..2013

PRIVATE AND CONFIDENTIAL

Report prepared by Dr X
Spec Occ Med

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……..

Attention: Ms

Dear Madam

Re:	**Ms X**
Date of Birth:	**…/…/…, aged .. years.**
Address:	……..
	……..
Handedness:	……..
Occupation:	…….
Employer:	…….
Your Reference:	…….
Date of Assessment:	**22 July 20..**

Thank you for referring Ms X for medical assessment and report. Based on Ms X's medical condition as specified in your referral, I confirm that my specialty is appropriate for the conduct of this assessment.

Having reviewed the available records and file data, interviewed and examined Ms X, I now submit a detailed medical report in answer to your request.

I obtained the following information from my interview with Ms X (unless otherwise specified).

Ms X attended the appointment accompanied by her work colleague, who remained present in the waiting room throughout the assessment and after the assessment asked for my comments regarding Ms X's current status of injury.

HISTORY:

Occupation/Work Duties:

Ms X's reported work history is as follows:

Duration	Employer	Position
06/..-present		
05/..-06/..		
01/..-05/..		
08/..-10/..		
08/..-08/..		
01/..-08/..		

Ms X explained that her job involves: 70% of her work time is computer work and 30% attending meetings.

She works 10.5 hours per day, five days per week.

Ms X reported that she has complained about her workstation arrangement since August 20...

Her computer screens were at an angle on the corner of a table and to check screens she would turn her neck repetitively and lean forward. She requested an ergonomic assessment of the worksite.

Ergonomic assessments was done on two occasions in March 20.. and adjusted up to Ms X's satisfaction.

Ms X reported that now two screens are in line and she moves her work chair to be able to work on both screens.

Mechanism of Alleged Injury/Sequence of Events:

Ms X reported that she could not recall of any specific accident that could cause her symptoms.

Ms X reported that she developed headaches in September or October 20.. and she commenced private treatment and in December she submitted a Workers Compensation Claim.

Ms X experienced headache in the occipital and parietal areas and dizziness, which was so prominent that she felt unsafe while driving a car thus she limited her driving.

Ms X described that while stationary she "would feel that the car moving backwards".

She had limited movements in the neck.

Ms X reported lower back pain and believes that prolonged sitting caused the lower back pain.

Initial/Early Treatment Received:

Ms X attended for deep tissue massages.

Subsequent Progress/Specialist Management:

Ms X also attended physiotherapy and chiropractic treatments.

Ms X reported that since the start of her symptoms she has been to……. for 6 weeks holiday and also attended treatments while over there.

She has also recently returned from a business trip of three weeks to Houston, US.

She initially was using Disprin to aid her symptoms but it caused reflux and therefore she ceased it.

She reported that she takes Panadeine (one tablet) with the start of a headache and one at night.

She reported improvement in her symptoms in June but then she ceased chiropractic treatment and her symptoms increased.

Ms X reported that she wears orthotics to aid her flat feet.

Ms X reported that she has been attending a gym exercise program three times per week since the middle of June 20...

Current Status:

Ms X estimated improvement in her symptoms at 60%.

Ms X reported that she develops headaches in the afternoon when at work, almost every day and also she is experiencing constant neck and lower back pain, and stiffness in the neck.

Ms X reported that she develops headaches between 4-5pm if not at work.

Ms X reported that her headaches start after five hours of work especially if she works on the computer.

When she moves her head (e.g. from flexion to extension) she develops “spins” (her surrounding moving).

She reported that lingering headache and dizziness are impacting her driving ability and work.

Ms X reported that she feels lack of balance when she closes her eyes.

Ms X reported no difficulties with sitting, standing or walking.

Present Work Status:

Ms X has been performing her normal, pre-incident duties and hours at work.

Present Activities:

Ms X reported no difficulties with her daily activities or maintaining her hygiene.

Ms X reported that she avoids performing household chores when symptomatic.

Ms X reported that she does not play any sport or has not done any specific exercising for fitness.

Present Treatment:

Ms X that she takes Panadeine (four days in a week).

Ms X reported that she attends a gym exercise program three times per week.

Past Medical History:

Ms X reported that she has been in good general health.

Ms X reported she was diagnosed with high blood pressure and recently her doctor recommended medication for it.

Personal/Social History:

Ms X is married and has two sons (11 and 5 years old).

Ms X reported she lives in a rented property.

Ms X reported she does not smoke tobacco or drink alcohol.

PHYSICAL EXAMINATION:

Ms X presented herself as a pleasant and cooperative ..-year-old, left/right-handed lady. Her height was 156.5cm and her weight was 82kg. Her BMI of 32kg/m^2 places her in the obese category.

She demonstrated normal gait and posture, and was able to move freely. She had no apparent difficulties in undressing or redressing, or climbing onto or down from the examination couch.

Head/Neck Examination:

Inspection showed symmetry and no muscle wasting or deformity in the neck.

Ms X reported that palpation caused tenderness at the base of her neck and in the left shoulder and neck junction.

Ms X demonstrated a good range of movements in the neck (flexion: 45°; extension: 45°; lateral flexion: 45° bilaterally; rotation: 60° bilaterally), but during extension reported dizziness and on lateral flexion she reported “hurting. She explained that if she closes her eyes while moving her neck she would not get “that dizzy.”

Upper Limbs/Shoulder Girdles Examination:

Inspection showed symmetry and no muscle wasting or deformity in the upper limbs. Her upper arm circumference was 33cm bilaterally and the circumference of the right forearm was 24.5cm and of the left was 25cm.

Ms X demonstrated a full range of movements in the shoulders (right and left shoulder: flexion: 180°, extension: 50°, abduction: 180°, rotation internal and external: 90°).

Ms X demonstrated a full range of movements in the elbows, wrists and fingers.

The neurological examination (reflexes, muscle tone and power and sensation to touch/two point discrimination) was unremarkable.

Back/Spine Examination:

Inspection showed symmetry and no muscle wasting or deformity in the back. She stated that palpation in the middle, a long, the lumbar spine “hurts.”

Ms X demonstrated a full range of movements in the back (flexion: 90°; extension: 30°; lateral flexion: 30° bilaterally; rotation: 30° bilaterally).

The supine ‘straight leg raising’ test was 65° bilaterally.

She could reach to 10cm above her ankles while her legs were fully outstretched when she was sitting on the examination couch.

She was able to walk on her heels and toes and squat with no apparent difficulty.

The neurological examination (reflexes, muscle tone and power and sensation to touch) was unremarkable.

INVESTIGATIONS:

7 May 20..	.	X-ray cervical, thoracic and lumbar spine with pelvis and bilateral hip: "1. Alteration of normal cervical curvature. 2. Minimal thoracolumbar curvature. 3. Possible lower lumbar facet joint arthrosis bilaterally (clinical correlation required). 4. Normal pelvic alignment."
13 April 20..		MRI cervical spine: "No significant abnormality demonstrated. No central canal or foraminal neural impingement at any level. The craniocervical junction appears normal."

SUMMARY AND ASSESSMENT:

Ms X a ..-year-old, left/right-handed, Project Interface Coordinator with …….l reported that she developed headache, neck and lower back pain and submitted a workers' compensation claim with date of accident 2 October 20...

Medical investigations (X-ray of the cervical, thoracic and lumbar spine with pelvis and bilateral hip and MRI of the cervical spine) were unremarkable.

Ms X reported that she could not recall of any specific accident that could cause her symptoms.

At the assessment Ms X reported some improvement in her symptoms as well as that she develops headaches in the afternoon, almost every day and she is experiencing constant neck and lower back pain, and stiffness in the neck.

The clinical examination at the assessment revealed generally good range in the spine but dizziness and soreness during the demonstration of the cervical spine movement was reported.

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing work) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work,

Ms X's doctor should consider further investigation to explore causation of her headaches, dizziness and intermittent lack of balance and soreness in her neck and lower back. He should also encourage Ms X to decrease her body weight and to exercise.

Diagnosis:

- Further investigation should be conducted for an appropriate diagnosis to be formed

You particularly requested me to cover the following issues:

1 The complete history that the worker describes to you regarding the onset of complaints and your comments as to whether you believe that the history given is consistent with the nature of the injury.

Ms X reported that she could not recall of any specific accident that could cause her symptoms.

Ms X reported that she developed headaches and in September or October 20.. she commenced private treatments and in December she submitted a workers' compensation claim.

She experienced headaches in the occipital and parietal areas and dizziness, which was so prominent that she felt unsafe while driving a car thus she limited her driving. She described that while stationary she "would feel that her car is moving backwards". She had limited movements in the neck.

Ms X reported lower back pain and believes that prolonged sitting caused her lower back pain.

The history does not explain/support Ms X's reported injury.

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing work) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work,

2 Your findings upon clinical examination and the result of any tests performed.

The clinical examination at the assessment revealed generally good range in the spine but dizziness and soreness during the demonstration was reported.

For all details please see under "Physical Examination".

3 What is your diagnosis of the worker's current condition?

Further investigation, regarding non-work caused/related symptoms, should be conducted for a diagnosis to be formed. I would suggest Ms X consult her GP to discuss this.

4 Are your objective clinical findings consistent with the worker's subjective presentation of complaints and symptoms?

The objective findings do not support Ms X's symptoms.

5 Does ….. require any further treatment and/or do any alternative treatment methods/referrals need to be considered? Please provide details including nature and likely duration of any such treatment. Please detail how exactly this is related to the workplace injury.

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing work) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work.

6 What would be the expected timeframe that ….could upgrade her restrictions to return to full pre-injury duties? Are there any barriers? If so please identify.

Ms X has been performing her normal, pre-incident duties and hours at work and, based on the history and objective findings at the assessment, in my opinion, she is fit to continue to do so.

7 Please provide your professional opinion on ……..s RTW plan and general comments on …….'s capacity for work in the short, medium and long term.

Ms X has been performing her normal, pre-incident duties and hours at work and, based on the history and objective findings at the assessment, in my opinion, she is fit to continue to do so.

8 Has the worker's employment as a Project Coordinator at …….contributed to the development of the injury to a significant degree? In your determination of this question we ask you to take the following factors into account:

a) The duration of the employment;
b) The nature of, and particular tasks involved in the employment;
c) The likelihood of the contraction, recurrence, aggravation or acceleration of the disease occurring despite employment;
d) The existence of any hereditary factors in relation to the contraction, recurrence, aggravation or acceleration of the disease;
e) Matters affecting the worker's health general; and
f) Activities of the worker not related to the employment.

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing work) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work.

9 Given the factual and medical evidence supplied, and considering the indicators (a-f) can you conclude that the worker's employment with ….. has contributed, or contributed to a significant degree? In your response we would appreciate if you could address all factors when firming your view and provide the grounds for your conclusion.

a) The duration of the employment;

The symptoms started in the first three months of commencing working as a Project Interface Coordinator with ……...

b) The nature of, and particular tasks involved in the employment;

Ms X explained that her job involves: 70% of her work time is computer work and 30% attending meetings. She works 10.5 hours per day, five days per week.

c) The likelihood of the contraction, recurrence, aggravation or acceleration of the disease occurring despite employment;

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing working) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work,

d) The existence of any hereditary factors in relation to the contraction, recurrence, aggravation or acceleration of the disease;

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing working) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work,

e) Matters affecting the worker's health general; and

I could not comment on Ms X's general health.

f) Activities of the worker not related to the employment.

I am not aware of Ms X's non-work related activities.

Based on the history (office type of work; no specific accident; symptoms started in the first three months of commencing working) and objective findings at the assessment and based upon a reasonable degree of medical certainty, in my opinion, Ms X's symptoms are not caused or related to her activities at work,

10 Please give your prognosis.

Further investigations should be conducted for a diagnosis to be formed and then I could comment on the prognosis.

11 Please provide any further comments you may have relating to this claim.

I have no further comments, thank you.

I acknowledge that I have read the Expert Witness Code of Conduct and agree to be bound by it.

The contents of this report are true to the best of my knowledge and belief.

I trust that the foregoing meets with your requirements regarding Ms X. Please do not hesitate to contact me if I can be of any further assistance.

Yours sincerely

Dr X
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MD (University of Sarajevo) 1977; MD 1990
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