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.

Left Knee - Patellar Tendinopathy

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 22 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 May 2025;
- A deployed health record and serology by the medical officer, Solomon Islands, dated 21 August 2006;
- A transplant operation report and discharge summary by the renal physician, dated 16 September 2009;
- An endocrinology consultation by the endocrinologist, dated 14 June 2010;
- A deployed health record by the medical officer, Middle East, dated 20 February 2013;
- A deployed health record by the medical officer, Middle East, dated 10 March 2013;
- An ultrasound and dual-energy CT left knee by the radiologist, role 2 facility, dated 20 March 2013;
- A sports medicine consultation by the sports physician, dated 14 October 2013;
- A procedure record by the contracted medical practitioner, Iraq, dated 8 April 2016;
- An ultrasound left knee by the radiologist, role 2 hospital, Iraq, dated 18 April 2016;
- An MRI left knee and orthopaedic consultation by the orthopaedic surgeon, dated 20 June 2016.

Your service

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

3 February 2004 and 28 June 2019

Left Knee - Patellar Tendinopathy

You have stated that your condition was caused by:

- *running or jogging an average of at least 30 kilometres per week for at least the four weeks before the clinical onset of patellar tendinopathy*
- *undertaking weight bearing exercise involving jumping or repeated flexion and extension of the affected knee, at a minimum intensity greater than six METs for at least four hours per week, for at least the four weeks before the clinical onset of patellar tendinopathy*
- *increasing the frequency, duration or intensity of weight bearing activity involving the affected knee by at least 100 percent, to a minimum intensity of five METs for at least two hours per day, within the seven days before the clinical onset of patellar tendinopathy*
- *having direct trauma to the patellar tendon of the affected knee at the time of the clinical onset of patellar tendinopathy*
- *having gout of the patellar tendon or distal quadriceps tendon at the time of the clinical onset of patellar tendinopathy*
- *being treated with a glucocorticoid drug as specified before the clinical onset of patellar tendinopathy*
- *being treated with a fluoroquinolone antibiotic within the 60 days before the clinical onset of patellar tendinopathy*
- *for distal quadriceps tendinopathy or rupture only, being treated with atorvastatin for at least three months within the one year before the clinical onset of patellar tendinopathy*
- *for patellar tendon or distal quadriceps tendon rupture only: having diabetes mellitus at the time of the clinical onset of patellar tendinopathy*
- *for patellar tendon or distal quadriceps tendon rupture only: having chronic renal failure at the time of the clinical onset of patellar tendinopathy*

Diagnosis: Patellar Tendinopathy

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 May 2025, and is supported by an ultrasound and dual-energy CT left knee by the radiologist, role 2 facility, dated 20 March 2013.

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

Statement of Principles concerning Patellar Tendinopathy (Reasonable Hypothesis) (No. 21 of 2020)

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

I am satisfied that you have met the following factor:

- *running or jogging an average of at least 30 kilometres per week for at least the four weeks before the clinical onset of patellar tendinopathy*
- *undertaking weight bearing exercise involving jumping or repeated flexion and extension of the affected knee, at a minimum intensity greater than six METs for at least four hours per week, for at least the four weeks before the clinical onset of patellar tendinopathy*
- *increasing the frequency, duration or intensity of weight bearing activity involving the affected knee by at least 100 percent, to a minimum intensity of five METs for at least two hours per day, within the seven days before the clinical onset of patellar tendinopathy*
- *having direct trauma to the patellar tendon of the affected knee at the time of the clinical onset of patellar tendinopathy*
- *having gout of the patellar tendon or distal quadriceps tendon at the time of the clinical onset of patellar tendinopathy*
- *being treated with a glucocorticoid drug as specified before the clinical onset of patellar tendinopathy*
- *being treated with a fluoroquinolone antibiotic within the 60 days before the clinical onset of patellar tendinopathy*
- *for distal quadriceps tendinopathy or rupture only, being treated with atorvastatin for at least three months within the one year before the clinical onset of patellar tendinopathy*
- *for patellar tendon or distal quadriceps tendon rupture only: having diabetes mellitus at the time of the clinical onset of patellar tendinopathy*
- *for patellar tendon or distal quadriceps tendon rupture only: having chronic renal failure at the time of the clinical onset of patellar tendinopathy*

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 pain localised to the inferior pole of the left patella, worse with jumping, running, squatting and descending stairs, with stiffness after rest and focal tendon tenderness on 10 March 2013.

The diagnosis was confirmed by ultrasound of the left knee on 20 March 2013, which showed thickening and hypoechoic change of the proximal patellar tendon with neovascularity, together with urate deposits in the tendon on dual-energy CT. With pain and tenderness localised to the patellar tendon and worse with activity, this meets the Statement of Principles definition of patellar tendinopathy: an acquired clinically symptomatic condition involving inflammation or degeneration of the patellar tendon. The excluded conditions, such as Osgood-Schlatter disease, Sinding-Larsen-Johansson syndrome and patellar tendon enthesopathy, were not present.

This has then led to further investigations and the diagnosis of your condition of *Patellar Tendinopathy*. I have accepted your condition of *Patellar Tendinopathy*.

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 wartime service.

I have therefore accepted that this condition is related to your service with effect from 9 March 2013.

Left Knee - Patellar Tendinopathy (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 22 May 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 22 May 2025;
- A deployed health record and serology by the medical officer, Solomon Islands, dated 21 August 2006;
- A transplant operation report and discharge summary by the renal physician, dated 16 September 2009;
- An endocrinology consultation by the endocrinologist, dated 14 June 2010;
- A deployed health record by the medical officer, Middle East, dated 20 February 2013;
- A deployed health record by the medical officer, Middle East, dated 10 March 2013;
- An ultrasound and dual-energy CT left knee by the radiologist, role 2 facility, dated 20 March 2013;
- A sports medicine consultation by the sports physician, dated 14 October 2013;
- A procedure record by the contracted medical practitioner, Iraq, dated 8 April 2016;
- An ultrasound left knee by the radiologist, role 2 hospital, Iraq, dated 18 April 2016;
- An MRI left knee and orthopaedic consultation by the orthopaedic surgeon, dated 20 June 2016.

Your service

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

3 February 2004 and 28 June 2019

Left Knee - Patellar Tendinopathy (Worsening)

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

- *running or jogging an average of at least 30 kilometres per week for at least the four weeks before the clinical worsening of patellar tendinopathy*
- *undertaking weight bearing exercise involving jumping or repeated flexion and extension of the affected knee, at a minimum intensity greater than six METs for at least four hours per*

week, for at least the four weeks before the clinical worsening of patellar tendinopathy

- *increasing the frequency, duration or intensity of weight bearing activity involving the affected knee by at least 100 percent, to a minimum intensity of five METs for at least two hours per day, within the seven days before the clinical worsening of patellar tendinopathy*
- *having direct trauma to the patellar tendon of the affected knee at the time of the clinical worsening of patellar tendinopathy*
- *having gout of the patellar tendon or distal quadriceps tendon at the time of the clinical worsening of patellar tendinopathy*
- *being treated with a glucocorticoid drug as specified before the clinical worsening of patellar tendinopathy*
- *being treated with a fluoroquinolone antibiotic within the 60 days before the clinical worsening of patellar tendinopathy*
- *for distal quadriceps tendinopathy or rupture only, being treated with atorvastatin for at least three months within the one year before the clinical worsening of patellar tendinopathy*
- *inability to obtain appropriate clinical management for patellar tendinopathy*

Diagnosis: Patellar Tendinopathy (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 22 May 2025, and is supported by an ultrasound and dual-energy CT left knee by the radiologist, role 2 facility, dated 20 March 2013.

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

Statement of Principles concerning Patellar Tendinopathy (Reasonable Hypothesis) (No. 21 of 2020)

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

I am satisfied that you have met the following factor:

- *running or jogging an average of at least 30 kilometres per week for at least the four weeks before the clinical worsening of patellar tendinopathy*
- *undertaking weight bearing exercise involving jumping or repeated flexion and extension of the affected knee, at a minimum intensity greater than six METs for at least four hours per week, for at least the four weeks before the clinical worsening of patellar tendinopathy*
- *increasing the frequency, duration or intensity of weight bearing activity involving the affected knee by at least 100 percent, to a minimum intensity of five METs for at least two hours per day, within the seven days before the clinical worsening of patellar tendinopathy*
- *having direct trauma to the patellar tendon of the affected knee at the time of the clinical worsening of patellar tendinopathy*

- *having gout of the patellar tendon or distal quadriceps tendon at the time of the clinical worsening of patellar tendinopathy*
- *being treated with a glucocorticoid drug as specified before the clinical worsening of patellar tendinopathy*
- *being treated with a fluoroquinolone antibiotic within the 60 days before the clinical worsening of patellar tendinopathy*
- *for distal quadriceps tendinopathy or rupture only, being treated with atorvastatin for at least three months within the one year before the clinical worsening of patellar tendinopathy*
- *inability to obtain appropriate clinical management for patellar tendinopathy*

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 pain localised to the inferior pole of the left patella, worse with jumping, running, squatting and descending stairs, with stiffness after rest and focal tendon tenderness on 10 March 2013.

The diagnosis was confirmed by ultrasound of the left knee on 20 March 2013, which showed thickening and hypoechoic change of the proximal patellar tendon with neovascularity, together with urate deposits in the tendon on dual-energy CT. With pain and tenderness localised to the patellar tendon and worse with activity, this meets the Statement of Principles definition of patellar tendinopathy: an acquired clinically symptomatic condition involving inflammation or degeneration of the patellar tendon. The excluded conditions, such as Osgood-Schlatter disease, Sinding-Larsen-Johansson syndrome and patellar tendon enthesopathy, were not present.

After the condition arose, it was worsened during your service. The 62 km a week of running in the four weeks before the worsening was performed on warlike service in Iraq. The seven hours a week of jumping and squat-based instruction in the four weeks before the worsening was performed on warlike service in Iraq. The increase to four and a half hours a day of weight-bearing instruction from 13 April 2016 occurred on warlike service in Iraq within the seven days before the worsening. The fall onto the front of the left knee on a concrete kerb on 15 April 2016 occurred on warlike service in Iraq, at the time of the worsening. Gout of the left patellar tendon flared on warlike service in Iraq and was shown on ultrasound on 18 April 2016, at the worsening. On 8 April 2016, on warlike service in Iraq, a contracted doctor injected 40 mg of methylprednisolone into the region of the left patellar tendon, ten days before the worsening and within the two weeks specified. Moxifloxacin was prescribed for pneumonia on warlike service in Iraq from 02 March to 8 March 2016, within the 60 days before the worsening on 18 April 2016. Atorvastatin 40 mg daily continued throughout the year before the worsening, from 18 April 2015 to 18 April 2016, including your warlike service in Iraq. On warlike service in the Middle East in 2013 and in Iraq in 2016 no sports physician, physiotherapist or MRI was available, you were kept on full instructional duties, and in 2016 a steroid injection was given near the tendon without imaging.

This has then led to further investigations and the diagnosis of your condition of *Patellar Tendinopathy (Worsening)*. I have accepted your condition of *Patellar Tendinopathy (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 wartime service.

I have therefore accepted that the worsening of this condition is related to your service with effect from 18 April 2016.

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.