

Dr James Powell
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22 November 2022

Robert

Claims Advisor
GIO Sydney Workers Compensation
GPO Box 1464
SYDNEY NSW 2001

Dear Robert

INDEPENDENT MEDICAL EXAMINATION

Re : ██████████
Date of Birth : ██████████
Date of Injury : **7 October 2014**
Claim No : ██████████
Date of Consult : **20 January 2020**

Thank you for asking me to see Ms ██████ on 20 January 2020 at my **Sydney** rooms.

Thank you for the documentation provided.

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. To the best of my ability this report has been prepared in accordance with the Code.

In the preparation of this report I have complied with the requirements of Medicins Legale's privacy policy as outlined in the Australian Privacy Principles.

INTRODUCTION

At the commencement of the interview I explained the purposes of an independent medico-legal examination. I indicated that I was not a treating doctor and that I was not able to provide any advice.

My report is based on the history provided by Ms ██████, the appropriate clinical examination and the documentation provided.

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DOCUMENTATION REVIEWED

- Initial Certificate of Capacity - Dr Chew dated 14 October 2014
- Certificate of Capacity - Dr Wu dated 7 October 2016
- Certificate of Capacity - Dr Wu dated 29 November 2019
- MRI scan left hip dated 10 July 2017
- Consultation Report - Dr Broe dated 6 August 2017
- Consultation Report - Dr Van Gelder dated 23 December 2016
- Consultation Report - Dr Van Gelder dated 20 February 2017
- Section 78 Notice - left hip dated 29 October 2019
- Response from Dr Wu

HISTORY

(History was mainly gained by Ms [REDACTED] reading from her mobile phone.)

Prior to commencing her job at a news desk in 2014, Ms [REDACTED] had been active doing a wide variety of activities including kayaking, swimming, rock climbing, bushwalking and cycling, without any physical difficulties.

Her previous work had been in the film industry doing freelance work as a director and producer's assistant, in which the work was widely variable with periods on set in studios, and so on.

In 2014, Ms [REDACTED] took on a new job at a news desk.

This was an office based job, where she sat at a desk using a computer for 9 or more hours a day, with very little breaks.

After several months of commencing this work she started to develop pain symptoms in the neck region, indicating around the right trapezius area posteriorly, extending down to the muscles medial to the scapula, and in the lower back on both sides of the upper sacrum and about the left hip region, initially around the gluteal muscles superior to the trochanter, which later radiated to involve the anterior groin area, trochanteric area, deep in the buttock extending to the upper posterior thigh, and more recently to the left lower abdomen.

Nothing in particular brought these symptoms on, and she concentrated initially on her neck and back symptoms, with her hip symptoms becoming more troublesome as time progressed.

She used local heat on the regions, but with little effect, and saw her local doctor a few months later.

She was given anti-inflammatories.

It was felt that her difficulty was her desk, and through the course of her troubles various ergonomic assessments were done, which found that her seat was too wide and too high, and her screen was too close. Her keyboard was also too wide, and all of this was felt to have caused her to develop the pain symptoms.

Ms [REDACTED] attended physiotherapy at various times and found that with the therapy her symptoms would improve a little, but then recur.

She also attended Pilates. While she did not continue her general activities, she kept on with swimming as this was part of the rehab programme.

She was, at different times, seen by a rehabilitation consultant and various programmes were implemented, mainly around posture and strengthening control exercise.

Ms [REDACTED] was assessed by a rheumatologist who felt that her symptoms were mechanical.

She was assessed by an orthopaedic surgeon, and had scan that identified tendinopathy at the origin of various tendons around the left hip region. Platelet rich plasma injections were suggested but were not carried out as she was doing Pilates and other activities at the time, and it was felt that the injections would not help in this circumstance.

She is to see a neurosurgeon shortly due to persisting neck pain.

CURRENT SYMPTOMS

Neck

Ms [REDACTED] has pain at the right side of the neck in the trapezius area, extending into the muscle mass medial to the upper to mid scapula. The symptoms fluctuate in intensity. She finds it difficult to sleep and to get a comfortable position and frequently wakes because of these symptoms.

Lumbar Spine

In the lumbar region, pain is to both sides of the upper sacral region. These symptoms increase with standing or walking for an hour or so and sitting for half an hour, and she needs to get up and move about to try and relieve these symptoms.

Left Hip

The left hip region symptoms occur in similar circumstances, with standing, sitting or walking.

She finds the impact of these symptoms, particularly in the back and hip region limit her ability to travel, both on public transport or driving, in movies, going out for friends for dinner, and so on, as she needs to constantly get up and move about and is uncomfortable after a short period.

She uses anti-inflammatory gel particularly for the low back and hip symptoms on a daily basis, and uses Voltaren and Brufen for more severe episodes of pain when needed.

No other treatments have been suggested at present.

Ms [REDACTED] is being cared for by her local doctor.

She has, through the course of her troubles, seen a pain psychologist and continues to do so.

PREVIOUS HISTORY

Prior to onset of symptoms in 2014 Ms [REDACTED] had had no previous injuries nor symptoms in the neck, back nor left hip region.

Apart from having her wisdom teeth out, she has had no other injury, illness nor operation and takes no regular medication.

WORK HISTORY

At the time of onset of symptoms Ms [REDACTED] worked on a news desk which was principally an office job.

She continued with this work until 2018. She found in holiday periods that occurred twice a year that her symptoms would reduce, but otherwise had no prolonged periods off work. She did reduce her hours in relation to her symptoms, and was let go in 2018, as she could not get back to her normal hours because of persisting symptoms.

She obtained a job in a design company and had taken her desk with her. (This having been modified for her, although it was subsequently found through a new rehab provider that it still continued to be inappropriate for her as the screens were too close.)

She did not last in this job as symptoms persisted.

She has been looking for work since then, but has been unsuccessful so far. She is looking mainly for office type work, as she cannot do any active work.

Prior to 2014, Ms [REDACTED] spent 5 or 6 years in the film industry as a director and producer's assistant.

ACTIVITIES

As outlined above, Ms [REDACTED] partook in a number of physical activities. Since onset of symptoms she has only continued with swimming, which forms part of her exercise programme.

DOMESTIC

Ms [REDACTED] lives in a single level house with her mother.

Her mother does all the cleaning, heavier shopping, and so on, as her symptoms preclude her from doing any of these activities.

EXAMINATION

Ms [REDACTED] appeared to sit comfortably through the interview.

She could bend down to floor level from the chair with synchronous recovery to get items from her bag. She could reach forward to the desk in front of her to bring out the various reports and things that she had in her bag and shuffled these without any obvious dyssynchrony nor discomfort.

She was able to dress and undress from a standing position with overall good power, balance and mobility in the torso and upper and lower limbs.

She was of thin build, not overweight, and her posture was normal.

Her gait was even, and she could turn and walk back without any difficulty and demonstrated good power and balance.

She could heel and toe-walk with good power and balance.

Single leg stance was normal on both sides, and she could do a single heel raise on both sides without difficulty. She could do a full squat and rise with normal synchronicity of movement.

Cervical Spine

There was some tenderness to deep palpation at the right mid trapezius region near the base of neck and this was where Ms [REDACTED] experienced her discomfort. This extends into the upper medial right scapular muscle.

Cervical movements were full and synchronous without any focal signs of irritability.

Upper Limbs

Muscle contours about the shoulder girdles, arms, forearms and hands were symmetric and within normal limits.

General circulation, temperature, sweating and soft tissue integrity through the upper limbs down to the palms and fingers was normal.

There was full synchronous motion at both shoulders, elbows, forearms, wrists and fingers with normal flexion, extension and cascade in the fingers.

Power about the upper limb joints was normal with strong well-sustained grip strength and intact intrinsic function.

Sensation was intact. Reflexes were symmetric.

Lumbar Spine

There was no particular tenderness of the lumbar spine in the midline and slightly to the left lower paraspinal muscles onto the upper sacrum on both sides.

Spinal movements in the thoracic and lumbar spine were full, synchronous and without irritability evident.

Chest movements were symmetric and normal, and there was no discomfort on springing the chest AP nor laterally.

There was no discomfort with loading of the pelvis, AP, laterally nor with rotation.

In the abdomen, there was slight tenderness at the left iliac fossa region, but no mass evident. The abdomen otherwise was soft with no masses and no posterior tenderness.

Ms [REDACTED] was able to do an unassisted sit-up from a lying position without difficulty.

Lower Limbs

Leg lengths were equal.

General circulation, temperature, sweating and soft tissue integrity were symmetric and within normal limits.

Reflexes at the knees and ankles were brisk and symmetric. Plantar responses were equivocal.

Straight leg raise was to 80° right and left.

Thigh circumference was equal at 44cm and calf circumference equal at 33cm. Muscle contour and tone in the thigh and calf were symmetric and normal.

Left Hip

There was tenderness in the lateral gluteal muscles extending down to the greater trochanter, and in the mid groin at the origin of the adductus and at the origin of the hamstrings on the ischial tuberosity. There was no gluteal wasting.

Hip movements were full, equal with the opposite side, and there was no irritability detected with hip movement.

Knee movements were full without irritation.

INVESTIGATIONS

Bone Scan dated 4 January 2017 showed some mild uptake at both sacroiliac joints, mild uptake in facet joints at C1/2, C3/4 and at L2/3 and L3/4.

Ultrasound Left Hip and Buttock Area dated 22 June 2017 reported some thickening in the trochanteric bursa region with tenderness, compatible with trochanteric bursitis. Some bulkiness was noted in the anterior acetabular labrum.

MRI Left Hip dated 10 July 2017 showed some signal change at the origin of semimembranosus at the ischial tuberosity. Some signal change in quadratus femoris muscle belly. Mild dysplastic features of the hip with slight reduction of head/neck offset. Some signal change at the trochanteric bursa.

MRI Lumbar Spine dated 25 November 2015 was within normal limits.

Dr Van Gelder in his letter to Ms [REDACTED] general practitioner from 20 December 2016 noted an MRI of the cervical spine that showed some disc bulges without any structural abnormalities.

SUMMARY

Ms [REDACTED] has developed pain symptoms in the lower right posterior cervical region, lower lumbosacral region and about the left hip region coming on several months after commencing an office type job.

Symptoms have persisted from that time, fluctuating in intensity.

Ergonomic difficulties with her desk had been identified as a possible source for her symptoms.

In answer to your questions:

1. **Based on your clinical examination of Ms [REDACTED] and review of the attached correspondence, what is the diagnosis of the left hip pathology for Ms [REDACTED] Could you please explain your rationale.**

It is difficult to provide a diagnosis of pathology around the left hip region to explain Ms [REDACTED] symptoms.

As outlined above, her history is of a spontaneous development of pain symptoms in the cervical region, lower lumbar region, and extending around the left hip region including anteriorly, laterally and posteriorly, and into the upper posterior thigh that developed some 4 months or so after starting a new job which was principally sedentary in nature nearly 6 years ago.

There was no specific incident that brought symptoms on and apart from the pain symptoms, no other presenting problem.

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Through the course of assessing her complaints, ergonomic assessments of Ms [REDACTED] workplace determined that her desk set-up was not appropriate for her. Despite these observations, there does not appear to have been any progress towards making her desk and workstation set-up appropriate for her, and she took her desk, inappropriate as it was, to a new job where it was also found to be inappropriate, but no changes made to address the determined source of her pain symptoms (from the ergonomist's perspective).

Despite her symptoms initially improving when she was on holidays, she has not enjoyed such improvement since stopping work completely in either job.

Sophisticated imaging around the left hip region with MRI has identified some imaging changes which include tendinosis at the semimembranosus origin at the ischial tuberosity and some thickening in the trochanteric bursa, and possible mild dysplastic features of the hip joint itself, principally with a slight alteration of femoral head/neck offset. (Comment was also made that there was some acetabular retroversion, although this is difficult to determine on a unilateral scan and MR is also not a good imaging modality to determine bony anatomy.)

Ms [REDACTED] physical examination demonstrates some areas of non-specific tenderness in the anterior groin about the trochanter and at the ischial tuberosity and posterior buttock region, without limitation of hip motion and without focal irritability of the hip.

Ms Chu also had investigation of her lumbar spine as symptoms developed in this region, but early imaging did not identify any structural nor secondary abnormality.

Determining the source of pain symptoms is difficult in many patients where there is no clear diagnosis to explain the symptoms.

Determining whether changes on imaging are a source of these pain symptoms is equally difficult in the absence of a clearly diagnosable condition that might include pain as a symptom.

Ms [REDACTED] has also been assessed by Dr Van Gelder, Neurosurgeon, principally for the neck and back pain component, who did not identify any specific source of pain symptoms in either region. (The disc bulging noted in the cervical MR in 2016 are within normal limits for age and not necessarily indicative of pathology.)

Ms [REDACTED] was also assessed by Dr Portek, Rheumatologist (and Physician), who did not identify any underlying inflammatory component, primary nor secondary, that might explain her presentation at that time. None of the imaging investigations throughout the hip region suggests a primary nor secondary inflammatory process.

Prior to onset of symptoms and taking up a sedentary job in 2014 Ms Chu had been very active for many years in sporting and general activities that require a high degree of physical fitness and expose the body to considerable loads in both the upper and lower limbs and trunk.

Ms [REDACTED] physical examination does not indicate any focal abnormality about the left hip other than non-specific tenderness, as noted above, and does not identify any specific abnormality about the lumbar spine nor its associated neurologic structures nor function.

Similarly, there are no findings or abnormalities in the trunk nor abdomen.

All of this makes identification of any specific pathology that might explain Ms [REDACTED] symptoms in a rationale manner and from an orthopaedic perspective, difficult.

Describing the imaging changes on MR about the left hip region as pathology is largely an over-statement of their relative importance.

They are largely incidental findings of doubtful if any clinical significance and were discovered by undertaking imaging in an effort to try and find the source of fairly vague symptoms with little to indicate a provisional diagnosis prior to undertaking the imaging.

In addition, as Dr Van Gelder identified some years ago, Ms [REDACTED] does have some very entrenched and definite ideas of the source of her pathology, little of which if any can be clinically substantiated.

Ms [REDACTED] history and clinical examination does not suggest any specific diagnosis nor pathology at the left hip region.

The sitting position in general office furniture with an individual who falls well within normal body habitus will not cause nor accelerate pathology of a musculoskeletal nature. (Ms [REDACTED] presentation is symptomatic only and symptoms do not necessarily indicate physical pathology.)

The imaging findings on MR, and to a lesser extent ultrasound, show a number of features but they are principally incidental findings as there was no clinical indication to undertake the study in the first place.

The mild dysplastic features would not be considered clinically significant. They are most likely to be developmental in origin in the later phases of growth and development about the hip, possibly representing a very mild slipped capital femoral epiphysis, but also are of a mild degree and are not seen infrequently in the general population, and may well simply be an expression of variation of normal anatomy. They are not of sufficient magnitude to cause primary arthrosis at the hip, nor are Ms [REDACTED] symptoms nor examination indicative of primary hip pathology. It unlikely that any of her symptoms arise from these changes.

Soft tissue changes noted on MR are difficult to interpret with minimal clinical indication for undertaking the scan. They are non-specific. Signal change in the origin of semimembranosus may represent an attritional tendinosis of one of the hamstring components. There is also some change about the hip joint capsule near the lesser tuberosity.

Given Ms [REDACTED] high level of physical activity prior to onset of symptoms it is likely that these imaging changes are a result of her previous level of high demand physical activity involving the lower limbs and represent a residuum of attritional loading in an individual who is also getting into the age group where such attritional changes in musculoskeletal structures start to appear. Whether they are considered pathology or just a variation of normal age related changes is always a matter of debate.

There are, however, no indications in Ms [REDACTED] general history that she suffers from any primary nor secondary connective tissue disorder that might contribute to these imaging changes.

Similarly, thickening of the trochanteric bursa region is a common finding with imaging, becoming more frequent with advancing age, but with variable clinical presentation. The bursa is in this region to help minimise loading of tissues that can suffer from loading and alteration of direction due to the prominence of the trochanter, and so secondary reactive change to such loading can occur to strengthen the region. Sometimes this can result in some inflammation of the interposed bursa.

These imaging changes are likely to represent the same reactive changes to Ms [REDACTED] level of previous of physical activity with some age component, but do not represent a primary pathology.

Pain symptoms in the region can be associated with referred pain from other structures. Frequently, in the musculoskeletal system, this is most associated with the lumbosacral spine. There is no clinical indication that Ms [REDACTED] lumbosacral spine is the source of symptoms in the left hip region as a referred phenomenon. There is no indication of primary pathology in the lumbar spine of a musculoskeletal nature. There is no indication of radicular involvement that might precipitate these symptoms.

Other regions that may produce such referred symptoms include pelvic pathology and retroperitoneal and lower abdominal pathology. As far as I can determine from Ms [REDACTED] history, there is no indication that these areas are likely to be a source of asymmetric symptoms, but an assessment by her general practitioner to look at other organ systems in more detail may be appropriate before ruling these areas out as a source of symptoms at least at the present.

Thus, overall from an orthopaedic perspective, I cannot identify any primary or secondary pathology in the left hip region to explain Ms [REDACTED] symptoms, presentation and current examination, nor can the imaging findings be put down to a specific pathologic diagnosis and are best considered as non-specific incidental findings of limited if any clinical consequence.

2. Is the mechanism of injury consistent with the diagnosis? Could you please explain your rationale and also comment whether the worker's other employment related musculoskeletal conditions have resolved?

There was no specific "*mechanism of injury*" in the left hip region nor elsewhere at any stage of Ms [REDACTED] given history.

Symptoms developed in the neck, low back and left hip regions several months after starting a principally sedentary job.

There was no indication that Ms [REDACTED] suffered any form of injury, direct nor indirect, to the musculoskeletal system in her work in 2014 nor subsequently.

As outlined above, there is no specific musculoskeletal diagnosis around the left hip region nor elsewhere to explain Ms [REDACTED] symptoms.

Imaging findings about the left hip are principally incidental findings are not of clinical consequence.

They have not arisen from any aspect of a sedentary job.

If associated with physical activity, it is the level of recreational activity that Ms [REDACTED] undertook prior to the onset of her symptoms, along with possible age related susceptibility to musculoskeletal degeneration.

They do not arise from a sedentary job whether the chair or desk is ergonomically designed for the individual or not.

From an orthopaedic perspective there is no indication that any of Ms [REDACTED] presentation arises from any aspect of her employment, about the left hip nor elsewhere in the musculoskeletal system.

Despite the period of symptoms, today's examination does not identify any specific pathology nor any evidence of long term dysfunction in the musculoskeletal system.

3. Is there a causal relationship between Ms [REDACTED] left hip pathology and the work-related injury/ies from 2014? Could you please explain your rationale?

There is no causal relationship between Ms [REDACTED] work and her left hip region symptoms. The rationale for this has already been outlined above in the discussion of previous questions.

Please do not hesitate to contact me should you require further information or clarification of this report.

Yours faithfully



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