Dr John Bosanquet
BscMed, MBBS, FRACS
Consultant Orthopaedic Surgeon

Corrected by Dr John Bosanquet
27 June 2023

Our ref: 60005528

CONFIDENTIAL

Gair Legal
PO Box 1277
DEE WHY NSW 2099

ATTENTION: Ms Alice Davis, Partner

INDEPENDENT MEDICO-LEGAL REPORT

Dear Ms Davis,

Re: [redacted]
Your Ref: [redacted]
Date of Birth: 02 April 1960 **Age:** 63 years
Handedness: Right hand dominant
Occupation History: Assistant in Nursing for Aged Care
Employer: [redacted]
Duration: «number»
Date of Accident: 21 June 2017
Date of Examination: 22 June 2023

Thank you for your letter of 24 May 2023 requesting a report on this woman. I saw and examined her in Sydney on 22 June 2023.

I explained to her the purpose of the visit and that a report would be forwarded to your company.

CODE OF CONDUCT

I acknowledge that I have read the Expert Witness Code of Conduct contained in Schedule 7 of the Uniform Civil Procedures Rules 2005. I agree to be bound by the Code.

I also acknowledge that I have read the PIC4 Procedural Directions for Expert Witness Evidence and I agree to be bound by these Directions. To the best of my ability this report has been prepared in accordance with these Directions.

Thank you for the enclosed medical documentation which comprised reports from;

- Dr Ronald Thomson, Injury Management Consultant 20 June 2019.
- Dr Peter Yu, Occupational Physician 27 February 2019.
- Dr James Bodel, Orthopaedic Surgeon 10 January 2018, 15 March 2020.
- Dr Robert Drummond, Orthopaedic Surgeon 28 June 2016.
- Associate Professor Al Muderis, treating Orthopaedic Surgeon 31 August 2017.
- Dr Edward Graham, treating Orthopaedic Surgeon 15 June 2018, December 2018 (arthroscopy right knee), 14 January 2019, 15 February 2019, 19 March 2019, 12 August 2019, 11 September 2019, 21 October 2019, 12 December 2019, 03 March 2020, 27 May 2020, 01 June 2020, 14 September 2020, October 2020 (total knee replacement), 17 November 2020, 10 December 2020, 25 January 2021, 02 February 2021, 07 April 2021 (MUA right knee), 13 December 2021, 11 May 2022 (revision total knee arthroplasty right), 21 June 2022, 02 August 2022, 05 September 2022, 03 November 2022 (MUA right knee), 21 November 2022, 23 January 2023, 22 March 2023.
- Dr Allan Nazha, Pain Management Specialist 20 July 2021, 31 August 2021, 11 October 2021, 23 November 2021.

Ms [redacted] understood that I could not offer her advice regarding the treatment of her orthopaedic condition.

SOCIAL HISTORY

Ms [redacted] is a 63-year-old woman (Date of Birth: 02 April 1960). She is married and has four of her own children and three stepchildren with 17 grandchildren. None of her children lives at her home. She resides with her husband at 11 Gregory Place, Harris Park, NSW 2150. She is right hand dominant and attended with her husband, Peter.

EMPLOYMENT HISTORY

Ms [redacted] is currently not working nor employed. She last worked in 2019 with Australian Unity as an Assistant in Nursing for Aged Care (Certificate IV). The facility was in Northmead, and she had worked there for 14 years on a permanent part-time basis. Prior to this she had been a Receptionist and had also worked in Police Headquarters. She had also worked in Customer Service with Woolworths. She migrated to Australia with her family in August 1961 from the UK.

HISTORY OF THE INJURY

She has had several injuries to the right knee; the first was in 2008 which will be covered under Past History.
The next was on 27 May 2015. As she was dressing a patient she bent down and had increased pain in the right leg.
On the next patient, she was unable to get down and squat and had difficulty walking. She notified her Supervisor, was taken by ambulance to Westmead Hospital where she was admitted for two weeks with physiotherapy following an MRI scan. She was off work for six weeks and went back on restricted light duties. Her knee remained painful. Although she was advised not to be involved with showering patients, she had to carry this function out.

She was then put onto a four-hour shift in the laundry, unloading drying and folding. She was put back into another section in medication.
A further injury occurred when she slipped on some urine on the floor twisting her right leg in 2017. She saw her local Doctor who performed an MRI scan. Her local Doctor referred her to Dr Al Muderis orthopaedic surgeon, who did not feel that surgery was indicated. She was then referred to Dr Edward Graham, an Orthopaedic Surgeon and after an MRI scan, he recommended an arthroscopy of the knee, performed in December 2018.
Following this, she had pain and swelling. She also had a PRP injection without any relief of her pain. Although the MRI scan showed good cartilage cover, Dr Graham proceeded with a total knee replacement on 14 September 2020. She went to rehab postoperatively and initially had a good range of movement.
However, she then had a recurrence of pain, swelling and restricted movement. A manipulation was performed under anaesthetic on 07 April 2021. She was put onto a CPM machine for some days and had continuing physiotherapy. Further swelling and restricted movement occurred. She was flexing to only 65°.
She consulted her Orthopaedic Surgeon, Dr Edward Graham and he recommended a *revision* of the knee replacement, which was performed on 11 May 2022. Once again, she had an initially good response but then increasing pain and restricted movement recurred.
Dr Graham referred her to Dr Allan Nazha, a Pain Management Specialist and a Psychologist. Dr Graham then performed a second manipulation on 03 November 2022, and she again was on a CPM machine for some days. In the meantime, she started a TAFE course doing Medical Terminology, Business Studies and Forestry. She also sought a second opinion from Dr Roger Brighton two weeks ago who advised no further procedures.

Current treatment is physiotherapy once a week. She is not having any hydro-therapy. She is no longer taking any medication apart from Panadol Osteo two tds.

CURRENT SYMPTOMS

Ms [redacted] has pain in the right leg that is constant; it radiates from her groin to her ankle. The right knee feels heavy. The pain is worse at night, and she has no pain free days. There is restricted movement; her walking distance is restricted. If she tries to walk further, she has pain on the following day. She goes up stairs one by one using the rail. She does not use a stick. There has been no giving way, but the leg will ‘seize’. She has replaced her car to one with a higher driving seat and this is automatic. She sleeps for two to three hours. She has not noticed any paraesthesia or numbness; there is always swelling. At times, she notices the leg goes bright red.

Lumbar Spine

She has had some back pain and interscapular pain on the right side.

DOMESTIC

Ms [redacted] lives in a single storey house with her husband who works. She is able to do some cooking and cleaning. She is unable to mop the floor and has a stick vacuum cleaner. Her husband cleans the bathroom. They shop together.

SELF-CARE

She has a chair in the shower. She has difficulty pulling on her underwear and needs to sit to do this. She needs to see a Podiatrist.

PAST HISTORY

She had an injury to the right leg at work and from the reports this appeared to have been a tear in her rectus femoris muscle.

GENERAL HEALTH

She has raised cholesterol.

MEDICATION

She is on Thyroxine

PAST SURGERY

Past surgery includes a hysterectomy.

EXAMINATION

This revealed a woman measuring 5ft 5" and weighing 88 kilograms. She could stand on her heels and toes and perform a minimal squat. She walked with a marked antalgic gait on the right side and her right limb was swollen. I

Right knee There was a 20 centimetre anterior scar that was healed. She was tender generally around the knee. Range of movement 30 to 60°. She had full movement in her right hip and ankle; there were no sensory changes.

INVESTIGATIONS

MRI right upper thigh 13 May 2008.

Comment: There is intermuscular and intramuscular haematoma in the adductor muscles adjacent to the lesser trochanter, the right femur. The less affected appears to be quadratus femoris which demonstrates possible intramuscular haematoma and evidence of partial thickness tear.

Whole Body Bone scan 12 May 2016.

Mild inflammatory arthritis of the medial compartment of the right knee.

Ultrasound right knee 11 May 2016.

Conclusion: 1. Joint effusion. 2. No muscle tear.

CT lumbosacral spine 19 May 2016.

Comment: Minor broad-based disc bulges in the lower lumbar spine. No definite neural impingement.

MRI scan right knee 16 June 2016.

Conclusion: Horizontal tear of posterior horn and body of medial meniscus breaching tibial articular surface. Grade II chondral wear of the medial patellofemoral compartment.

X-ray right knee 22 June 2017.

Conclusion: No bony injury is seen.

Ultrasound right knee 23 June 2016.

Conclusion: Small suprapatellar effusion.

MRI scan right knee 06 June 2018.

Conclusion: Mucoid degeneration of medial meniscus with significant fraying and undersurface tearing of the posterior horn and body of the medial meniscus. Previously noted horizontal cleft tear of the posterior horn is no longer evident.

MRI right knee 21 August 2018.

Conclusion: 1. Articular cartilage cover complete. No reactive bony oedema. 2. Minor tear body medial meniscus.

X-ray right knee 08 October 2020.

Total knee prosthesis has been performed.

OPINION

This 63 year old woman, who has worked as an AIN in Aged Care has sustained an injury to her right knee in 2015 with a further injury in 2017 for which she had an arthroscopic meniscectomy. She had ongoing pain, and a total knee replacement was performed which gave her a poor result. She had a revision on 11 May 2022 followed by a further manipulation. She has ongoing pain, restricted movement and has been unable to return to work.

In answer to your specific questions:

- **The history you obtained.**

  Please see report under History of Injury.

- **Your findings on examination.**

  Please see report under Examination.

- **Your diagnosis.**

  Her diagnosis is right lower extremity pain, unrelieved by two total knee replacements.

- **Your views as to the worker's fitness for employment.**

  Ms [redacted] has difficulty with the activities of daily living. She is unable to return to her previous employment as an AIN. She may be able to work in a completely sedentary role sitting at a desk and using her computer.

- **The extent of any required treatment.**

  The only treatment she is having is Panadol Osteo and this is appropriate. I would not recommend any further surgical procedures.

- **Your opinion in respect of the worker's physical condition and its relationship to employment.**

  Ms [redacted] has had a couple of injuries to her right knee, but the source of her ongoing pain has not been totally diagnosed. In the belief that it was due to bone changes in the knee, two knee replacements have been performed which have not given any relief of pain and she has ongoing restricted movement. Her physical condition is partly due to her injury at work and also a reaction to that injury.

In addition, we would also appreciate:

- **Whether you consider the worker's condition has stabilised and reached maximum medical improvement.**

  Using the SIRA Guidelines, Fourth Edition, page 4 paragraph 1.15, it is my opinion that Ms [redacted] has reached maximum medical improvement and the assessment of whole person impairment can be made.

- **Your assessment of any whole person impairment suffered by the worker to her right knee and your opinion as to whether or not that whole person**

impairment is a result of the work injury on 21 June 2017. Please provide reasons for your opinion.

Using the AMA Guides, Fifth Edition and the SIRA Guidelines, AMA 5 Table 17.35
Pain 10 points; Range of movement 6 points; Stability 25 points, a total of 41 points.
Deductions Flexion contracture greater than 20°, 20 points, giving a total of **21 points.**

With reference to AMA 5 this is a *poor* result for with a **30% whole person impairment.** This is the result of the work injury on 21 June 2017. There is an added 2% for scarring giving **a total of 32%.**

- **We would appreciate your opinion as to any deduction that you would apply to reflect a pre-existing condition suffered by the worker. Please provide reasons for your opinion.**

  There are no deductions.

  The total whole person impairment is 32%.

- **We would appreciate your opinion as to any impairment that relates to any subsequent and/or unrelated injury. Please provide reasons for your opinion.**

  There is no deduction for previous injury.

Yours faithfully

John Bosanquet