FIRST MEDICAL REPORT PREPARED FOR THE COURT

DATE OF REPORT:	12th October 2016
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CLIENT NAME:	Mr B
CLIENT ADDRESS:	Withheld
OCCUPATION AT TIME OF ACCIDENT:	Delivery Driver and Operative
DATE OF BIRTH:	05 11 50
DATE OF ACCIDENT:	25 01 16
TIME ELAPSED SINCE ACCIDENT:	Eight-and-a-half months
TIME OFF WORK DUE TO ACCIDENT:	Five months
INSTRUCTING PARTY:	T Solicitors
INSTRUCTING PARTY REFERENCE:	Withheld

This Report is prepared for the Court under instructions from T Solicitors. I confirm that consent to the examination has been given.

I understand that my duty is to give objective help to the Court on all matters within my expertise.

I understand that this duty overrides any obligation to the person by whom I have been instructed or by whom I am paid. I have complied with this duty.

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MEDICAL REPORT

1 METHODOLOGY

1.1 Instructing Brief: I have been instructed by T Solicitors to review Mr B with regards to a rupture to his left distal biceps tendon which occurred on 25 01 16.

1.2 I.D. Provided: Passport.

1.3 Accompanied by: No-one.

1.4 Medical Records available: Hospital and GP notes available.

1.5 Communications difficulties: None.

Sections 3 to 11 inclusive of this report were dictated in front of the Claimant in order to agree on content

2 SUMMARY

2.1 Mr B was involved in an accident on 25 01 16 sustaining a distal biceps rupture on the left dominant arm.

2.2 It is my opinion the symptoms he describes are in keeping with the mechanism of injury that has been described.

2.3 Unfortunately due to a delay in surgery, primary repair was not possible to the biceps.

2.4 It is my opinion there has been an impact on his ability to carry out his work and activities. It is my opinion it is early in the post-surgical period in order to give a definitive prognosis and it is my opinion it will be up to a year post surgery before he reaches a plateau in recovery. It is however my opinion that due to failure to repair the biceps tendon he will be left with some permanent loss of flexion and supination strength, as well as endurance, of between 30-40% which will have an impact on certain activities including certain heavier and twisting type activities.

2.5 It is my opinion there has been no exacerbation of any underlying pre-existing condition.

3 BACKGROUND

3.1 Mr John B is a 65-year-old, left-handed, full-time delivery driver and operative. He lives in a house with his wife.

3.2 He was involved in an accident at work on 25 01 16 sustaining a distal biceps tendon rupture which subsequently required surgical intervention.

4 HISTORY OF INDEX ACCIDENT

4.1 On 25 01 16 Mr B was carrying out his usual work activities of delivering patio sliding doors to customers. He was unloading his lorry with a female colleague. He had slid the doors to the back of the lorry and was slowly lowering the doors to the floor. One of the doors suddenly dropped at speed while Mr B was holding on to the door. His left elbow was suddenly extended and he felt a tearing sensation in the left elbow area. This was associated with pain and pins and needles.

4.2 He did not notice any subsequent swelling but he did notice a bruise around the elbow area.

4.3 He had a lunch break an hour later and then continued with his day's work, albeit in discomfort.

5 PROGRESSION OF SYMPTOMS

5.1 He continued working for a further ten days but was experiencing pain and discomfort in the elbow as well as some swelling. Ultimately he saw his GP ten days later who felt it was initially just a strain. He saw a further GP a week later who diagnosed a probable distal biceps tendon rupture and referred him for an urgent scan.

5.2 Unfortunately he waited four weeks for the scan to occur where the diagnosis was confirmed. He was then referred to an upper limb clinic at Torbay Hospital and the surgical options were given to him. He ultimately underwent a surgical procedure to the left distal biceps tendon in April. This was done as a day case under general anaesthetic and he was discharged home in some form of brace which he wore for around four weeks. Once the brace was removed at four weeks he had only one session of physiotherapy. He was ultimately discharged from the clinic and has had no further investigations or treatments.

5.2 The left elbow was his only injury at the time of the index accident.

6 PRESENT SITUATION

6.1 Today Mr B believes his left elbow is 50% back to normal. He describes an occasional ache during the day; however he has episodes of significant pain when undertaking any heavy activity. This pain is a cramp-like pain in the biceps area which lasts for two to three minutes after he has undertaken heavy activity. It then settles after rest.

6.2 He complains of bilateral pins and needles in the hands which has been present for a number of years.

6.3 He feels the left arm is weaker than the right arm.

6.4 He is not sure if the left elbow is improving with time.

7 PAST MEDICAL HISTORY

Mr B was asked directly about his past medical history and confirmed the following:

7.1 No previous injuries to his left elbow or left biceps prior to the date of the index accident.

7.2 He is otherwise fit and healthy. He has had an appendicectomy in the past.

7.3 He is currently not taking any regular medication.

8 DOMESTIC HISTORY

8.1 At the time of the index accident Mr B was living at home with his wife in a house.

8.2 With regards to domestic activities including washing, cooking, cleaning and self-care, he was able to continue with these activities after the index accident and prior to the surgery albeit with some weakness and some discomfort.

8.3 Post surgery he believes it was four weeks before he was able to return to the majority of his domestic activities.

8.4 At the present time he is able to undertake all that is required of him but does struggle with certain activities including heavier activities as well as putting cutlery and other items onto high shelves.

8.5 He has not returned to DIY activities as yet.

8.6 He did not drive for four weeks following the surgery but continued driving after the index accident.

9 WORK

9.1 Mr B works as a delivery driver and operative for a patio door manufacturer.

9.2 He was off work from around 4th February 2016 up until his date of surgery and was then off until the end of June 2016.

9.3 He returned to lighter factory work for a week and then returned to his previous role as a delivery driver and operative. He tells me he undertakes pretty much the same job he did before the index accident albeit he does try and protect the elbow with regards to heavy lifting. There have been no specific changes to his role however.

9.4 Of note, Mr B had already passed his sixty-fifth birthday at the time of the index accident. When he became sixty-five he decided he was going to probably retire eighteen months later.

10 PASTIMES

10.1 Mr B's main pastime was fishing. He undertook beach fishing as well as sea fishing from a kayak. He has been unable to return to either of these activities. He is unable to return to shore fishing due to his inability to cast the rod and is unable to return to sea fishing due to his inability to return to his kayaking.

10.2 There have been no other specific pastimes affected by the index accident.

11 PSYCHOLOGICAL INFLUENCES

11.1 There has been no significant psychological effect secondary to the index accident.

12 ON EXAMINATION

Mr B was helpful throughout the interview and did not appear to be in any obvious distress. There was no inappropriate behaviour.

12.1 Examination of Left Elbow:

12.1.1 Inspection:

(a) He has a 15cm longitudinal scar over the anteromedial aspect of the upper arm extending from just below the shoulder to just above the elbow. There is obvious wasting of the biceps musculature which becomes more noticeable during resisted flexion. There is also evidence of retraction of the biceps tendon when compared to the right side.

12.1.2 Palpation:

(a) No tenderness over the scar. No other significant tenderness noted on palpation around the shoulder, upper arm and elbow.

(b) There is no palpable distal biceps tendon noted on the left side.

12.1.3 Range of Movement:

(a) Full range of movement of the left shoulder, left elbow and left wrist when compared to the right side. This includes full extension and full flexion, as well as full prosupination of the left elbow.

12.1.4 Special tests:

(a) Neurological examination shows intact musculocutaneous, radial and post interosseous nerves left side.

(b) Resisted flexion on the left side is discernibly weaker than resisted flexion on the right side, as is resisted supination on the left side compared to the right side.

(c) Grip strength left hand 20kg; right 40kg.

13 REVIEW OF MEDICAL RECORDS

13.1 Review of GP records in relevance to this claim:

04 02 16 GP note: Eleven days ago experienced pins and needles left arm on lifting a window frame. Saw a bruise over the biceps region at the time heavy lifting. This has settled but soon afterwards developed right-sided (*sic*) localised area of pain that is ongoing. Tender over biceps tendon and slight depression over area of pain. Good range of movement.

Diagnosis: Biceps tendinitis.

12 02 16 GP note: History as above. Pain arm on lowering heavy window, feels asymmetrical, aches after movement. Due back to work. Pain on changing gear as well as lifting. Query partial tear lateral tendon. Plan: physio and ultrasound scan.

17 03 16 Ultrasound scan left biceps: There appears to be a rupture of the distal end of the short head of biceps muscle with retraction of the muscle body. The tear measures 4.7 x 2.2cm.

17 03 16 GP note: Range of movement improving considerably. Keen to get back to work. Has scan tomorrow.

28 04 16 GP note: Two weeks post surgery to left biceps. Has one long stitch in situ and steri strips over.

04 05 16 GP note: Steri strips and sutures removed from arm following surgery. Healed well except for one small area at top of wound.

13.2 Review of Hospital records in relevance to this claim:

23 03 16 Torbay and South Devon Orthopaedic Outpatient note: I saw this gentleman in clinic today. Eight weeks ago he slipped while carrying a heavy window frame and sustained a distal rupture of the biceps tendon in his dominant left arm. He has got very significant retraction of the tendon to mid humerus level. I have explained that at this time post injury it can be quite difficult to re-attach but given that he is still working physically we should give this a go. The aim would be to re-attach the native biceps tendon if possible with an Endobutton. If this is not possible then we may be able to interpose a split FCR tendon graft and if that is not possible a myodesis procedure to stitch the biceps belly down to brachialis which would help to reduce some of his symptoms and restore a modicum of flexion strength. He has gone to pre-assessment today and I look forward to seeing him when he comes in.

14 04 16 Orthopaedic Operative note: Plastic repair of biceps brachii tendon. Anteromedial approach to arm. Biceps tendon unravelled to approximately 4cm length of tendon. With full freeing of the biceps this could be brought to approximately 6cm above the cubital flexion crease. This was not sufficient for attachment to proximal radius even with a FCR graft. Therefore myodesis carried out. Tendon carefully freed protecting musculocutaneous nerve. Brachialis exposed down to its tenderness portion. Biceps tendon sutured to this throughout its length using No.2 Vicryl. Post op: Sling at 90 degrees flexion for two weeks then gradually extension as comfort dictates. No lifting four weeks, no heavy lifting eight weeks.

08 06 16 Torbay and South Devon Orthopaedic Outpatient note: He underwent a myodesis of the left biceps on 14th April. It was not possible to get a full repair of his distal biceps avulsion owing to significant retraction. He had a myodesis of the biceps muscle belly to brachioradialis and seems to have a good result with that. His scar has nicely healed and he has almost full elbow extension and feels that functionally essentially he is back to normal.

I have not arranged to see him in the fracture clinic again but will happily do so should any problems arise.

14 DIAGNOSIS

14.1 Left distal biceps rupture.

15 OPINION AND PROGNOSIS

The opinion and prognosis below is based on the balance of probabilities.

15.1 **Left Distal Biceps Rupture**

15.1.1 **Mechanism of injury:** Mechanism of injury would have been an element of resisted flexion with supination at the time of the index accident leading to an avulsion of the distal biceps insertion.

It is my opinion the symptoms he describes and subsequent diagnosis is in keeping with the mechanism of injury that he has described.

15.1.2 **Relevant past medical history:** There appears to be no previous history of left distal biceps pathology prior to the date of the index accident.

15.1.3 **Recovery:** Mr B describes only a 50% recovery since the date of the index accident and surgery. It is however my opinion that he has a functional left arm, albeit there is some loss of flexion and supination strength as well as some ongoing mild discomfort in the biceps muscle bulk.

15.1.4 **Examination:** Clinical examination today shows a well-healed surgical scar with obvious retraction of the biceps muscle belly, and some loss of resisted flexion and supination.

15.1.5 **Reasonableness:** It is my opinion that Mr B's account, actions, treatments and period of time affected are all entirely reasonable with regards to the index accident and the injuries sustained.

15.1.6 **Relationship of symptoms to index accident:** It is my opinion that all symptoms to the left elbow are related to the index accident.

15.1.7 **Exacerbation of underlying condition:** It is my opinion that there has been no exacerbation of any underlying condition.

15.1.8 **Acceleration of symptoms:** It is my opinion that there has been no acceleration of any underlying asymptomatic condition.

15.1.9 **Prognosis of symptoms:** Mr B is now almost nine months since the date of the index accident and six months since the date of his surgery.

In view of the delay between the date of the index accident and the date of surgery, primary repair of the biceps tendon was not possible and therefore only suturing of the biceps to the brachialis muscle was possible.

It is my opinion that it is still relatively early in the post injury and post-surgical period to give a definitive prognosis. It is my opinion it will be up to a year post surgery before he reaches a plateau in recovery with regards to strength.

In view of the fact that a primary repair was not possible, it is my opinion that one could suggest in the long term there will be some loss of flexion and supination strength which could be classified as permanent.

Studies have shown that untreated biceps tendon injuries can leave patients with up to 30% loss of flexion strength and up to 40% loss of supination strength as well as endurance strength loss of between 30-40%.

It has been noted that Mr B is close to retirement and therefore the chances of this having a significant impact on his work activities for the rest of his career would be relatively minimal. It is however my opinion that by the one year post surgical period he will have reached a plateau in recovery, however will notice ongoing loss of flexion and supination strength which could be classified as permanent as well as loss of endurance as noted above. This will have an impact with certain activities including heavy lifting and twisting type activities.

15.1.10 **Risk of future osteoarthritis:** It is my opinion that there has been no significant increased risk of osteoarthrosis occurring in the left elbow secondary to the index accident.

15.1.11 **Prospects on open job market:** It is my opinion there was a significant effect on his ability to work from the date of his injury up until June 2016. It is my opinion he is able to return to his role as a delivery driver, however there will be an ongoing effect on his ability to do heavy lifting and twisting activities up until his date of retirement which was due to be eighteen months following the date of his sixty-fifth birthday. It is however my opinion that he will be able to continue in his role up until this declared retirement date. It is however my opinion there will be an ongoing effect on his ability to undertake all heavy lifting and twisting type activities secondary to 30-40% loss of strength and endurance.

15.1.12 **Activity prognosis:** It is my opinion there would have been a mild to moderate effect on his activities following the date of the index accident up until his date of surgery. It is my opinion there would have been a more significant effect on his activities for a further four to eight weeks following the date of his surgery.

At this stage it is my opinion he is able to undertake the majority of his activities, however heavier lifting and twisting type activities including certain DIY activities as well as fishing may be affected in the long term. As noted above, it is my opinion it will be at least twelve months post surgery before he reaches a plateau in recovery with regards to strength and endurance. However in the long term it is my opinion there will be a mild to moderate effect on these heavier and twisting type activities which could be classified as permanent, albeit it is my opinion he will be able to return to these activities albeit with some modification.

15.1.13 **Treatment recommendations:** Mr B describes only one episode of physiotherapy post surgery. It is my opinion he should have a proper integrated course of physiotherapy rehabilitation to try and maximise strength and endurance in the long term as well as to decrease the cramping that he describes. One would suggest number of sessions would be tailored to clinical improvement, however up to six sessions would be warranted in the first instance. It is however my opinion there is no indication for further surgical treatment of this left arm as things stand at the present time. It is my opinion there will be no requirement for further surgical intervention in the future.

16 STATEMENT OF TRUTH

I have set out in my report what I understand from those instructing me to be the questions in respect of which opinion as an expert are required.

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.

I have endeavoured to include in my report those matters of which I have knowledge or of which I have been made aware that might adversely affect the validity of my opinion.

I have indicated the sources of all information I have used.

I have not, without forming an independent view, included or excluded anything which has been suggested to me by others (in particular my instructing lawyers).

I will notify those instructing me immediately and confirm in writing if for any reason my existing report requires any correction or qualification.

I understand that

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

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

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

I confirm that I have not entered into any arrangement where the amount of payment of my fees is in any way dependent upon the outcome of the case.

I confirm that I have made clear which facts and matters 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 matter to which they refer.

I confirm that I understand my duty to the Court and have complied with and will continue to comply with it. I also confirm that I am aware of the requirements of CPR Part 35, Practice Direction 35, the protocol for the instruction of experts to give evidence in civil claims, and the Practice Direction on pre-action conduct.

Signed……..... Date…….....

21 10 16

MR SIMON RICHARDS FRCS
Consultant Orthopaedic Surgeon

17 MEDICAL EXPERT C.V. SUMMARY

MEDICO-LEGAL CURRICULUM VITAE
Mr Simon Richards FRCS (Tr & Orth)
Consultant Orthopaedic Surgeon

G.M.C No: 3658358
M.D.U No: 302833X

Qualification: The Royal College of Surgeons, England. FRCS (Tr&Orth)

Current Appointment Royal Bournemouth and Poole Hospitals NHS Trusts, Dorset.
Position: Consultant Orthopaedic Surgeon

Secretary: Jen Campbell,
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Consulting Rooms: The Bournemouth Nuffield Hospital,
67 Lansdowne Road,
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The Harbour Hospital,
St Marys Road,
Poole. BH15 2BH

Medico-Legal Experience

I have been compiling medico-legal reports for over 10 years. I am fully up-to date with the Woolf reforms and the subsequent changes this has made to report compiling.
My reports are fully compliant with the Civil Procedures Rules, 1998 - Part 35, and subsequent Practice directions 35 (October 2009).
My work is predominantly Personal Injury claims.
My expertise is in General Orthopaedic conditions. This includes soft tissue spinal injuries, as well as a specialised interest in injuries of the upper limb.
I compile 120-150 reports a year. The average time to be seen is 2-4 weeks. The turn-around time in returning a completed report, if all medical records have been made available, is less than 2 weeks.
I provide Personal Injury reports for claimant's solicitors in about 60% of cases, as a Single Joint Expert in about 35% and for the defence solicitors in about 5% of cases.
I am a member of the Society of Expert Witnesses and a registered expert with The Association of Personal Injury lawyers.

Conferences Attended:

April 2005: Medico-Legal Report Writing Seminar.
Pangbourne, Berks
June 2008: Essential Elements Medico-legal Training.
Royal College of Physicians, London.
October 2008: Medico-Legal Course, Healthcare Knowledge Ltd.
London.