……2014

PRIVATE AND CONFIDENTIAL

Report prepared by Dr ……..
Consultant Orthopaedic Surgeon

…….
…….
……

Attention: Ms ……

Dear Madam

Re:	**X KIM**
Date of Birth:	**../../19.., aged .. years**
Address:	**……..**
	…….
Handedness:	**Right-Hand Dominant**
Occupation:	**Assistant in Nursing**
Employer:	**……**
Duration of Employment:	**From 10 January 20..**
Interpreter:	**……**
Interpreter Services:	**……..**
Date of Accident:	**1 November 20..**
Date of Work Cessation:	**1 November 20..**
Date of Work Resumption:	**Mid February 20..**
Your Reference:	**…….**
Date of Assessment:	**…….. 2014**

Thank you for referring Ms X Kim for medical assessment and report. Based on Ms Kim'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, interviewed and examined Ms Kim, I submit the following detailed medical report in answer to your request.

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

TO: The Registrar
The Supreme/District Court of Queensland
George Street
Brisbane 4000

STATEMENT OF QUALIFICATIONS/EXPERTISE:

Qualifications	•
Special Expertise	•
Professional Associations	•
Professional Status	•

Summary

I am an Orthopaedic Surgeon …

EXPERT'S DUTY:

I confirm that, as a potential expert witness giving evidence in a proceeding, I have a duty to assist the Court. I understand that my duty overrides any obligation that I might have to any party to the existing or anticipated litigation or to any person who is liable for my fees or expenses. I understand that, as an expert, I am not an advocate for any party to the litigation.

I have complied with the duty.

PATIENT DETAILS:

Re: **X KIM**
Date of Birth: **../../19.., aged .. years**
Address: **……..**
…….
Handedness: **Right-Hand Dominant**
Occupation: **Assistant in Nursing**
Employer: **……**
Duration of Employment: **From 10 January 20..**
Interpreter: **……**
Interpreter Services: **……..**
Date of Accident: **1 November 20..**
Date of Work Cessation: **1 November 20..**
Date of Work Resumption: **Mid February 20..**
Your Reference: **……**
Date of Assessment: **…….. 2014**

HISTORY:

Occupation/Work Duties and Education:

Ms X reported she was born and lived in South Korea. She studied maths at university and worked as a maths tutor. She also worked as a barista and in graphic design. She came to Australia in 20.. on a working holiday visa and worked as a waitress and kitchen hand. She then returned to South Korea.

She returned to Australia on a student visa to study nursing. She initially did office cleaning but from 10 January 20.. she was employed in aged care at ……. as an assistant in nursing. She was off work following the motor vehicle accident. She did try returning to work in mid February 20.. but only lasted two weeks on light duties. She now has a certificate stating she is unfit for work. She has had difficulty continuing her studies for the nursing course and has not yet finished her practical work. She has been told not to return to work until she is fully fit for pre-injury duties. She hopes to find some lighter work at present to get back into the workforce.

Mechanism of Alleged Injury/Sequence of Events:

On 1 November 20.. at approximately 4:00pm Ms X reported she was a pedestrian in a car park of the apartment block at her unit on the Gold Coast. She was waiting for her friend to pick her up in the lower ground car park. Unfortunately, the friend accidently accelerated the vehicle and pinned her to a concrete wall crushing her right leg front on. She fell to the ground as the car was reversed. She was helped into the car by the driver and taken to the ……. Hospital, next to …….. University. She reported there was a long time of wait to be seen by a doctor, so she self-discharged and went home. She was unable to walk and took analgesics.

The next day Ms X noticed extensive bruising and pain in her right lower leg. She attended the A&E Department at ……. Hospital and had an assessment as well as an X-rays. The small wounds in her right leg were dressed. There was considerable bruising in her right thigh and calf area and she showed pictures on her mobile phone to me. She was mobilised on crutches which she continued to use for about two months. She went home to stay with a friend as she needed help with self-care.

A few days later, she had increased pain, so she attended her general practitioner. She was told to go to the A&E Department of ……. Hospital and attended there. She was prescribed analgesics. She commenced physiotherapy.

Towards the end of November 20.., she was referred to an orthopaedic surgeon and saw Dr …….. She had an MRI scan of her pelvis, hips and right knee which showed some bone bruising and possible microfracture around the knee. She continued on physiotherapy.

She stated that a few days after the accident she did develop pain in the low back region and her neck area. She had difficulty turning over in bed or lying on her side.

On 20 December 20.., she was reviewed by an orthopaedic surgeon, Dr ……., regarding her spine. She had an MRI study of the lumbar spine which showed some disc bulging but no other abnormality.

In mid-February 20.., she tried returning to light duties but only lasted two weeks. She was talking to patients and spending about three hours a day at work. She moved out of her friend's unit and then went to stay with another friend in a unit as she needed further help with self-care.

She had a nerve conduction study for the persisting numbness in her right thigh but this did not show any major peripheral nerve injury.

On 27 March 20.., she had increased back pain and neck pain. She was admitted to ……. Hospital for rehabilitation and remained there for two weeks. She took analgesics and attended physiotherapy. She remained off work but after discharge from hospital, moved to another friend's place to live in a unit. She continued the day therapy at …… Hospital with physiotherapy, hydrotherapy and occupational therapy. She remained under the care of Dr ….. until about two months ago. She stopped the day care about two months ago.

She has remained under the care of a general practitioner, Dr …….. She has not had any further specialist review. She now attends physiotherapy twice a week and does Pilates exercises. She has not yet returned to work. From August 20.., she has been living by herself in her own unit but close to her friend's place.

Current Status:

Ms X stated she has constant low back pain with pain down her right leg to her ankle. She has difficulty with sitting for more than 15 minutes. Her symptoms often wake her at night.

She has constant pain around her right knee and swelling. She still has some loss of sensation over a small area at the front of the right thigh.

She has intermittent neck pain and occasional stiffness, particularly in the morning.

She can walk for only 10 to 15 minutes. She can stand for about half an hour. She needs to use the rails when going up and down stairs.

She stated she is dependent on her left leg more and has occasional soreness in the left leg. She does not have any problems with her arms.

Current Work Status:

Ms X is off work at present.

Present Activities:

Ms X stated she can drive a car a short distance for only about 15 minutes and has done so for the last two months.

After the accident, she needed help with self-care until January 20..and again for about three months from discharge from hospital in March 20... She stayed with a friend until about August 20.. to help with her self-care and as she was unable to do any housework.

She is now able to manage her own self-care. She does some light housework including cooking, light cleaning and washing her clothes. Most of the housework is done by her friend and she estimated she needs help about six hours per week including for shopping. She is unable to vacuum. She is unable to carry a shopping bag and does not go shopping by herself. She is not required to do any yard work.

Typical Daily Physical Activities:

Ms X stated that prior to the injury she was very active, involved with dancing, outdoor soccer, hiking, swimming and badminton. She also would occasionally go jogging and attend a gym. She has not been able to continue any of those activities.

She now walks about 10 to 15 minutes daily. She has been unable to go to the cinemas as she cannot sit for any time. She stated her social life is markedly reduced.

Present Treatment:

Ms X takes regular Panadol and Mobic tablets. She takes tramadol tablets about four times a week. She only takes Endone tablets on occasion.

She attends physiotherapy twice a week but believes this will soon be ceased. She attends gym on occasions only. She stated she walks for about 10 to 15 minutes a day for exercise.

Past Medical History:

Ms X stated her general health is good.

She denied any past history of injury or condition with the right limb or spine.

Family History:

Nil relevant.

Personal/Social History:

Ms X is single and presently lives in a unit by herself. She does not smoke.

REVIEW OF FILE RECORDS:

1. Dr ……. (Orthopaedic Surgeon), 16 November 20...
2. Dr ……. (Neurosurgeon), 6 November 20...
3. Personal injury claim form.
4. …….. Medical Centre medical notes.
5. ……. Hospital records.
6. …… Hospital records.
7. …….. Hospital records.
8. …….. Physiotherapy records.
9. Rehabilitation files.
10. Dr …… (Orthopaedic Surgeon) letter, 15 February 20...
11. Dr ……. report, 17 June 20...

PHYSICAL EXAMINATION:

Ms X's height was 154 cm and weight was 57 kg. She walked with a very slight limp, tending to walk with her right leg turned out. She had slight difficulty walking on her toes and heels in the right leg but could manage on the left. She had difficulty balancing on her right leg but could manage on the left. She could only half squat. She had normal lower limb alignment. There was equal forearm circumference.

Head/Neck:

She was noted to move her neck freely during the consultation. There was normal cervical posture and no tenderness. There was some tenderness in the suprascapular region in both shoulders. She had full symmetrical range of movement of the cervical spine with no muscle guarding or spasm. Forward flexion and extension were 40° each. Lateral flexion to either side was 30°. Rotation to either side was 60°. There was no neurological deficit in her upper limbs with normal power reflexes and sensation.

Upper Limbs/Shoulder Girdles:

There was no muscle wasting of either shoulder. She had full and equal range of movement of both shoulders though complained of some discomfort in the trapezius area.

Back/Spine:

There was no scoliosis and she had a normal lumbar lordosis. There was some tenderness on palpation in the thoracic spine and in the lower lumbar spine with a positive axial compression test. She had full symmetrical rotation of the thoracic spine to 50° in either direction with no muscle guarding or spasm.

On examining the lumbar spine, there was a asymmetrical loss of movement with guarding. Forward flexion was to 50° and extension only 10°. Lateral flexion to the right was 30° but the left limited to 20°. Straight leg raising was 80° on both sides with no nerve root tension. She had equal leg length. There was no neurological deficit in the lower limbs with normal power, reflexes and sensation.

Lower Limbs:

There were minor scars on the right anterior shin and the back of the calf area. There was a 12cm oval area with reduced sensation at only grade 4 at the front of the right thigh which appeared to be from the crush injury. This was not peripheral nerve injury as such, but rather an area of deep tissue damage. There was tenderness on palpation of the proximal medial tibia.

The hips had full and equal range of movement. The right knee flexion was 0° to 140°. There was no patellofemoral crepitus and no patellar tenderness. She had negative Clarke's test for patellar chondritis. Her knee joint was stable with no effusion. The right thigh was reduced to 0.5cm when measured and compared 10cm above the patella. The right calf was reduced to 0.5cm at the maximal point. She had normal peripheral circulation in her lower limbs.

INVESTIGATIONS:

X-Rays – Pelvis and Right Hip (6 November 20..): These were essentially normal with no signs of fracture.

X-Ray – Right Leg (28 November 20..): This showed a possible undisplaced fracture of the proximal fibula with a small area of classification.

MRI – Pelvis: This showed no fracture. There was oedema in the proximal right thigh.

CT Scan – Pelvis: This showed no fracture.

MRI – Lumbar Spine (4 December 20..): This was reported as showing disc bulging and a small annular tear at L4/5 level but no disc protrusions at other levels. There was no nerve root compression.

MRI – Right Knee (26 December 20..): This showed bone bruising on the medial femoral condyle and fibular head with a possible undisplaced fracture of the fibular head. The ligaments and menisci were intact. There did not appear to be any bone bruising around the patella.

Nerve Conduction Study – Right Lower Limb (12 February 20..): This showed normal sensory and motor conduction velocity.

SUMMARY AND ASSESSMENT:

Ms X is .. years of age and was a pedestrian involved in a motor vehicle accident on 1 November 20.. where she primarily suffered a crush injury to her right lower limb. She later developed spinal pain. Outwardly, she has recovered well from these injuries but does still have constant discomfort, particularly in the right lower limb and lumbar spine area with restrictions of activities. There does not appear to be any further treatment that need be undertaken; however, she would need to concentrate on her own exercise program and attempt to get back into the workforce to improve her mobility and strength.

Diagnoses:

Ms X was a pedestrian involved in a motor vehicle accident on 1 November 20.. with the following injuries.

1. Crush injury to her right lower leg with bone bruising to the right knee and possible undisplaced fracture of the fibular head.
2. Soft tissue injury to her lumbar spine.
3. Soft tissue injury to her cervical spine.
4. Minor scarring not requiring assessment.

Assessment:

The injury is consistent with the history as stated. Ms X has recovered well considering the severity of the injury but she still has ongoing symptoms.

Answers to Questions:

1. The nature and extent of the symptoms/injuries reported by the Claimant;

The nature and extent of the symptoms and injuries are as listed above.

2. The circumstances of the accident as reported by the Claimant;

The circumstance of the accident is that Ms X was pinned against a concrete wall by a car, suffering primary crush injury to her right leg and later onset of discomfort in her neck and low back region.

3. Your clinical findings concerning the nature and extent of the Claimant's injuries;

The clinical findings are as listed above.

4. The Claimant's pre and post-accident medical history;

She denied any past history of injury or condition and has not had any post-accident injury.

5. With reference to the enclosed medical and rehabilitation documentation, whether the reported injuries are consistent with having been caused by the accident;

Injuries are consistent with the history as stated.

6. Is there any discrepancy between the symptoms/injuries as reported to you by the Claimant and the clinical findings? If so, what is the discrepancy and can it be reasonably related to the accident?

There is no discrepancy between the symptoms/injuries as reported to me and the clinical findings.

7. Whether the Claimant is currently undergoing any treatment;

She is presently attending physiotherapy twice a week though understand this is soon to finish. She does take regular analgesics or Panadol or Mobic tablet.

8. Whether the claimant is at Maximum medical improvement?

The injury is now stable and has reached maximum medical improvement.

9. Whether the Claimant is suffering from a whole person impairment and, if so, whether the Claimant's whole person impairment arises from the injuries sustained in the accident, as opposed to any pre-existing impairment.

We ask that you provide details as to how you calculated the Claimant's impairment (if any) and also that your assessment be based on criteria provided under AMA Guidelines (5th edition) ('AMA5') and that you state:

(a) the provisions of AMA 5 setting out the criteria upon which you relied; and
(b) if a range of percentages is available under AMA 5 your reason for assessing the injury at the selected point in the range;

Impairment can be assessed using AMA 5th Edition Guidelines.

For the cervical spine, this is assessed as DRE I as she has full symmetrical range of movement with no muscle guarding or spasm. The Table 15.5 on page 392 indicates 0% whole-person impairment.

For assessment of the lumbar spine she is DRE Category II with asymmetrical loss of movement and muscle guarding. This is assessed using table 15.3 on Page 384 at 5% whole-person impairment. There is an addition of 2% for restriction of activities of daily living, giving a total of 7% whole-person impairment.

For assessment of the right lower extremity, this can only be performed on range of movement using Table 17.9 and 17.10 on Page 537. This equates to 0% whole-person impairment. There was no painful patellofemoral crepitus and no significant muscle wasting.

The scars did not rate an impairment and the sensory disturbance in the right thigh was minimal and not involving a peripheral nerve. It was due to a soft tissue deep damage.

No deductions required for pre-existing condition.

I have reviewed the report by Dr ……. and Dr …….. and disagree with their impairment assessment. She was noted to have full symmetrical range of movement of the cervical spine today. She did have asymmetrical movement of the lumbar spine. There was no evidence of painful patellofemoral crepitus on examination today.

10. Whether the Claimant is a candidate for further treatment and/or surgery and, if so, the nature of such treatment/surgery, when you consider such treatment/surgery is indicated and your estimate of the current cost of such treatment/surgery (including hospitalisation, if applicable);

She does not require any further treatment and there is no indication for surgery. I believe that physiotherapy could be ceased and that she would need to concentrate on her own exercise program and attend a gym for strengthening exercises. She should also return to regular walking of longer distance and try and return to the workforce to increase her strength.

11. Whether such surgery would have an impact on the percentage whole person impairment should the surgery prove to be successful;

Not applicable.

12. Your detailed opinion as to whether the injuries have impacted on the Claimant's ability to carry out his/her day to day work duties and/or employment and if so the manner and extent that these duties/employment have been affected;

She had considerable difficulty with self-care and doing the housework for some time after the accident as outlined above in the report. She was also unable to continue her work as an assistant in nursing. This is detailed above in the report.

13. Your detailed opinion as to whether the injuries have impacted on the Claimant's ability to carry out his/her activities of daily living and if so, the nature and extent those activities have been affected.

She is presently able to manage her own self-care but still can only manage light housework. She has not been able to return to her pre-injury activities and has not yet been able to return to work. She presently has a friend come in and help with housework and also to take her shopping. I believe this should not be required for more than another one month as she demonstrated ability to walk unaided and has obtained full lower limb range of movements with no significant muscle wasting.

14. With reference to the enclosed medical and rehabilitation documentation, outline the diagnostic studies/procedures already undertaken by the claimant and those in your opinion that are still required (if any).

These are as listed above. Nil further are required.

15. Please provide your opinion on the Claimant's capacity to work post-accident in relation to university study (Nursing) and working in an aged care facility.

She is presently on a certificate stating she is unfit for work; however, I believe she is fit for light duties of full work hours and should return to the workforce as soon as possible. Unfortunately, the assistant in nursing work is not available until she is cleared fit for full pre-injury duties. She may be fit for full pre-injury duties within the next six months if she concentrates on a strengthening exercise program and increases her activities. I would expect her to be able to return to pre-injury duties in the future without restrictions as a result of this injury.

16. Please comment on the Claimant's current capacity for work and your opinion on her capacity for study and work into the future.

I would expect that in the future she would be able to return to her studies and pre-injury work within the next six months.

The factual matters stated within this report are, to the best of my knowledge, true and correct. I have completed all enquiries that I consider appropriate in formulating my conclusions. The opinions stated by me within this report are genuinely held by me. The report contains reference to all matters which I regard as significant. I understand my overriding duty as an expert is to assist the Court and I have complied with this duty.

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 your requirements regarding Ms Kim. Please do not hesitate to contact me if I can be of any further assistance.

Yours faithfully

Dr …….
Consultant Orthopaedic Surgeon