MEDICAL REPORT PREPARED

FOR THE COURT ON

Mr XXXXXX XXXXXXXX

Photograph for identification

Dated 00/00/0000

Name	**Mr XXXXXX XXXXXXXX**
Date of Birth	**00/00/0000**
Date of accident	**00/00/0000**
Date of examination	**00/00/0000**
Address	**X, XXXX XXXXX**
	Xx, Xxxxxxxx, XX1 3XX
Your Ref	**12345678**
Solicitor Ref	**ABCD/123/EFG**

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SUMMARY

1. **Mrs Xxxx was involved in a road traffic accident on XX/XX/XXXX. The accident occurred whilst she was driving on the motorway, in company with her sister in law, who was a front seat passenger. Due to poor visibility caused by poor weather conditions, they unfortunately, had no choice but to pull over onto the hard shoulder of the motorway, to clear the windscreen. She got out of the vehicle and both she and her sister-in-law were attempting to clean the windscreen.**
2. **Another car coming from behind also came onto the hard shoulder and struck their vehicle. The impact jolted their car forward and indirectly pushed Mrs Xxxx, which knocked her onto the floor. She tells me she actually landed onto the motorway, but fortunately there were no vehicles coming along and she managed to move quickly back onto the hard shoulder.**
3. **She sustained soft tissue injury to the lumbar spine. In addition she sustained soft tissue injury to the cervical spine, which has caused pain to the neck and also radiation of pain into both shoulders.**
4. **Following the accident, she was able to drive her vehicle home. However, later that same day, her daughter took her to Xxxxxxx Hospital where she was examined and had an x-ray of the cervical spine. She was provided with a collar which she wore for one week. She tells me that subsequently she has consulted with her GP and has had 3 sessions of physiotherapy treatment. This treatment has helped but unfortunately, she continues to experience pain in the neck, both shoulders and low back.**
5. **I examined her on XX/XX/XXXX. She was able to walk unaided, could tiptoe, walk on her heels and squat without difficulty. She has a good range of forward flexion, being able to reach to her ankles on bending forwards. She has tenderness in the cervical spine with range of movement being slightly limited by around 20%. There is also tenderness over both shoulders in the supraspinatus and subacromial region. Impingement is slightly positive on both shoulders. Range of motion again is limited by around 20% in abduction and forward flexion. She also has some tenderness in the lumbar spine, but this is less than in the neck.**
6. **I have only been provided with the GP records for review and so have not seen the full clinical notes relating to her attendance at the hospital. However, the records include correspondence from the hospital, which confirms the circumstances of the index accident and the injuries sustained.**

7. **Prior to the index accident, she has consulted her GP on several occasions with neck and shoulder pain. In July XXXX it is documented that she sustained an injury to the left shoulder following a fall and this injury was still troubling her in October XXXX. An x-ray of the left shoulder dated XX/XX/XXXX did not show any abnormality. In June XXXX, she was referred for a bone density scan, due to a family history of osteoporosis. This scan was performed on XX/XX/XXXX and showed osteoporosis in the whole of the spine ad osteopenia in the hip. No fractures were identified.**
8. **Following examination I am of the opinion that she is genuine and her symptoms are real. I am also of the opinion that the injuries sustained and the symptoms complained off following the index accident is compatible with the mechanism of injury described to me.**
9. **I now recommend a course of physiotherapy treatment to treat the cervical spine, lumbar spine and both shoulders. The modality and the number of sessions are to be determined by the therapist. In addition to the physiotherapy treatment, she would also benefit from joining a Pilates or Yoga class. The exercises taught in these classes will build up the muscles around the spine and improve core stability to help with her neck and back pain. She should practice the exercises at home, 2 – 3 times per day, for around 5 – 10 minutes each session. However, she must ensure that his exercise routine is consistent and that she avoids a "boom and bust" approach.**
10. **I also recommend that she purchase the self help book detailed in my report and follow the advice provided. With treatment and a committed course of home exercise, I am of the opinion that the symptoms in the lumbar spine, cervical spine and both shoulders will resolve within 12 months following the index accident i.e. by December XXXX.**
11. **On the balance of probabilities there will be clinical impairment and disability caused by the index accident for 12 months following the index accident. On the balance of probabilities no long term harm will follow from the index accident beyond the predicted recovery period.**
12. **In the unlikely event that the symptoms do not resolve as anticipated, I would like to re-examine her. If a re-examination is required, I will provide a further report. I may also request MRI scans of the body parts injured following the re-examination.**

INTRODUCTION

I, Mr George Ampat am a Registered Medical Practitioner (General Medical Council Registration Number 4392747, MedCo ID: DME7313) and have been in clinical practice since October 1986. I have been a Consultant in Orthopaedics and Trauma with special interest in Spinal Disorders since January 2002 and I am a member of the Royal College of Surgeons, Glasgow. My academic qualifications include FRCS (Tr & Orth), MS (Orth), FRCS (Surg in Gen), Dip N B (Orth) & D.Orth.

I have produced reports for Road traffic accident victims and Personal injury cases for the last 16 years.

This report is completed following interview and examination of Mrs. Xxxx on XX/XX/XXXX at Xxxxxx Xxxxxxx, Xxxxxxx, Xxxxxxxx xxx.

Documentation available to me at the time of the examination included a Letter of Instruction from Xxxxxx Xxxxxxx, Xxxxxxx, Xxxxxxxx xxx.

I had access to the contemporaneous medical records.

Claimants are provided with a questionnaire to fill in prior to the interview and examination. The questionnaire was received and filled in by Mrs Xxxx,

The identity of the Claimant was checked by seeing her Passport.

HISTORY

Mrs Xxxx tells me that she was involved in an awkward accident on XX/XX/XXXX. She says that she was driving. Her sister-in law was in the front passenger's seat. There was no one else. It was snowing and the weather was poor and unfortunately visibility was poor and they parked by the hard shoulder and both of them got out of the car and were cleaning the windscreen when unfortunately another vehicle moved into the hard shoulder and collided onto the rear of their vehicle. The impact jolted the vehicle forward and in turn both of them were thrown onto the floor. Mrs Xxxx was thrown onto the motorway but luckily there were no other vehicles coming and no other secondary injuries. She managed to gather herself and got up. She landed on her right shoulder and neck. She says majority of the injuries were to the neck and both the shoulders and some to her lower back. She says that she was winded but luckily not knocked out. She managed to exchange details with the driver of the bullet vehicle. Subsequently after gathering herself, she managed to drive the vehicle and went home. That evening their children took them to Xxxxxxxx Hospital where she was interviewed and examined. She had x-rays of the neck and apparently she was given a collar which she wore for a week. Collars are not usually given and it looks like she was

given collar. Subsequently she has consulted her doctor on numerous occasions and has been prescribed with pain killers and Meloxicam. She has had 3 sessions of physiotherapy.

TIME OFF WORK

Not relevant as claimant does not work outside her home.

TIME UNABLE TO DRIVE A MOTOR VEHICLE

One month.

TIME TAKEN TO RETURN TO NORMAL ACTIVITY

Claimant says that she has still not returned to normal activity.

PROGRESS ACCORDING TO THE CLAIMANT

A week after the accident, very sore. A month after the accident, little bit better but sore. 3 months from the accident, slightly sore and still having to take pain killers when it gets sore.

SPECIFIC DIFFICULTIES

AT HOME

Claimant says that she had difficulty vacuum cleaning, dusting, sleeping and driving.

AT WORK

Not relevant.

AT LEISURE ACTIVITIES

Claimant says gardening is difficult.

CURRENT COMPLAINTS

1. Pain in the neck with radiation into both the shoulders. She says at onset it was 8/10. Currently it is 5/10. She says the pain in the neck and shoulders is more than the pain in the lower back. She says any activity increases the pain. Cold gel, ice seems to provide relief.
2. Pain in the lower back. She says at onset it was 9/10. Currently it is 5/10. Lying in same position increases the pain. Pain killers and moving about provides relief. She says that she has never had any previous accidents or no complaints in these body parts in the past.

PAST MEDICAL HISTORY

Claimant says that she has not been involved in any previous accidents or injuries no previous illness or hospitalisation or compensation claims in the past.

DRUG HISTORY

Claimant is not on any regular medication.

SOCIAL HISTORY

Claimant is a house wife. She is married. Has 3 children aged 37, 34 and 31. She is not in receipt of Disability or Incapacity Living Allowance. She is right handed. She does not smoke cigarettes and does not drink any alcohol.

PERSONAL HISTORY

Claimant says that her sleep is not disturbed. She says her height is 5 feet 2 and her weight is 50 kgs. She feels her weight has remained constant in the last six months. She has good control of her waterworks and bowels and is able to open them regularly. She can climb a flight of stairs without being breathless.

PAIN DIAGRAM

The questionnaire provided to Claimants has a diagram of the front and back of the human body. Claimants are requested to mark on the diagram areas where they have pain.

Mrs. Xxxx marked the **neck, both the shoulders and the lower back.**

VISUAL ANALOGUE SCALE

Visual analogue scale is a subjective method of assessing the level of pain. The Claimant is asked to indicate the level of pain by using the following guide. A 10-cm horizontal line as shown is drawn. The beginning of the line on the left has a value of 0 / 10 and indicates no pain. The end of the line on the right has a value of 10 / 10 and indicates the worst / most severe pain that he could imagine. The Claimant is then asked to mark a point 'X' across this line to indicate the level of pain.

0 1 2 3 4 5 6 7 8 9 10

Mrs. Xxxx scored the following values

1. Immediately after the accident 9 / 10
2. Twenty-four hours after the accident 9 / 10

3. One week after the accident 8 / 10
4. One month after the accident 7 / 10
5. Three months after the accident 6 / 10
6. Now 6 / 10.

Global Rating of Scale (GROC)

The Global Rating of Change Score (GRoC) is an outcome measure that has been used to independently score self-perceived improvement in a patient and has been used as an anchor method to determine minimal clinically important change scores. The GRoC is a single-item, recall-based questionnaire of well-being that is based on progress (or lack of progress) since an initial treatment encounter. Patients are routinely asked to make global ratings on changes in regards to their level of well-being on a 15-point self-report scale (from −7 to 7), although other scale values have been used.

7	A very great deal better
6	A great deal better
5	A good deal better
4	Moderately better
3	Somewhat better
2	A little better
1	About the same
0	No change
-1	About the same
-2	A little worse
-3	Somewhat worse
-4	Moderately worse
-5	A good deal worse
-6	A great deal worse
-7	A very great deal worse

The intention of any rehab / treatment programme following injury is to return the patient to their normal pre-accident state of health ie 0 or 1 on the above scale.

Mrs. Xxxx scored -6 (a great deal worse) a few days after the accident and -3 (Somewhat worse) on the date of the examination.

REVIEW OF MEDICAL RECORDS

XX/XX/XXXX. - Bursitis - shoulder Right.

XX/XX/XXXX. - Bursitis - shoulder Right.

XX/XX/XXXX. - GP Surgery: 2-3/12 shoulder pain to neck, has had physio, feels tired. History: Muscles sore needs fbc/esr ues /lfts bone chem / ck ra test 96/52 60 reg. O/E - BP reading low - Repeat after an Interval.

XX/XX/XXXX. – GP Surgery: 2-3/12 shoulder pain to neck, has had physio, feels tired.

XX/XX/XXXX. – Physiotherapy Discharge Report: Diagnosis: Upper Thx, neck and bilateral shoulder pain. Summary: Pt was making progress. Pain was not as severe. Pt FTA two appointments. Pt was informed previously if FTA next appointment with no contact she would be discharged. No further physio.

XX/XX/XXXX. –Excerpt from Letter, Diagnosis: Left knee medial collateral ligament sprain emoral attachment. Current Situation: I am glad to say that over the last week or so she is feeling a great difference from physiotherapy, ultrasound and acupuncture treatment. Again pain is just above the medial joint line. For the first three weeks of physiotherapy there was no improvement at all. I suspect that she could have an element of a medial meniscal tear as well though it is not a classic presentation. As she continues to have trouble getting up from the sitting position with pain and discomfort mainly on the medial side I would advise an MRI scan to rule out a contributing element from a medial meniscal injury. I have advised her to wear a protective knee strap when she is visiting her native country India where she is going to climb a mountain for prayer reasons. I will review her with the MRI scan before she leaves for India hopefully on the 2nd of August.

XX/XX/XXXX. – GP Surgery: History: 2-3 weeks of general malaise, right shoulder and arm sore with occasional muscle twitching. increased tiredness and cough. O/E: chest clear, CN in tact and neurology grossly intact. BP 100/70 mm Hg. HR 70, reg. Comment: Check routine bloods. advised to contact if any deterioration or further concern.

XX/XX/XXXX. – GP Surgery: History: Sudden onset upper back in between shoulders last week when bending/twisting. Has had physio privately to some effect. No trouble sleeping. Pain only when moves. wt stable. Some stiffness. No LL/UL Sx. Examination: Tender along upper thoracic spinous processes, more so in bilateral paraspinals. Tense. Poor ROM due to pain. Comment try diclofenac and pcm.

XX/XX/XXXX. – GP Surgery: strong FH history osteoporosis. Refer dexa.

XX/XX/XXXX. – DEXA. Scan Results: (the hip or spine site with the lowest T-score is used for diagnostic purposes). Region: Total Lumbar Spine (L1- L4). T-score: -3.8.

Region: Femoral Neck (Left). T-score: -2.6. Total Hip (Left). T-score: -2.2. Report: Severe osteoporosis of the total lumbar spine. Osteoporosis of the femoral neck. Osteopenia of the total hip. Interpretation of vertebral assessment scans: There are no obvious vertebral fractures seen on the lateral vertebral assessment from T8 to L4, however overlying lung markings make it difficult to assess the vertebrae above T8. Fractures (over the age of 50 years): None.

XX/XX/XXXX. – GP Surgery: History: Recent fall 2 wks ago left shoulder still sore. Examination: Some restriction in ROM left shoulder but quite good try meloxicam. Medication: Meloxicam Tablets 15 mg. DEXA result discussed, start tx, check bloods.

XX/XX/XXXX. – GP Surgery: History: Persis pain left shoulder. keen on x ray, persis RTI Comment: Persis RTI try AB [3/52 til Canada hols] x ray shoulder.

XX/XX/XXXX. - XR Shoulder Lt: Clinical Indication: Fell and injured left shoulder 5 weeks ago. Persistent pain and stiffness. ? any bony injury. Report: No significant bone or joint abnormality is seen; no particulate no evidence of bony injury or dislocation.

XX/XX/XXXX. – GP Surgery (Sister Clare): Ongoing pain in left shoulder, x-ray results satisfactory. Doesn't feel pain relief works. Limited ROM will return to see GP.

XX/XX/XXXX. – Ayr Hospital A&E Discharge Letter: Presenting Complaint: RTA back/shoulders. Diagnosis: Neck pain. Treatment: Advice. Investigations: X-Ray. Discharge: Usual place of residence, no follow up. Additional Information: Muscular neck pain -was standing next to car cleaning windscreen, car hit her car and she fell backwards, tender to palpate over C5/6, X-ray: No #, no other injury sustained. Plan: advised simple OTC analgesia, to seek R/V SOS.

XX/XX/XXXX. – GP Surgery: History: shoulder pain, not been taking osteoporosis meds and not taking Vitamin D, managing to work. Examination: Restricted ROM in left shoulder, Right shoulder ok, Comment ? low mood and muscular pain Check bloods and review. Medication: Ketoprofen Gel 2.5 %.

XX/XX/XXXX. – GP Surgery: History: Advised of bloods, await vit D levels. Shoulder still sore. Examination: BP 110/70 mm Hg. reading restricted movement right shoulder but seems muscular try oral NSAIDs. Medications: Meloxicam tablets 15 mg. Omeprazole capsules (gastro-resistant) 20 mg.

EXAMINATION

GENERAL

Systemic enquiry revealed normal cardiovascular, respiratory, gastrointestinal, genitourinary and central nervous systems. She was able to walk unaided, could tiptoe and walk on her heels. She had better flexibility. Whilst standing erect she was able to bend forwards and reach up to her ankles. She was able to squat without difficulty. But full range of motion maybe neck limitation by about 20% and

CERVICAL SPINE

On inspection there was a normal lordotic contour. Mild (10%) restriction of range of motion in the cervical spine. Tenderness in the cervical spine. No sensory, motor or deep tendon reflex deficit in both upper limbs. No long tract signs.

UPPER LIMBS

On inspection there was normal contour of both upper limbs. No evidence of any deformity, abnormal swelling or muscle wasting. In the shoulder the end 20% of abduction and forward flexion is limited. There was full range of motion in elbows and wrists. Tenderness over both the shoulders, both the supraspinatus, both the subacromial region and impingement slightly positive both shoulders. Distal pulsation in the radial well felt. Capillary refill in the nail beds was normal.

LUMBAR SPINE

On inspection there was normal lordosis. Expected range of motion in the lumbar spine. Straight leg raising was negative bilaterally. Femoral stretch test was negative bilaterally. There was no sensory, motor or deep tendon reflex deficit in both lower limbs. Some tenderness in the lumbar spine but less than the neck. Faber's and pump handle was negative bilaterally.

LOWER LIMBS

On inspection there was normal contour of both lower limbs. No evidence of any deformity, abnormal swelling or muscle wasting. There was full range of motion in hips, knees and ankles. No tenderness on palpation of any part of the lower limbs. Distal pulsation in the posterior tibial and dorsalis pedis was normal. Distal circulation in the foot was normal.

DIAGNOSIS

1. Soft tissue injury to the cervical spine, both shoulders and lumbar spine. I anticipate that with physiotherapy and self-help, all these should resolve. I recommend physiotherapy, self-help books, Pilates or Yoga. If it does not resolve by the first anniversary, I would like to see her again for consideration of an MRI Scan.

CLINICAL IMPAIRMENT, DISABILITY AND PROGNOSIS

Definitions

Impairment = Loss, weakening, damage, or deterioration, especially as a result of injury or disease.
Disability = Inability to function normally, physically or mentally.

On the balance of probabilities there was clinical impairment and disability caused by the index accident for 12 months following the index accident. No long term harm will follow from the index accident.

FURTHER INVESTIGATION

1. No further currently investigation is required. However, in the event her symptoms do not resolve as anticipated, I would like to re-examine her.

FURTHER TREATMENT

1. I recommend a course of physiotherapy treatment, the number of sessions to be determined by the therapist.
2. I also believe that it is good to actively do group exercises and build up the muscles of the spine. To this effect I feel Mrs Xxxx should attend either Pilates or Yoga classes. Both of these forms of exercise will improve core stability to maintain a healthy spine. She should learn the exercises shown and perform them on a regular basis, gradually and slowly increasing the time and intensity of the exercise. The buzz words to remember are “little but often”. She should learn the exercises and do them repeatedly in her free time. I am of the opinion that Mrs Xxxx is positive and optimistic. With adequate support and rehabilitation she should make great improvement.
3. In addition to the above, I recommend that the claimant purchase one of the following self-help books and follow the advice provided. Please note that the first book has been authored by myself (disclaimer).
    a. Simple Steps to Help with Back & Neck Pain 2016 Paperback – 1 Dec 2016 by George Ampat (Author) Paperback: 48 pages ISBN-13: 978-0995676916 https://www.amazon.co.uk/dp/0995676917

b. Treat Your Own Neck [Paperback] Robin McKenzie (Author) 5 edition (Jan 2011) Language English ISBN-10: 0987650416 ISBN-13: 978-0987650412. This costs about £6 and can be purchased online at Amazon.com. http://www.amazon.co.uk/Treat-Your-Neck-Robin-McKenzie/dp/0987650416/ref=pd_sim_b_1

c. Sarah Key's Back Sufferers' Bible Paperback: 204 page Language: English ISBN-10: 0091814944 ISBN-13: 978-0091814946. This costs about £15 and can be purchased online at Amazon.com. http://www.amazon.co.uk/Sarah-Keys-Back-Sufferers-Bible/dp/0091814944/ref=sr_1_2?ie=UTF8&qid=1372158609&sr=8-2&keywords=back+pain

d. Healthy Shoulder Handbook by Karl Knopf Publication Date: 4 Feb 2010 | ISBN-10: 1569757380 | ISBN-13: 978-1569757383 It costs about £10/-. This is available from Amazon and I have provided the link for convenience. http://www.amazon.co.uk/Healthy-Shoulder-Handbook-Karl-Knopf/dp/1569757380

FURTHER REPORT

1. No further reports are currently required. However, if a re-examination becomes necessary, I will provide a further report following re-examination.

DECLARATION AND SIGNATURE

I, Mr George Ampat declare that

1. I understand my overriding duty is to the court, both in preparing reports and giving oral evidence. I have complied with and will continue to comply with that duty.
2. I am aware of the requirements of Part 35 and practice direction 35, the protocol for instructing experts to give evidence in civil claims and the practice direction on pre-action conduct.
3. I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.
4. I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters that 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.
5. I have drawn attention to all matters, of which I am aware, that might adversely affect my opinion.
6. Wherever I have no personal knowledge, I have indicated the source of factual information.

7. I have not included or excluded anything which has been suggested to me by anyone, including those instructing me, without forming my own independent view of the matter.

8. I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

9. I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity and I may be cross-examined on my report by a cross examiner assisted by an expert.

10. I have not entered into any agreement where the amount of payment of my fee is in any way dependant on the outcome of the case.

Statement of truth:

I confirm 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 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.

Mr George Ampat MS FRCS (Tr and Orth)
Consultant, Trauma & Orthopaedics,