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 - Quadriceps Tendinosis With Partial Tear

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 16 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 16 June 2025;
- A deployed health record by the medical officer, East Timor, dated 14 November 1999;
- A periodic health examination and pathology by the medical officer, dated 12 September 2008;
- A renal medicine consultation by the renal physician, dated 10 March 2010;
- A deployed health record by the medical officer, Afghanistan, dated 24 March 2011;
- A deployed health record by the medical officer, Afghanistan, dated 19 April 2011;
- An ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 2 May 2011;
- A procedure record by the medical officer, Afghanistan, dated 10 July 2013;
- An ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 21 July 2013;
- An MRI left knee and orthopaedic consultation by the orthopaedic surgeon, dated 28 October 2013.

Your service

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

6 February 1987 and 30 September 2016

Left Knee - Quadriceps Tendinosis With Partial Tear

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: Quadriceps Tendinosis With Partial Tear

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 16 June 2025, and is supported by an ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 2 May 2011.

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 at the upper pole of the left patella and over the patellar tendon, worse with squatting, lifting from a squat, stairs and running, with tenderness and swelling above the kneecap and pain on resisted knee extension.After the 2013 worsening you had weakness of knee extension, difficulty climbing stairs and rising from a chair, and episodes of the knee buckling on 19 April 2011.

The diagnosis was confirmed by ultrasound of the left knee on 2 May 2011, which showed thickening and hypoechoic change of the distal quadriceps tendon at its patellar insertion with urate deposits. With pain and tenderness localised to the distal quadriceps tendon and worsened by activity, this meets the Statement of Principles definition of patellar tendinopathy, which includes distal quadriceps tendinitis or tendinopathy.

This has then led to further investigations and the diagnosis of your condition of *Quadriceps Tendinosis With Partial Tear*. I have accepted your condition of *Quadriceps Tendinosis With Partial Tear*.

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 18 April 2011.

Left Knee - Quadriceps Tendinosis With Partial Tear (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 16 June 2025;
- A Diagnosis Form (D9287) by Dr Thomas Perkins, General Practitioner, Veterans Health Centre, dated 16 June 2025;
- A deployed health record by the medical officer, East Timor, dated 14 November 1999;
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- A renal medicine consultation by the renal physician, dated 10 March 2010;
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- An ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 2 May 2011;
- A procedure record by the medical officer, Afghanistan, dated 10 July 2013;
- An ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 21 July 2013;
- An MRI left knee and orthopaedic consultation by the orthopaedic surgeon, dated 28 October 2013.

Your service

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

6 February 1987 and 30 September 2016

Left Knee - Quadriceps Tendinosis With Partial Tear (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: Quadriceps Tendinosis With Partial Tear (Worsening)

Basis of diagnosis: The diagnosis was made in the Diagnostic Assessment by Dr Thomas Perkins dated 16 June 2025, and is supported by an ultrasound left knee by the radiologist, role 2 facility, Afghanistan, dated 2 May 2011.

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 at the upper pole of the left patella and over the patellar tendon, worse with squatting, lifting from a squat, stairs and running, with tenderness and swelling above the kneecap and pain on resisted knee extension.After the 2013 worsening you had weakness of knee extension, difficulty climbing stairs and rising from a chair, and episodes of the knee buckling on 19 April 2011.

The diagnosis was confirmed by ultrasound of the left knee on 2 May 2011, which showed thickening and hypoechoic change of the distal quadriceps tendon at its patellar insertion with urate deposits. With pain and tenderness localised to the distal quadriceps tendon and worsened by activity, this meets the Statement of Principles definition of patellar tendinopathy, which includes distal quadriceps tendinitis or tendinopathy.

After the condition arose, it was worsened during your service. The 61 km a week of running in the four weeks before the worsening was performed on warlike service in Afghanistan in 2013. The seven hours a week of loaded squat, lunge and step-up circuits in the four weeks before the worsening were performed on warlike service in Afghanistan. The increase to five hours a day of tower stair climbing and carrying from 15 July 2013 occurred on warlike service in Afghanistan within the seven days before the worsening. The fall onto the front of the left knee on a steel guard tower stair on 19 July 2013 occurred on warlike service in Afghanistan, at the time of the worsening. The gout flare with enlarged distal quadriceps tendon tophi occurred on warlike service in Afghanistan, shown on ultrasound on 21 July 2013. On 10 July 2013, on warlike service in Afghanistan, a medical officer injected methylprednisolone 40 mg into the suprapatellar region alongside the distal quadriceps tendon for gout pain, 11 days before the worsening and within the two weeks specified. Norfloxacin was prescribed for dysentery on warlike service in Afghanistan from 30 May to 3 June 2013, within the 60 days before the worsening on 21 July 2013. Atorvastatin 40 mg daily continued throughout the year before the worsening, from 21 July 2012 to 21 July 2013, including your warlike service in Afghanistan from 10 March 2013. On warlike service in Afghanistan in 2011 and 2013 no physiotherapy, sports medicine or MRI was available, heavy duties continued, and in 2013 a corticosteroid was injected beside the tendon without imaging.

This has then led to further investigations and the diagnosis of your condition of *Quadriceps Tendinosis With Partial Tear (Worsening)*. I have accepted your condition of *Quadriceps*

Tendinosis With Partial Tear (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 21 July 2013.

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.