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FIRST MEDICAL REPORT

PREPARED FOR THE COURT

In compliance with P35 of the CPR 1st October 2009.

20th JANUARY 2011

Mr A X
DOB: 23/01/1963
ADDRESS: …..Road,
District,
Town
Postcode
Back Injury
20/10/2009

PREPARED AT THE REQUESTED OF:
…….Solicitors,
…….Road,
……..,
Lancashire,
Postcode

Ref: PR.CL.X A

Purpose of this report: Material Instructions: Request for a full and detailed report, relevant pre-accident history, injuries sustained, treatment received, present condition, capacity for work and prognosis.

This report up to the 'Examination' section has been taken from a questionnaire completed by Mr X and dictated in the presence of Mr X, who was offered the opportunity to amend or alter these facts during the dictation.

I examined Mr A X of …….(Address) on 20th January 2011 for the purpose of preparing this medical report.

Mr X did not present any identification at today's consultation.

I examined the following documents:

DOCUMENTS CONSIDERED:
I also examined the following documents:

A mix of GP and hospital records that date from 1974 to 8th September 2010, which included copies of correspondence from different hospital practitioners, imaging and laboratory reports.

Mr. X's undated Witness Statement.

Radiographs on a CD format.

A photograph of a warehouse, I am advises by Mr. X that this is not where his accident took place it happened outside the building in the yard.

(Some of these copies were of very poor quality, some were illegible and some were poorly photocopied either black or very faint)

We have been advised by the referring agency that we are in receipt of all available notes for Mr X.

Mr X has given his consent for the records to be accessed and examined.

HISTORY: (as appears in the notes and as told by Mr X, which I take on his own responsibility as true and accurate):

OCCUPATION:
At the time of the accident the subject of this report Mr X was working as an Air Conditioning Engineer for Booth Air Conditioning Ltd, Universal House, Elizabethan Way, Milnrow, Lancashire OL6 4BU.

This involves lifting objects some of which are very heavy, bending, walking, driving and climbing.

CURRENT OCCUPATION:

Direct Sales RAC Motoring Organisation.

This job involves very little physical work, sitting and walking.

Mr X's change of job is not due to his injury.

ACCIDENT DETAILS:

Mr X had an accident at work in the morning of 20th October 2009 at Booth Air Conditioning Ltd, Universal House, Elizabethan Way, Milnrow, Lancashire OL6 4BU.

During a quiet period Mr X was asked to clear out a unit of old materials, kit, etc. some of which were very heavy. He had been dismantling some sheets with plastic diffusers with a hammer and felt some twinges and discomfort in his back particularly on the day of his accident. He then had to move a sheet of steel, which he could not pick up on his own, he was helped by a colleague and he did move it but on trying to pick it up his back locked. He had stabbing pain down his legs.

Mr X was wearing steel toe-capped shoes as part of Health and Safety regulations and company uniform.

No First aid was given.

As far as he is aware the accident was not recorded in the accident record of the site.

There is no CCTV footage in connection to the accident but Mr X has photograph of the metal sheet lifted. (I believe these are also kept in his solicitors files).

PROGRESS OF THE CASE:

Mr X was aware of immediate pain in his back more on the right side. He continued working and he struggled at work for 3 more days where he was gradually getting worse.

The day after the incident Mr X was unable to get out of bed so he contacted the emergency on call doctor who gave him an injection. Mr X was advised to take Ibuprofen.

He eventually called his GP who prescribed him painkillers Mr X saw his GP who referred him for a MRI scan of his lumbar spine a few weeks after his injury.

Mr X had pain interfering with his sleep for approximately 6 - 7 weeks. He was taking Tramadol 50mg 2 – 4 daily, Dicolfenac 50 mg 3 times daily and initially Codeine, which he found did not help his pains much.

He did not do any of his share of household duties and activities for about 8 weeks.

He did not drive for about 7 weeks.

Mr X only when shopping when driven by his wife or if in walking distance for approximately 7 weeks.

Mr X's pains were severe enough to interfere with sleep, household duties, driving and shopping for 7 – 8 weeks.

Mr X's pains have become more manageable mainly to odd twinges. There has been further episodes of recurrence of pains in the form of numbness in back, lower leg and foot depending on how he lie down.

TIME OFF WORK:

Mr X was off work for 50 days according to his employer. On return he undertook lighter duties in the form of restricting what he carried and less lifting.

TIME OFF RECREATIONAL ACTIVITIES:

Mr X did not do any gardening as it was the wrong time of year.

Mr X missed out on doing any DIY.

Mr X could not do any running.

Mr X is now doing all his pre accident domestic chores but has not returned to running as he feels his right leg is not in sync.

PSYCHOLOGICAL TRAUMA:

Mr X was upset about the case as he was not mobile, could not drive and could not sit down comfortably.

Management to date:

Mr X stayed in the hospital for 1 day, 11.12.2009 .

Mr X visited his GP on 4 – 5 occasions.

He attended physiotherapy on 3 – 4 sessions; he does not think they have helped him much.

He has not attended osteopath, chiropractor or acupuncture treatment.

PRESENT CONDITION AND COMPLAINTS:

Mr X still experiences residual pain very occasionally. The pain is aching and numbness to the lower back, lower leg and foot. This pain is aggravated if he lies in a particular position and sitting for a prolonged length of time radiating to both legs, right side of calf, top of foot and big toe.

This pain does not seem to be worse in the cold and damp weather. The pain is not worse in the morning. There is no morning stiffness. His pain is not worsened with coughing and sneezing.

Mr. X has no bowel problems but he finds passing urine is giving him intermittent flow with no force but he does not lose water without knowing and he has not gone into episodes of retention (where he could not pass urine).

He does not have any problem bending.

His pain can disturb his sleep if he sleeps in a particular position.

He is still using medication in the form of painkillers on as required basis.

As a result of the injury Mr X has a reduction in his mobility as he feels his right leg seems to be out of sync with his left leg.

Mr X feels that as his mobility had become dramatically restricted from his usual everyday life it caused him to become depressed followed by low moral. He has cramp down his right leg on walking and his walking distance varies from a few yards where there has been times when he managed to walk around a lake for a few miles without any pain or cramp.

This had a knock on effect with his direct family and home life and put a strain on communication and effort in daily living. This included not being able to drive or attend work, and also put him in financial strain as he only received statutory sick pay.

Mr X does not feel he has had to readjust his lifestyle too much.

Mr X's has had erection problems since his injury.

Mr X is not sure if he has weakness of his muscles or if they are affected by his injury.

Mr X is still trying not to lift any excessive weigh.

EXAMINATION OF RECORDS IN CONNECTION WITH THE INJURY:

There is entry dated 26th October 2009 indicating that he was improving, he was passing urine (PU) ok, his bowel was ok there was no sudden anaesthesia and he was asked to return on SOS basis.

He was seen again by his GP on 29th October 2009 with 10-day history of low back pain due to possible injury at work, it is noted that analgesia (painkillers) and NSAID (non steroidal anti-inflammatory drugs have eased his pain but certain movements are painful. He was able to walk slowly but not sit for a long time. He has pain on lying down, bowel and bladder were normal, and there was no obvious neurology. He was advised to continue with analgesia and referred to physiotherapy.

There is a letter dated 3rd November 2009 advising that on 8:59 hours of that day he was seen in the Accident & Emergency Department of Rochdale Hospital complaining of low back pain and right sided sciatica and a letter suggested to the GP to consider him for MRI scan.

He was seen on 10th November 2009 complaining of right-sided buttock pain and numbness on the dorsum of the right foot, there was no bowel or bladder problem. Straight leg rising was normal, he had pain on flexing the toes and he had a right foot drop. His left straight leg raising was 70 degrees, he has already had physiotherapy there was no red flags (signs indicating that he needs urgent surgical attention), or saddle anaesthesia he was given a leaflet about low back pain and referred to have MRI scan of his lumbar spine.

On 23rd November 2009 it is entered that he had left (this is possibly a typographical error because his symptoms have always been on the right side) but it is not better with Co-codamol. He was asking for renewal of his sick note, he has not yet had his MRI scan and he was attending physiotherapy.

On examination there was no abnormal neurological findings seen and he was give MED5 (sick note) for 2-weeks.

On 7th December 2009 he was referred to a neurosurgeon for right sided sciatica with a referral letter indicating that he was able to sit for 1-hour, analgesia was not helpful. He had L4/5 disc problem, he was constipated and the referral was seeking the opinion from the Neurosurgeon about the next plan or further action.

On 9th December 2009 there is a letter from physiotherapy indicating that he was seen once for initial assessment and told the physiotherapist that he is having private physiotherapy arranged therefore the NHS physiotherapist has discharged him.

Mr X was seen by the Neurosurgeon/Pain Clinic on 31st December 2009, it was noted that he had sciatica since mid October after a rather heavy lifting in mid October. He had pain radiating to the right big toe he had some back pain initially but this settled almost completely. There was no paraesthesia but he had numbness on the lateral aspect of the right calf and top of the foot. Left leg was asymptomatic, he can manage stairs but cannot find a comfortable position in bed and sleep. He was

noted to suffer with hypertension. His MRI performed on 27th November 2009 findings were noted (findings will be discussed below). Surgical intervention was proposed, the pros and cons of surgery were explained. Mr X was keen to go ahead with surgery and he was listed for surgery and he was told about the post-operative rehabilitation plan. However, Mr X did not attend his pre-operative clinic assessment on 3rd February 2010 therefore his name has been removed from the list. Mr X is advising that he has actually cancelled his pre-operative assessment.

In the GP records there are further numerous entries connection to other conditions, there has been no mention of his back problem or if his back problems has been mentioned it has not been entered.

There is an entry dated 29th January 2010 where he was seen for a medication review and it is noted that he is awaiting surgery without specifying what kind of surgery.

PAST HISTORY AND EXAMINATION OF MEDICAL RECORDS:

Mr X recalls a previous injury to his back in Sept 2008 but only for a short period, he advised this was not the middle of his back and he pointed to the sacroiliac region.
There are entries in connection with other injuries and orthopaedic conditions, such as a right foot injury in 2003 and he had a neck injury in 1995.

There are entries in connection with totally unrelated non-orthopaedic medical conditions, such as:
He had headaches in December 2009, coughs and colds, he suffered with high blood pressure 2009, alcohol problem 2009, foreign body in the eye 2008, colitis 1995, acne 1994, pharangitis, laryngitis 1998, sinusitis in 1997 and 2006. He had a vasectomy in 2000, urological problem 2006, renal colic 2006, and abdominal pains, URTI. He had adenoidectomy 1974, he had diarrhoeas in 1993 and there are entries in connection with vaccinations.

ON EXAMINATION:
General Examination:

Mr X appeared fit and well. He was seen walking through a long corridor at the consulting room premises (without knowing he was being watched) with no abnormal limp. He has a steady gait at good pace.

He has no hesitation shaking hands at the beginning or end of the consultation.

He sat comfortably while giving his history and did not appear to play up his symptoms. He gave impression that he is getting on with the activities of life.

He has no difficulty sitting down or rising from a sitting position, getting dressed or undressed, getting in and out of and turning around the examination couch. He has no difficulty getting shoes and socks off or on.

He demonstrated good intrinsic and extrinsic hand muscle function when looking for his photo ID.

EXAMINATION OF THE LUMBAR SPINE AND LOWER LIMB:

Mr X had a straight leg raising of 70 degrees bilaterally with very tight hamstrings that have restricted his straight leg raising. He had negative bowstring and sciatic stretch signs.

He has decreased sensation on the lateral aspect of his right leg and over the lateral toes. He has weak ankle dorsi flexors but intact EHL (Extensor Hallucis Longus), he has normal plantar flexors and FHL (Flexor Hallucis Longus) power. He otherwise had intact reflexes, sensations and motor power, he was tender over his right upper part of the sciatic nerve on the buttock, there was no paravertebral spasm, listing or scoliosis in his paravertebral muscles and he was not tender over his sciatic nerve. He could flex his lumbar spine and touch his toes; he had full lateral flexion and extension of the lumbar spine.

There was no distal neurovascular deficit.

INVESTIGATIONS:

Mr X's investigations were supplied on a CD from Salford Royal Hospital. There was a MRI scan of the lumbar spine taken on 27th November 2009; there was no report encountered or possible to access from the CD.

There were T1 and T2 series of sagital and coronal sections. There was straightening of lumbar lordosis, there were end plate changes on the edges and sides of L5 and S1 vertebral bodies.

At the L4/5 level there was a bulge especially on the right side compromising the exiting nerve recess on the right side. There were little facetal joint degenerative changes.

Mr X's MRI scan report was encountered in his records and describes similar findings but with different language. There was marked straightening of thoroc-lumbar spine suggesting muscle spasm, there was a normal cornus and canal dimensions, there was end plate changes at L5/S1, the bone marrow signal was satisfactory. There were ***longstanding*** degenerative changes with loss of height and signal; there was moderate spondylosis and circumferential disc/osteoarthritic

bulge. There was no focal disc herniation and normal exiting nerve roots. Whereas, on the L4/5 level there was more dominant pathology with mildly degenerative disc and broad based indenting theca whose saturn sequestration into the right antero-lateral recess behind L5 body. This has completely effaced lateral recess fat causing severe compression on the exiting L5 root. The L3/4 level was normal.

There was a transitional lumbo sacral segment with a remark from the reporter to be careful if surgery is contemplated to confirm the correct level of surgery.

OPINION:

Mr X had a soft tissue injury to his lumbar spine with a confirmed subsequent disc prolapse and sciatica.

He has the inconvenience of pain interfering with his sleep, work, household and leisurely activities and leading to repeated attendance to different health practitioners.

His condition has not fully settled down.

Causation: The complaints of Mr X were confirmed by clinical examination and examination of records. An injury similar to what he sustained during the index accident could give rise to his symptoms and signs.

PROGNOSIS:

80-90% of soft tissue injuries to the spine will recover in 18-24 months from the time of the accident. During the recovery phase there are periods of remissions and exacerbations. During the episodes of exacerbations, patients are not able to perform heavy manual work, perform household duties or enjoy leisurely activities and high contact sports.

The episodes of pain and discomfort gradually fade away in severity of pain, duration and frequency of the episodes. During these episodes of pain, supplementary physiotherapy and painkillers may be required. Recovery of a soft tissue injury is commonly seen in the younger age group and in patients who do not have radiation of their pains to the inter scapular region (between the shoulder blades) or to the limbs. It is also seen in those who do not have any symptoms of headaches, dizziness or blurring of vision.

On the other hand there is a 10-20% chance that such injuries do not fully recover; where the accident would have caused an irreversible progressive degenerative change and damage to the soft tissue and joints in the spine. These degenerative changes will gradually increase in frequency, duration and severity of the pain during these episodes.

The treatment of this condition is initially conservative with physiotherapy and painkillers. Should signs or symptoms of nerve compression become apparent, further investigations, ideally in the form of a MRI scan will be required. Subject to the findings of the MRI scan, the treatment may be conservative with physiotherapy with painkillers (non-steroidal anti-inflammatory drugs). The form of treatment will depend upon the experience and the choice of the treating surgeon.

Degenerative changes may take up to 2 years to become visible by radiographic (X ray) examination. A radiograph (X Ray film) taken 2 years from the time of the accident, may be required and should the case merit, can be of great help especially if that is compared with a previous radiograph film. 4-10% of patients are sufficiently disabled that they are unable to return to work.

With episodes of pain, heavy manual activity and heavy contact and high impact sports would be inadvisable. If the condition deteriorates such activities will have to be avoided putting patients at a disadvantage from the labour market point of view. More sedentary work will then be recommended. However sitting for a long time, keeping the spine still in one position would also be inadvisable, whether that is sitting on a desk as a driver or a passenger. Patients would be advised to take shorter breaks to ‘walk about and stretch their legs’.

The E C and Health & Safety Regulations regarding arrangement of desk furniture such as lighting, positioning and height of VDU screens and keyboards and such other office furniture, will be of great advantage in alleviating and preventing occurrence of symptoms.

Cervical and lumbar spine injuries are commonly associated. Generally lower lumbar spine injuries and degeneration of disc prolapses can be overlooked by a more severe kind of neck injury. (Gay and Abbott, 1953; Norris and Watt 1983; Osti et al 1992).

CONCLUSIONS:

Mr X’s injury is over 15 months old. It has shown some signs of settling down, however it has been proven that he is a suitable candidate for surgical intervention.

It is to be mentioned very clearly that surgery is mainly aimed to improve sciatica with no guaranteed recovery of any sensory or motor deficit he might have developed meaning that he may continue to have some residual weakness or sensory loss if his nerves have been damaged beyond repair.

Although it is possible for patients to return to previous level of activity they are usually left with one less disc putting more load on the remaining discs in the lumbar spine and subjecting them to further damage and deterioration. Therefore it is better that patients avoid

heavy manual work and prolonged sitting whether at a desk or as a passenger or driver. Therefore, Mr X is at a disadvantage from the labour market point of view and he will be recommended to take lighter kind of duties.

Disk prolapse is an event waiting to happen anyway and it is caused by repeated minor damage to the lower lumbar spine until the last fibre of the disc capsule (annulus fibrosus ruptures) leading to disc prolapse. Therefore, Mr X's disc prolapse was waiting to happen anyway and is not related to any lifting or handling of any particular object.

Disc prolapse is a condition worsened by repeated lifting and handling, it also had a genetic predisposition, therefore some people in heavy manual industries are more prone to disc prolapse than others. Watching Health and Safety regulations help protecting the discs against damage and prolapse.

There is no actual science behind acceleration, it is fully understood that the Court requires a valuation of a claim but it is to be mentioned that Mr X's disc prolapse was waiting to happen sooner or later.

Currently, Mr X's condition appears to be settling or passing through a phase of remission, therefore there is no urgency about surgery but he may develop a relapse at any stage where surgery may become indicated.

Surgery carries its own risks and complications, which are outside the scope of this report.

There are also risks and complications and changes of relapse, which should be discussed with Mr X prior to proceeding with surgery.

The time Mr X took off work and had restricted activity is reasonable.

Causation: Mr X's symptoms are solely due to the index accident. Had he not have had the index accident he would not have complained of the above described symptoms and signs.

Mr X does not need more time off work.

his position from the labour market point of view is compromised.

his Earning capacity is compromised.
Similarly his ability to return to Pre accident hobbies and activities is compromised

he is not left with a permanent scar or cosmetic problem.

REFERENCES:

Gay J R, Abbott K H: Common Whiplash Injuries of the Neck. Journal of the American Medical Association 1953, 152, (18): 1698-1704

Norris S H, Watt I: The Prognosis of Neck Injuries Resulting from Near-end Vehicle Collisions: Journal of Bone and Joint Surgery 1983,65B:608-611

Osti O, Vernon-Roberts B, Moore R: Annular Tears and Disc Degeneration in the Lumbar Spine: Journal of Bone and Joint Surgery 1992, 74B : 678-682.

DECLARATION:

I have no previous knowledge of Mr X or have had any reason to meet Mr X or any member of his family or associates prior to being instructed to prepare this report.

I have not entered into any agreement whereby the amount of payment of my fees will be dependent upon the outcome of the case.

I understand that my overriding duty is to the Court both in preparing and giving oral evidence.

This report complies with the 2009 modification of P35 of the CPR 2009 as amended 1st October 2009.

I have set out in my report what I understand from those instructing me to be questions in respect of which my opinion as an expert are required. I have described the extent and scope of this report in section I titled 'Purpose of this report'.

I have done my best in preparing this report, to be accurate and complete.

I have mentioned all matters, which I regard as relevant to the opinions I have expressed. All of the matters on which I have expressed an opinion lie within my field of expertise.

I have drawn to the attention of the Court all matters of which I am aware, which might adversely affect the validity of my professional opinion.

Wherever I have no personal knowledge, I have indicated the source of factual information and references.

I have not included anything in this report, which has been suggested to me by anyone, including the instructing parties, without forming my own independent view of the matter.

I understand that my duty in writing this report is to help the Court on the matters within my expertise. Where in my view, there is a range of reasonable opinion; I have indicated the extent of the range in the report.

At the time of signing the report, I consider it to be complete and accurate.

I will notify those instructing me, if for any reason, I subsequently consider the report requires any correction or qualification.

I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I make before swearing to its veracity.

I believe that the facts I have stated in this report are true and the opinions I expressed are accurate and correct.

I have indicated within this report all sources of information used in its completion.

I have indicated within my report the identity of any person other than myself, who has carried out tests or experiments that have been relied upon in its completion, including their qualifications and experience.

I have not, without forming an independent view, included or excluded any information that has been suggested to me by others.

I have endeavoured in my report and in my opinion to be accurate and cover all relevant issues concerning the matters stated, of which is have been asked to address.

I understand that:

My report, subject of any corrections before any swearing as to its correctness, will form the evidence to be given under oath or affirmation.

I may be cross-examined on my report by a cross-examiner assisted by an expert witness.

I am likely to be subject to adverse public criticism by the Judge if the Court concluded that I have not taken reasonable care in trying to meet the standards set out above.

I confirm that my report contains a comprehensive summary of the conclusions reached and includes any relevant pre-accident medical information and history, treatment received and present conditions, dealing in particular with the capacity for work (where appropriate) and giving full prognosis. I have fully assessed the claimant's injuries to establish the extent and duration of any continuing disability and impact on daily living in my opinion.

I trust the contents of this report are true to the best of my knowledge and belief. I understand that my duty as an expert witness is to the Court. I have complied with that duty. This report includes all matters available and relevant to the issues on which my expert witness is given. I address this report to the Court.

Mr A H Ismaiel M.Sc. (Orth) FRCS
Consultant Orthopaedic Surgeon
Honorary Senior Clinical Lecturer