. In the four weeks before the worsening, from 15 July 2016 to 12 August 2016, you ran an average of about 62 kilometres a week, on the base perimeter in Iraq until 20 July 2016 and then on the battalion program after your return, before the bursectomy of 3 August 2016 and resuming briefly against advice. Within the two months before the worsening, from 12 June 2016 to 12 August 2016, you knelt on gravel ranges for about four hours a day instructing partner-force soldiers in marksmanship in Iraq until

20 July 2016, more than 100 hours, and knelt to unpack and clean stores for about 30 hours after your return before surgery. Within the two months before the worsening, from 12 June 2016 to 12 August 2016, you rode all-terrain vehicles around the range complex in Iraq for about three hours a day with the inner side of your left knee pressed against the vehicle frame, a cumulative period of more than 90 hours. On 14 July 2016, 29 days before the worsening, you knelt onto a metal fragment on the range, bruising the skin over the right prepatellar bursa, and the handlebar of an all-terrain vehicle struck and lacerated the inner side of your left knee over the pes anserine bursa. The left medial knee laceration was surgically sutured at the role 2 facility on 15 July 2016, and an elective right prepatellar bursectomy was performed at a garrison hospital on 3 August 2016, 28 days and nine days before the worsening on 12 August 2016. The wound swab and bursal aspirate of 12 August 2016 grew Staphylococcus aureus, a bacterial infection of the affected right knee bursa present at the worsening. The recurrent right knee bursitis was septic, and you were still taking methotrexate 15 mg weekly, an immunosuppressive drug, when it worsened on 12 August 2016. Psoriatic plaques over both knees were recorded at the bursectomy of 3 August 2016 and the admission of 12 August 2016, involving the extensor surface of the affected right knee at the worsening. Psoriatic arthropathy remained active, requiring methotrexate and with a raised C-reactive protein, when the bursitis worsened on 12 August 2016. During warlike service in Iraq from February to July 2016 you had no access to ultrasound, rheumatology review or the blood monitoring required for methotrexate, and your recurrent knee swelling was treated with simple analgesia until you returned to Australia.

This has then led to further investigations and the diagnosis of your condition of *Bursitis / Knee Pain (Worsening)*. I have accepted your condition of *Bursitis / Knee Pain (Worsening)*.

Having considered your service records and the available medical evidence, I am satisfied the SOP is met and that the worsening of this condition is related to your peacetime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 12 August 2016.

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