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FIRST MEDICAL REPORT

PREPARED FOR THE COURT

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

Date: 12th December 2001

MR R…….P

DOB: 29TH AUGUST 1961

1234 ABC ROAD
GRIFFITHSTOWN
PONTYPOOL
GWENT
NA4 5XX

MULTIPLE INJURIES
Date of Accident:
19TH AUGUST 2000

PREPARED AT THE REQUESTED OF:

Lloyd Green Solicitors
Kensal House
77 Springfield Road
Chelmsford
Essex
CM2 6JG

Ref: 128/162/AIC01/92

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 has been dictated up to the 'Examination' section in the presence of Mr…….who was offered the opportunity to amend or alter these facts during the dictation.

I examined Mr of 6 ABC Close, Collier Row, Romford, Essex RM5 2PA on 20th July 2002 at the Holly House Hospital for the purpose of preparing this medical report.

Copies of his GP record and hospital record were not available at the time of preparing this medical report.

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

- At the time of the accident, the subject of this report, Mr ……. was working in a chemical plant as an operator, and his job involved the lifting of heavy objects, bending and driving forklifts and walking about the plant site. He is still doing the same job but taking lighter duties.

ACCIDENT DETAILS:

- Mr ……..had a road traffic accident around 1730 hrs of 12th December 2001 on the A12 near Leabridge, heading for Romford. Mr ..... was driving his motorbike in the middle lane at less than 30 mph when a car from the right hand lane suddenly changed lanes in front of him crossing to the left hand lane. As he saw this happening he started applying the brake, but the car still knocked him, he lost his balance and was thrown off his motorbike. Apparently, one car has run over his right (dominant) arm. At the time of the impact Mr ..... was wearing a crash helmet and all the protective leather gear. The road condition was dry, the streetlights were on, the visibility was good and the road surface was not particularly, icy, skiddy or slippery. Mr ..... estimates the speed of the car that hit him was about the same speed of around 30 mph.

- On falling down Mr ..... landed mainly on the left side of his body and he rolled around. He did not lose consciousness but he was stunned and dazed. The police and ambulance were not involved at the scene, but insurance details were, somehow, exchanged. Mr ..... was given a lift by one of the accident witness to his front door.

PROGRESS OF THE CASE:

- By then he was mainly complaining of right (dominant) arm pain, lower back pain and left leg pain, and he found that he had bruises in his right shoulder and left side of his body.

- Mr ..... was unable to move or do much about the house. He initially thought that his injuries would settle down but this did not materialise. His non-dominant forearm, in particular, started to swell

and blow up. He took up non-steroidal anti-inflammatory drugs (painkillers) hoping that his condition would settle down. His sleep was disturbed and he had to sit on a chair all through the night. The following morning he reported to the Accident and Emergency department of Hornchurch Hospital, Romford, giving an account of his injuries. He had radiographs taken of his forearm and he was found to have a fracture to the lower end of his right radius and there was a suspicion that he might have fractured his scaphoid bone as well. His fracture was treated in a full forearm case incorporating the thumb and he was given a triangular sling and advised to keep his hand elevated and to try and exercise his fingers as much as could be tolerated.

- Mr ..... was a one-handed person as he was unable to use his non dominant forearm in a good number of activities, in particular, doing up his shoelaces and buttons, using a knife and fork. He has to look after the plaster and to avoid getting it wet so he was also unable to do any washing up, taking a shower or a bath, and he was unable to do his own self-care and hygiene. Mr ..... was given a follow-up appointment to return to the fracture clinic. On return to the fracture clinic a lighter weight plaster was applied and he returned to the fracture clinic on several occasions where his plaster and lightweight plaster were exchanged. His right arm and thumb were immobilised in a cast for about 8 weeks. During this time he was also complaining of low back pain associated with radiation of pain and numbness and tingling radiating all the way down his thigh to his toes. This has also interfered with his ability to walk around and bending, carrying heavy objects and picking objects up off the floor. He was unable to drive, his pain disturbed his sleep and he continued to have back pain on coughing and sneezing.

- Mr ..... has a pre-existing back problem that was settled down and sorted with the help of osteopath and physiotherapy until he had his recent accident where all the problems in his lower back reappeared.

TIME OFF WORK:

- Mr ..... was off work initially for 8 weeks and on return to work was given lighter duties and he gradually built up his activities over about 3 months but he is not fully back yet, because of his back pain and right arm pain. He could not afford to take any further time off work, but his condition continued to affect his ability to work. He is using his annual leave instead of using sick leave. He has not had any osteopath or physiotherapy treatment for his back as a result of his injury.

PRESENT CONDITION AND COMPLAINTS:

- Mr ..... is still complaining of right (non dominant) hand pain that is interfering with his ability to grip objects. He has a tendency to drop heavy objects and is unable to lift anything heavy at work. Any activity that requires leaning on the hand such as, using power tools and leaning on handlebars can give rise to wrist pain. He is avoiding using his right (non dominant) hand in lots of activities and is trying to avoid lifting and handling small objects in his hand. He is taking up to 8 tablets of co-dydramol a day. His pain is interfering with his sleep and the level of pain varies with the amount of activity he does.

- Mr ..... is complaining of back pain that radiates from the upper to the lower part of his back, occasionally to the right buttock region but not any further. He was not complaining of any back problem prior to his accident, with the help of physiotherapy and osteopath treatment, which he had done privately. His back pain is about the same as it used to be and occasionally radiated down to his lower limb as far as the knee together with occasional numbness of the toes. His pain interferes with his sleep and he is unable to sit for long periods, and he is unable to lean, bend or pick up heavy objects. He also had variation in the intensity of his pain with the amount of activity he does which is worse, of course, at work, but he unable to take any time off work or lighter kind of duties to keep his pay.

- Since the accident Mr ..... is unable to do a lot of activities in the house because of his hand and back problem. He lives alone and he relies on others helping with shopping, hoovering and cleaning. He had not done any gardening since his accident and he has not done any DIY activity at home. He was a target and clay pigeon shooter and he has not done any of these since his accident. He also used to enjoy motorcycling but now he is restricting this to the minimum because of his wrist and back pain. He uses his motorbike only to commute to work. He has put on about two-stone in weight since his accident.

- Initially, Mr ..... was very nervous about the road and about driving, he had nightmares and flashbacks about his accident but now he is taking a practical attitude and he is getting on with his lift. He is now seriously giving up motorcycling completely.

PAST HISTORY AND EXAMINATION OF MEDICAL RECORDS:

- Mr .....'s records were not available at the time of preparing this medical report but he does not recall any previous injury to his right wrist and hand but he had low back pain for many years as a result of more than one motorcycle accident. His back was gradually giving occasional pains until he had one episode with his back "went" and that was treated with a chiropractor with very good results with only the occasional odd twinge of the back, but he had no other problems.

ON EXAMINATION:

- Mr ..... appeared well. He is 6'1" tall, 20½ stones (120 Kg). He walked through a long hospital corridor (without knowing he was being watched) with some limp, he had no normal posture, and he was sitting restlessly whilst giving his history. He was wearing a double tubi grip (compression) bandage around his right (non dominant) wrist that was badly worn out indicating that it is in continuous use. He was slightly reluctant to shake hands at the beginning and at the end of the consultation, but accidental touching of his hand did not give rise to any exquisite pain or tenderness.

- Mr ..... also has difficulty doing and undoing his shoelaces, and some difficulty getting his clothes off and climbing in and out of the examination couch.

EXAMINATION OF THE RIGHT (NON DOMINANT) HAND: (Findings are based on comparison between the two sides)

- Mr ..... had a puffy swollen right hand compared to the other side but with no evidence of shiny skin or abnormal hair patterns of RSD. He was tender in the anatomical snuffbox and in the inferior radio unlar joint region with positive springing of Grade 1, which was also tender. He had full wrist extension, ulnar and radial deviation compared with the other side but with restricted wrist flexion to 45 degrees (compared to almost 90 degrees on the other side). He had negative scaphoid grind and thumb grind test. He had a negative Finkelstein sign and he had full spination and pronation. The rest of the hand and finger joints showed full range of motion with no evidence of collateral instability. He had satisfactory intrinsic and extrinsic hand function with no distal neurovascular deficit.

EXAMINATION OF THE LUMBAR SPINE AND LOWER LIMBS:

- Mr ..... had 75 degrees of straight leg raising that was restricted because of tight hamstrings. He also had positive sciatic stretch test with equivocally positive bowstring signs. He had intact reflexes, sensations and motor power in both lower limbs with no distal neurovascular deficit. He was not tender over his sciatic nerve and he had a negative femoral nerve stretch test. He could flex his lumbar spine almost to leg level and he has good extension and good lateral flexion. There was no evidence of listing, scoliosis or para vertebral spas. He was tender on the right side of his dorsal lumber region over the right lower ribs. He had satisfactory dorsal spine rotation.

OPINION:

- Mr ..... has sustained a soft injury to his lumbar spine and an injury to his right (non dominant) wrist the nature of which is not entirely clear.

- He had the inconvenience of pain interfering with his sleep, household and leisurely activities, and interfering with his ability work with repeated attendance to GP for further management.

- The condition of Mr ..... has settled down but is not fully resolved.

- **CAUSATION:** The complaints of Mr ..... were confirmed by clinical examination. An injury similar to what he sustained during the accident, the subject of this report, 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 should 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) to the limbs. Also it is 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 radiograph examination. A radiograph 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 as 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)

- We will need to identify the exact nature of Mr .....'s hand and wrist injury by the sighting of records and radiographs.

- It appears that he has residual inferior radio ulnar instability and restriction of wrist movement. Any fracture around the wrist would have been well healed by now. Mr .....'s hand swelling is reminiscent of reflex sympathetic dystrophy (RSD) but he does not have all the other symptoms. This is a condition that takes a long time to settle and because it is not showing all the other signs it is unlikely that it will require the usual line of treatment that includes nerve blocks.

- The other possible cause of Mr .....'s hand swelling would be a fracture or subuxation that was not fully diagnosed or improperly healed.

CONCLUSIONS:

- More information is required about Mr .....'s wrist injury before a definite prognosis can be given.

- Mr .....'s back injury is 7 months old. He is still within the 24-month recovery period set out above. He does not have any positive neurological findings other than positive sciatic stretch test, therefore, he is still likely to settle with the help of one or two courses of physiotherapy as outlined above.

CAUSATION:

- Mr ..... has a pre-existing back problem, which was triggered off or worsened by his new accident. That does not contradict the previous statement that he is having 80% of return to his pre-accident condition within 24 months time from his injury with the help of physiotherapy.

- If Mr ..... continue to have problems with his back it will be concluded in retrospect that his new accident has become a chronic non resolving condition and it may be concluded that his accident has worsened, brought forward or triggered pre existing degenerative changes.

    - It will be totally unscientific and a matter of guess work to try to divide the blame in percentage or the share in percentage of any future symptoms and signs on the previous injuries. Should Mr ..... continue to have problems in two years from the time of his accident he will need to be reassessed and re-examined

    - On the balance of probabilities and from the available information, all Mr……'s arm problems are caused by his accident. He would have not complained of any problem in his hand should he have not sustained the index accident.

    - On the other hand the major part of his back complaints are due to his pre-existing back condition. On the balance of probabilities he would have complained of his lumbar spine any way by the age of……. Therefore the index accident has accelerated his dormant symptoms by ……years

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 ..... or have had any reason to meet Mr ..... 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 understand my duty to the court and have complied and will continue to comply with it. I am aware of the requirements of Part 35 and practice direction 35, this protocol and the practice direction on pre-action conduct.

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 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