MEDICAL REPORT

THIS IS A REPORT TO THE COURT BASED UPON THE HISTORY OF THE INJURIES SUSTAINED BY THE CLAIMANT, THE TREATMENT, CONDITION AND PROGNOSIS.

NAME:	Shoulder
ADDRESS:	Birmingham
DOB:	Age 62
ACCIDENT DATE:	February 07
REPORT DATE:	January 08
INSTRUCTIONS FROM:	Ref: A N Other Solicitors.
REPORT BY:	**DR S L BROWN** MA, (Cantab) LLB, (Hons), LLM, MB, ChB, DRCOG, DCH, FRCGP

1. Professional Qualifications

I am Dr S.L.Brown of Pailton Court, Pailton, Rugby, Warwickshire. I hold the following qualifications; MA, (Cantab) LLB, (Hons), LLM, MB, ChB, DRCOG, DCH, FRCGP and have experience in general medicine, general surgery, casualty, psychiatry, hypnotherapy, paediatrics, and obstetrics and gynaecology.

I have been a GP since 1984 and a GP Vocational Training Scheme Trainer since 1987. I have a special interest in musculo skeletal problems. I am advisor to Rugby PCT on orthopaedic services and a GP with special interests in musculoskeletal medicine.

I was a Disability Analyst for the Benefits Agency for ten years.

I was Chairman of the Warwickshire Multi-disciplinary Audit Advisory Group for the ten years of its existence.

I was an Associate Research Fellow of the University of Warwick for ten years.

I am a member of the British Institute of Musculoskeletal Medicine and the British Society of Medical and Dental Hypnosis.

I am registered in the Law Society Directory of Expert Witnesses.

I understand my duty to the Court is to help the Court on matters within my expertise and I have complied with that duty and will continue to do so.

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I confirm that insofar as the facts stated in my report are within my knowledge I have made clear which they are and I believe them to be true, and that the opinions I have expressed represent my true and complete professional opinion.

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2. Summary

Mr Shoulder was involved in an accident where he fell injuring his neck, shoulder, and knees. He has on-going problems and these are discussed in the Prognosis section.

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3. Circumstances of Accident

Mr Shoulder was walking to visit his sister. He tripped over a raised paving stone and fell forwards hitting a tree with the point of his shoulder, his neck and the side of his head. He describes that he was in pain and that initially this was severe enough to make him feel nauseated. He was also aware that his middle finger on the left hand hurt as well as significantly scuffing his knees causing significant abrasions with skin loss.

However, as he got up and moved he felt that the pain sort of settled and he went home expecting that he would have a few bruises but that there would be no major problems. However, he describes that the pain and stiffness in his neck and shoulder increased.

His knees were significantly bruised with two large skin loss abrasions.

He tried to carry on with simple first aid measures but found that the pain in his neck and shoulder was increasing. He found anything that needed him to move his arm was very painful. He went to see his GP approximately 10 days later because things were worse than initially and there was no settling of the conditions.

His GP sent him for an X-ray on his shoulder. Physiotherapy was also arranged and he had 8 sessions which he felt restored some movement in his shoulder and neck but did little for the pain or discomfort. The improvement was not long-lived after the Physiotherapy finished.

Mr Shoulder describes that his knees healed and settled and left a scar. His knees were back to normal in terms of function without discomfort somewhere in the region of 6 weeks.

However, he still has on-going problems with his neck and shoulder.

Work

Mr Shoulder had taken early retirement at the time of the accident but now works as a Chauffer. He finds that by the end of a day he is in considerable discomfort with his neck and shoulder.

Domestic Role

Housework Mr Shoulder helps around the house but can do nothing that needs him to lift his arms up above shoulder level.

DIY Mr Shoulder would normally do all the day to day DIY work but is unable to do anything because it is so painful to lift his arms up above his head.

Hobbies/Sports/Interests

Mr Shoulder is a retired martial arts competitor. He no longer competes but has taught martial arts for some time. He finds that he is very limited in what he can do and struggles to do any demonstrating.

Driving

Mr Shoulder found that initially driving was particularly uncomfortable. Turning to look for on-coming traffic at junctions was very difficult and reversing was extremely painful. He describes that even now these activities and movements are painful. To a certain extent, he has less pain because he has adapted in the way that he turns.

Long journeys, sat still in the car, are a major problem for his neck and shoulder.

Effects on Activities of Daily Living

Mobility This was reduced initially because of the pain and discomfort in his knees.

Transferring Mr Shoulder noticed that in the morning he was especially stiff and uncomfortable and it was over an hour before the pain and discomfort had eased as the stiffness gradually reduced. Even now, he is more aware of his neck and shoulder first thing in the morning.

Bathing Getting in and out of the bath was awkward.

Sitting Sitting for too long initially was particularly problematical causing increased stiffness in the neck and shoulder and, even now, it is a problem and especially so with driving.

Dressing Initially, it was very difficult to get dressed. Anything that required movement of the shoulder was problematical. Even now, Mr Shoulder tells me that he struggles with putting on shirts and jackets.

Grooming Putting his hands up above his head to wash his hair was particularly problematical initially and remains difficult and uncomfortable to a lesser degree.

Psychological Impact

Sleep Mr Shoulder describes that initially sleep was dreadful. It was difficult to find a comfortable position for his neck and shoulder but the worst problem was that turning during the night or rolling onto the shoulder would produce pain in his neck and shoulder which would wake him up for a significant period of time. Even now, his sleep is disturbed more nights than not.

Present State

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Mr Shoulder describes that his finger join is still swollen, stiff and painful.

Mr Shoulder still has considerable problems with his shoulder and neck which limits his activities, causes problems with his hobbies and disturbs his sleep.

4. Examination

Mr Shoulder appeared fit and well. He was able to cope with the stairs without any obvious difficulty.

It was quite clear that when he got undressed that he had problems removing his jacket and shirt because of his shoulder problem.

Examination of the shoulders showed active elevation and abduction to 145^{o} and 90^{o} on the left; this was compared with full range of movement on the right. There was almost full elevation on passive movement and abduction was increased to 120^{o}. Internal rotation was reduced compared with the right, the left hand reaching the sacrum whereas the right hand could go 25cm further up.

External rotation was marginally limited on the left. There was a marked impingement sign and supraspinatus appeared weak though it would be difficult to say whether this was pain related.

Examination of the neck showed gross restrictions in movement. Rotation was stiff from 20^{o} and absolutely limited by pain and stiffness at 45^{o}. Side bending was only 20% of normal. Flexion and extension were stiff, painful and limited to approximately 50% of normal. There were multiple myofascial trigger points. Neurological examination was normal.

Examination of the hands showed a normal appearance of the hands but with early Heberden's Nodes on the little fingers on both hands.

The proximal inter-phalangeal joint on the left middle finger was swollen and stiff consistent with Osteoarthritis and a significant soft tissue injury.

The left knee showed a well healed pink superficial scar of 2cm diameter and there was a similar scar on the right knee of 1cm diameter.

5. Past Medical History

Mr Shoulder told me that he is generally fit, well and active. He had a major injury as a young man and as a result has had problems with his ankle and knees and has been diagnosed as suffering from Osteoarthritis. He has had previous problems with his neck and back approximately 10 years ago when he was involved in a fall but this settled and he had no on-going problems prior to the accident. Mr Shoulder describes that he has had no previous hand problems.

I have been provided with the records. The Physiotherapy records confirm attendance at

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Physiotherapy on 8 sessions. The Physiotherapy records contain a lot of abbreviations and are difficult to decipher.

In essence, it appears that there was some settling with the initial Physiotherapy before the problem flared up. The Physiotherapy records confirm the problems of pain and discomfort in the shoulder, neck and in the hand.

The records would suggest that Mr Shoulder stopped attending and was discharged on 7th September 2007. This is peculiar because he attended 10 sessions.

The GP records appear to be complete. There is a note on 28th February 2007 that Mr Shoulder had fallen on Sunday 18th February when he tripped on a block of stone in the footpath; sustained left shoulder, left hand and both knees injuries. He was referred for an X-ray and Physiotherapy.

The medical records confirm that Mr Shoulder has had considerable problems with his knees and ankles. He has significant Arthritis in his ankle.

On 29th January 1999 he was referred for an X-ray because of pain in his neck and back after a fall.

The X-ray performed on 28th February 2007 is reported as left shoulder no bony injury seen; normal alignment; there is early degenerative change in the AC joint; glenohumeral joint space is normal; no soft tissue calcification seen; left hand no definite bony injury seen; there is severe arthritic change at the middle finger proximal inter-phalangeal joint with joint space narrowing and prominent osteophyte formation. There is a prominent step in the cortex at the head of the proximal phalanx which is probably due to osteophyte formation but as a fracture could not entirely be ruled out the patient was referred to Leigh Walk-in Centre for assessment.

28/02/2007	Walk-in Centre assessment; Physiotherapy was confirmed and it was thought that there was a fracture to the head of the proximal phalanx of the left middle finger.

There is a letter from the Physiotherapy Department on 5th January 2005 stating – thank you for referring the patient for Physiotherapy on 30th June 2004 with knees, right hip and shoulder pain. The letter then goes on to describe problems with the knees with no mention of the shoulder. Unfortunately, I am not able to find any corresponding notes on the referral.

6. Prognosis

Mr Shoulder was involved in an accident where he fell impacting his neck and shoulder on a tree.

His recovery has stalled and he has significant on-going problems. His description of the

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accident and his problems are entirely consistent.

In my opinion, the issues are complicated in that there is clearly a history of Osteoarthritis in other joints. The X-ray suggests Osteoarthritis in the finger though there was no problem and Mr Shoulder describes that there was no significant swelling or stiffness prior to the accident.

The X-ray of the shoulder, importantly, showed a normal shoulder joint.

In my opinion, Mr Shoulder had a normal finger with wear and tear at the time of the accident. In my opinion, had he not had the accident I do not believe that he would have had any particular problem with his finger. The present appearance of the finger is very typical of soft tissue trauma at or around the finger and it is not unusual for these swellings to take a considerable period of time, often more than a year, to settle. As people get older there is a tendency for these swellings to become more chronic and never resolve completely.

I believe that he should have some intense Physiotherapy to try and restore as much function into that joint as possible.

The knees have permanent scarring but, otherwise, have returned to their previous state and there is no attributable on-going problem in the knees from the accident.

Mr Shoulder has a very mixed picture of the shoulder. The Physiotherapist suggested he had a traumatic capsulitis. In my experience, it is a relatively rapid onset to have a traumatic capsulitis within 10 days of an accident.

He has very clear weakness in the supraspinatus as well as a positive impingement sign. I believe that he may well have damage to the rotator cuff and that this could account for the pain, stiffness and limitations that he has.

He needs definitive treatment and this, in my opinion, would involve an injection into the subacromial space of steroids to try and settle any inflammation and the subacromial space should be investigated along with the shoulder joint. One alternative would be an X-ray to check for acromial impingement and an ultrasound scan to assess the capsule and the rotator cuff. This is often done in the NHS because it is more readily accessible and marginally cheaper than an MRI scan. However, the gold standard test is an MRI scan which would define the nature of the problem.

The way forward would be defined by the response to the injection and the results of the scan. If there are good results from the injection and the scan did not suggest any impingement or supraspinatus tear, then Physiotherapy to try and further restore movement would be appropriate. However, if there is a significant tear or a significant impingement, then the opinion is required of a Shoulder Specialist. This would need to answer the questions of whether any surgical intervention is required and, in particular, whether any acromial impingement was due to the accident or to pre-existing changes in the bone.

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