

CONDITION AND PROGNOSIS REPORT ON XXX

DATE

REFERENCE:

CLAIMANT NAME – dob XX XX XX

Address 1

Address 2

Address 3

Postcode

This report is prepared by Mr Paul Smith, FRCS, Consultant Plastic and Reconstructive Surgeon at the request of (Solicitor). The medical report is prepared to aid the Court in the case of (Claimant). I, Mr Paul Smith, understand my duty to the Court is to prepare an unbiased, honest and accurate report in this case and I believe I have complied with that duty.

For the purposes of this Medical Report, (Claimant) was seen via remote video consultation / seen at The XXXX on (Date).

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BACKGROUND

Date of Accident: XXXX

Date of Report: XXXX

Date of Birth: XXXX

Identification: XXXX

Time off work: XXXX

Current Occupation: XXXX

Instructing Party: XXXX

Documents available:

- General Practitioner Records
- X-rays, MRI and Scan images
- Photographs
- Hospital Records

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1. The circumstances of this accident as described to me by (Claimant) on (Date).

HISTORY

2. Firstly, this accident occurred on the 18th September 2019 whilst playing a pre-term rugby match during which his left middle finger was dislocated after injury. He described to me very accurately, the position of his finger which was deviated sideways in the ulnar direction. He was attended by the physiotherapist, this was virtually the last phase of play in the match and the physiotherapist at first assessed whether or not he could move his finger, but then manipulated it into position from the dislocated position and strapped it to an adjacent finger.
3. As XXX was going home the next day, he waited until he returned home and then went to the local Accident and Emergency department at XXX Hospital where he was x-rayed, no bony injury was noted, a splint was applied which was removed some

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three weeks later and active mobilisation commenced.

4. Over the next six to eight weeks he developed a flexion contracture at the proximal interphalangeal joint (PIP) which was eventually diagnosed as a Boutonnière deformity and he underwent surgical correction of this deformity on the 31st December 2019.

5. Within the subsequent two weeks, he developed an infection and he required four further operative interventions, all involving debridement and washouts of the wound, associated with this, a tendon repair was undertaken to the central slip, a VAC dressing was subsequently applied and a subsequent local flap cover of a defect followed by leech therapy, as the flap circulation was not satisfactory. In essence, once his wounds had healed, he attended the plastic surgery outpatients and physiotherapy, however, COVID-19 interfered with continued physiotherapy, plus XXX felt that he was not making any progress and that his finger was stuck in a fixed position. I have had confirmation that he had not

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received any hand therapy between the 27th November 2019 and the 31st December 2019.

6. Progression of symptoms:
7. There has been no improvement in XXX situation over the last six months.

PSYCHOLOGICAL IMPACT

8. There has been a significant psychological impact in that it interferes with his ability to undertake his tasks at home, he cannot partake in the gym as he used to, he cannot participate in sports as he used to. These are still ongoing problems and he would benefit from a report from a consultant psychiatrist or clinical psychologist as to the long term psychological effects of this injury.

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PAST MEDICAL HISTORY

9. There was nil of relevance. There were no pre-existing problems which have been exacerbated or accelerated.

REVIEW OF RECORDS

10. The emergency department note from the XXX Hospital on the 19th September 2019 documents that he had swelling and bruising to the proximal and middle phalanx, there was no erythema, no wound, there was tenderness to the middle and proximal phalanx, there was no tenderness to the distal phalanx, the finger was neurovascularly intact, there was a decreased range of motion on the distal interphalangeal joint (DIP joint), proximal interphalangeal joint (PIP joint) and metacarpophalangeal joints (MCP joint), due to swelling and pain. No fracture was seen and he was referred to plastics.

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11. He was assessed by the plastic surgeons on the 19th September 2019 at 22.06 hrs. X-rays confirmed the correct position of the joint, he was provided with a Zimmer splint, an outpatient ultrasound was requested for a possible volar plate injury, hand therapy and clinic review was booked.
12. The hand written notes on the 19th September 2019 at 21.00 hrs, page 205/705 document the following:
Left middle finger swelling PIP joint, unable to flex the PIP joint, actively or passively, unable to flex the DIP joint actively, better passively. Held in flexion, unable to fully extend, neurovascularly intact, closed injury. He was put in a Zimmer splint and outpatient for ultrasound, hand therapy the following day and to be seen in the plastic dressing clinic on the 25th September 2019.
13. Unfortunately, there is no notification of whether passive extension of the PIP joint was possible and if it was possible, there was no further documentation of whether or not a central slip attenuation test was undertaken. The fact that the PIP joint could not be passively flexed implies that there was something

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- preventing the joint from moving, most likely to have been a volar plate problem.
14. X-rays revealed no fracture. He was put into a splint, plastic dressing station in two weeks, avoid contact sports for six weeks.
15. The likely outcome in an injury of this nature is a progressive volar plate contracture and so it is important to keep the patient under review for eight to twelve weeks and to deal with any developing volar plate contracture by the use of a Capener splint. The x-rays do demonstrate a posture which is associated with a Boutonniere deformity, namely flexion of the PIP joint and hyperextension of the DIP joint.
16. The outpatient note on the 7th October 2019 noted stiff +++ stable joint, no rotation or scissoring. Outpatient in three months.
17. I consider this to be inadequate supervision of a situation where there is potential for a volar plate contracture to develop.

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18. There is a note on the 19th November 2019 where it is clear that he had an established Boutonnière deformity and that an ultrasound had shown central slip attenuation. *Reference: Listers The Hand, page 178, 179, 536)*
19. He was then seen on the 3rd December 2019 ,where it was noted that he had a central slip injury to his left middle finger and an established Boutonnière deformity. This was explained and it was suggested that he should have centralisation of the lateral bands, release of the joint and repair of the central slip and a k-wire to the proximal interphalangeal joint (PIP), a long period of splinting and he was warned that it may re-occur.
20. He was then admitted and had surgery on the 31st December 2019. The operation note documented on page 371 / 705 describes the following: dorsal curvilinear incision, volar plate freed, lateral bands freed, lax/attenuated but intact central slip, tightened using a 3/0 Juggerknot anchoring device inserted into the middle phalanx. At the end, the patient had a PIP joint which was straight and able to flex and was able to flex the distal interphalangeal joint. Wound

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closure 4/0 Ethilon, two weeks for the removal of stitches. Plastic dressing station in two weeks, outpatient three months. (Again, I feel that this is far too long of a gap to leave a patient after such complicated surgery and that a much closer eye should have been kept on his progress by the hand surgeons. The responsibility for monitoring his post-operative progress cannot simply be offloaded onto the hand therapy department.)

21. The operation note correctly notes that it was possible to flex the DIP joint, this means that the conjoined lateral bands were not tight. It also correctly points out that the PIP joint was capable of being straight, but what it does not do, is tell us whether or not it was possible to fully flex the PIP joint, in other words, it does not tell us whether the central slip repair was too tight. He was dressed with cosmopore, cobane (this is a self-gripping circumferential dressing which does not expand), a Zimmer splint with the PIP joint in full extension but allowing him to flex the DIP joint.

22. He was seen in the plastic dressing clinic nursing station on the 8th January 2020. It was noted that the

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dressing was very tight, the fingertip was dusky and the capillary refill was less than three seconds. (In view of the fact that the finger was dusky, I suspect that the nurse meant to say the capillary return was greater than three seconds as this would more closely correspond with the physical sign of duskiness.) The dressing was changed. He was seen on the 11th January 2020 at 19.27 hrs, they document that he had been seen in the plastic dressing clinic four days earlier, the wound had been redressed and placed in a splint, but he has been feeling unwell since Wednesday, fainted when removing the bandage, he has been off his food but no nausea and no vomiting.

23.

Examination of his left middle finger showed that it was diffusely swollen, fusiform, there was erythema of the left middle finger with tracking cellulitis to the dorsum of the hand, pus +++ with exudate from the wound, sutures were released and a pus swab was sent. Impression – post-operative wound infection. Plan was to take bloods, given intravenous antibiotics, mark the extent of the erythema, elevation, he was given a Betadine bath and wound

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review to be undertaken the following day to see if it was necessary to wash out the wound in theatre.

24. On the 12th January 2020, he was taken to theatre for a wound washout. He wound was dry, there was no pus, tendons were exposed, patient was well and comfortable, Betadine dressing was applied and second look planned for Tuesday. He was returned to theatre on the 14th January 2020 for a second look and he had debridement and washout as well as tendon repair. He underwent a third look under anaesthesia when the wound was debrided and washed again and a VAC dressing was applied. He was also on intravenous clindamycin and previously had been on intravenous co-amoxiclav.

25. On the 21st January 2020 he returned to theatre for a reconstruction of the soft tissue defect with a local flap and split skin graft. However, the flap became congested and leech therapy was commenced on the 22nd January 2020. His intravenous clindamycin was stopped on the 27th January 2020. All antibiotics were stopped by the 28th January 2020 and the leech therapy was stopped on the 28th January 2020. He was discharged, I believe, on the 29th January 2020.

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26. The detailed operation notes read as follows:
27. 31st December 2019: (Page 371) Mr XXX. Dorsal curvilinear incision, volar plate freed, lateral bands freed, lax/attenuated but intact central slip, tightened using 3/0 Juggerknot anchor into the middle phalanx, at the end, the PIP joint was straight and he was able to flex the DIP joint.
28. Page 383 – 12th January 2020. Left middle finger down to dorsal and wound explored, pus +++, pus swab sent, extensor tendon repair unreadable, unreadable, unreadable skin debridement. Washout with hydrogen peroxide and normal saline, Inadine dressing, may require second look.
29. Page 464 – 14th January 2020. Surgeon Mr XXX. Second look, finger washout left middle finger. Findings – Extending necrotic skin edges, advancing volarly, extending necrosis of the extensor tendon, both central slip and lateral bands, black necrotic bone at insertion of central slip, pus exuding from the proximal interphalangeal joint (PIP), proximal interphalangeal joint very early evidence of chondrolysis, collateral ligaments OK, necrotic

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tissue debrided, Juggerknot suture removed, bone specimen sent for microbiology culture. At this point, questions were beginning to be raised by Mr XXX about discussing everything with patients mother in regard to control of the infection, debridement of dead tissues, possible reconstruction, possible amputation.

30. Page 494 – 17th January 2020. Mr XXX. Third look, debridement and VAC application. Wound looks clean, no pus, over granulation proximally over residual extensor tendon, joint open, no pus, thorough irrigation, minimal debridement of desquamated skin, VAC applied, good suction.

31. Page 521 – 21st January 2020. Mr XXX. Defect dorsum left middle finger, post severe infection, local Quaba flap reconstruction and split skin graft. Very wide defect from metacarpophalangeal joint (MCP) to just short of the distal interphalangeal joint (DIP), swollen ++, clean, bone bleeding. Perforator identified by Doppler in the second web space. Two perforators identified. Flap raised at level of peritenon. Initially good bleeding, but the tip not perfused, therefore shortened, (meaning the flap), the

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- more proximal perforator ligated to allow flap to reach the defect. Swelling ++ of flap. Split skin graft harvested from the left thigh.
32. There is a diagram illustrating skin graft placed on either side of the flap. 4/0 Monocryl was used to close the dorsum of the hand, it was dressed with chloramphenicol Jelonet, a sponge tie over.
33. Page 550 – The Institution of leech therapy – this went from 22nd January 2020 through to the 26th January 2020.
34. Hand therapy notes are documented on pages 618 – 668 and it is clear that he had face to face hand consultations from the 29th January 2020 until the 16th March 2020. At the last visit, they were instructed by the medical staff to discontinue mobilisation as they were planning to fuse the PIP joint. At that stage, his active range of motion in his middle finger at the MP joint was 0 – 80 degrees, at the PIP joint, it was fixed at 80 degrees of flexion, the DIP joint it was fixed in neutral. He was subsequently noted on the 12th June 2020 to have wrist flexion of only 45 degrees compared to 90 degrees on the other side.

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35. Photographs – page 658 / 705 how the state of the wounds on the 21st January 2020 when there has clearly been a complete breakdown of all the dorsal tissues. There is significant skin loss, exposure of bare bone, the joint is exposed, there is no central slip and the extensor apparatus has been extensively damaged.
36. The photograph number 2/19, provided by the claimant shows subcutaneous bruising around the base of the finger, an extremely soggy area over the dorsum of the finger. There is some erythema of the skin over the proximal phalanx. There is no evidence of pus appearing, but this appearance should have alerted the nurse to obtain an opinion from one of the medical staff. No antibiotics were provided at this stage and three days later, frank pus was seen to be emerging from the wound. It is important to note that the very soggy area which is white and does not look particularly viable, is exactly the area that coincides with subsequent skin loss.
37. Photograph 3 taken on the 11th January 2020 – shows a finger that is undoubtedly infected.

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38.	12 th January 2020 – one can see the dehisced area.
39.	13 th January 2020 – it is clear that there is de-vascularised bone, an open joint, destruction of the dorsal apparatus.
40.	By the 23 rd January 2020 – one can see the Quaber flap which has become grossly swollen. Clearly, this flap has significant circulatory problems.
41.	By the 31 st January 2020 – the photograph shows most of the flap has survived but there are significant open wounds with flexion deformity at the PIP joint.
42.	By the 17 th February 2020 – there are still open wounds on either side of the flap and again on the 21 st February 2020 and even similar on the 13 th March 2020.
43.	By September 2020, there is clearly significant deformity of the finger with radial deviation of the tip of the finger, supination of the tip of the finger and a flexion deformity at the PIP joint.
44.	Cultures taken on the 12 th January 2020. MRSA Multisite screen culture, methicillin, resistance

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staphylococcus aureus not isolated. Report date 15th January.

45. There is report on the 23rd January 2020 about a specimen collected on the 12th January 2020 and this grew a heavy growth of staphylococcus aureus, sensitive to flucloxacillin and tetracycline and resistant to erythromycin. A similar report collected on the 15th January 2020 and reported on the 22nd January 2020 confirmed the same organisms.

46. 25th March 2020 MRI hand with contrast, patient with devastating soft tissue infection of left middle finger, now has x-ray changes in the middle and distal phalanx. Urgent MRI with contrast to rule out osteomyelitis of the distal phalanx. Finding: There is distal cortical destruction of the middle phalanx with scalloping of the distal cortex marked enhancing medullary signal alteration. There is destruction of the third distal interphalangeal joint and proximal interphalangeal joints (by this he means the middle finger joints), with and cortical destruction of the distal aspect of the proximal phalanx of the middle finger and enhancing medullary signal alteration.

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There is marked enhancing surround soft tissue inflammation with periosteal reaction. No collection demonstrated. Impression – Liver – the patient has the leak, appearances are compatible with (can't read text). (Clearly from impression onwards, this is an error on the report).

47. X-ray Left hand 26th March 2020 – osteopenic appearance of the middle finger. There is a large amount of soft tissue swelling of the dorsal aspect of the middle finger. The middle phalanx of the finger shows a loss of bony cortex and irregular erosion within the dorsal aspect of the middle phalanx. There is periosteal reaction seen. The middle phalanx also appears to be subluxed from the proximal interphalangeal joint. It is noted that the patient has had a subsequent MRI.

48. *Refer to appendix for diagrams of operation*

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PRESENT SITUATION

49. He presents with a stiff left middle finger with no movement at the proximal interphalangeal joint (PIP) or the distal interphalangeal joint (DIP).
50. He presents with significant scarring affecting his left middle finger and the dorsum of his hand.
51. He presents with some restriction of wrist flexion and extension.
52. He presents with rotational and lateral deformity of his left middle finger.
53. All of these are permanent.

ON EXAMINATION

54. It is clear that he has a stiff left middle finger which is not incorporated into motion when he attempts to make a fist. Looking at the left middle finger, the

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range of motion, both active and passive, is as follows:

- i. Metacarpophalangeal joint (MCP) : 0-90 (normal)
- ii. Proximal interphalangeal joint (PIP) : 55-55 (a fixed flexion contracture of this joint)
- iii. Distal interphalangeal joint (DIP): 50-50 (a 50 degree fixed flexion contracture of the distal interphalangeal joint.)

55. On the dorsum of the finger, there is a flap, 7 cm by 1.5 cm, which is raised and prominent. On the ulna side of this flap, there is a split skin graft which is hyperpigmented, there is twisting at the tip of the finger with the terminal phalanx supinated to 20 degrees. There is ulnar deviation at the proximal interphalangeal joint when viewed from dorsally. When viewed from the palmar aspect, there is a significant rotational deformity to the radial side, especially distal to the proximal interphalangeal joint.

56. On the dorsum of the hand, from the metacarpal area to the wrist area, there is a scar which represents the

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donor site of the flap that was rotated into position onto the dorsum of the finger. This scar is some 13 cm by a maximum width of 1.5 cm. Wrist flexion is to 70 degrees on the left side compared to 90 degrees on the right. Wrist extension is to 70 degrees on the left side compared to 90 degrees on the right.

57. He is left with a permanently stiff finger at the PIP joint and DIP joint. There is altered sensation over the grafted area and also over the skin flap. He regards the sensation on his finger tip as pretty normal. But on the side of his finger, where the flap and skin graft meet, he finds that area quite sensitive and experiences odd sensations when it is touched. (this is permanent)

LOSS CONSEQUENTIAL TO THE INJURY

58. At work – He lost a complete year of his university education as a result of this injury.
59. Prospects in the open job market – These are significantly affected. It is clear that he would be unable to undertake any activity or occupation which

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involved reliance on the manual use of his hand. It will also interfere with his ability to indulge in keyboard skills although he should manage to undertake academic activities such as teaching history, practising law etc.

60.

At home – He continues to have problems. The flexed finger makes washing more difficulty. Household chores are more difficult. He finds it difficult to hold cutlery, cooking pots and oven trays. It interferes with his ability to put on clothes, often getting caught, which is then painful. All of these are ongoing. Early on, his mother had to help him with the normal activities of daily living such as dressing, washing and eating. His mother undertook dressings, he recalled for about two months. I suspect that it was much longer than this, until at least February or March 2020. Hand therapy continued for approximately six months, as did his outpatient consultations, but these were all interfered with by the COVID-19 pandemic.

61.

At leisure – He enjoys cycling and tends to do off-road cycling, but the vibration from this is painful for

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his finger. He recommenced this about June 2020.

Playing rugby makes his finger extremely painful for a couple of days and he recommenced playing rugby in September 2020 however, he cannot continue to play cricket. He finds it hard to play video games. He has a limited number of exercises that he can participate in the gym. For example, he cannot put pressure on his wrist to do press-ups. It also makes it more difficult to grip the steering wheel when driving and he has had to change to an automatic car as it was difficult to grip the gear shift.

62. The above seem to be entirely reasonable in my opinion.

OPINION AND PROGNOSIS

63. This gentleman has a permanently stiff finger as a result of the index accident and the subsequent treatment. The current situation is entirely compatible with the history given and with the treatment received.

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64. The present situation can be taken as the final situation unless further surgical intervention is envisaged. He appears to be an entirely reliable witness.

RECOMMENDATIONS

65. The possibilities are as follows:
- i. Fusion of the proximal interphalangeal joint (PIP) associated with thinning of the flap, excision of the grafted area. The advantages of this are that it would allow the portion of the finger, distal to the PIP joint, to be corrected in terms of angulation and rotation. The fixation of the PIP joint would be absolute, no movement would be possible, but he would be left with a stiff finger which did not incorporate into grip much as he is at present. If he feels that he can cope with the present position of the finger, but wishes to avoid any discomfort when the PIP joint is stressed, then fusion I think is a realistic suggestion.

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- ii. Arthroplasty of the PIP joint. This is appealing because it would allow mobility of the joint, however, having been immobile for eighteen months, there will be numerous adhesions affecting the dorsal apparatus, the central slip, the volar plate, possibly the flexor tendons and so, arthroplasty would have to be accompanied with Tenolysis. There would be a significant recovery time. There would be the problem of instability laterally of the prosthetic joint, but there would be the advantage that the finger would be incorporated into grip. In most circumstances, arthroplasty is preferable to fusion of a PIP joint, but in this set of circumstances, the associated problems related to the dorsal apparatus, flexor tendons, make the outcome highly uncertain.
- iii. The final prospect is amputation. This should be through the proximal interphalangeal joint (PIP) with rounding off of the head of the proximal phalanx as appropriate. This would allow the proximal phalanx to still be incorporated into grip and would avoid the troublesome lack of incorporation of the middle finger beyond the PIP joint into grip. Amputation at this level would

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mean that there would be no projection of the middle finger beyond the PIP knuckles when making a fist.

66. There should be no effect on life expectancy. The effect on his future life is that all of these things are permanent. There is already evidence of osteoarthritic degeneration in both the PIP and DIP joints and this will only deteriorate. On the balance of probabilities, I expect him to have to make a decision about surgical intervention within the next five years.

PROGNOSIS

67. Without further treatment, the situation in my view will deteriorate with pain increasing at the PIP and DIP joints of the left middle finger, particularly when the PIP joint is stressed.

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“I confirm that I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my own knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth”

I confirm that I understand my duty to the Court and have complied with it and will continue to comply with it and am aware of the requirements of Part 35 and Practice Direction 35, the Protocol for the Instruction of Experts to give evidence in civil claims 2014, as amended, and the practice direction on pre-action conduct. (Dated XX.XX.XX)



Paul Smith, FRCPS (G), FRCS (Eng)
Consultant in Plastic and Reconstructive Surgery
(GMC number – 1217702)