

Dr James Powell
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Orthopaedic Surgeon

22 November 2022

Ms Loren Rich
Solicitor
Hicksons Solicitors - Newcastle
Level 6, 352 Hunter Street
NEWCASTLE NSW 2300

Dear Ms Rich

INDEPENDENT MEDICAL EXAMINATION

Re	:	██████████
Date of Birth	:	██████████
Date of Injury	:	7 October 2014
Claim No	:	██████████
Date of Consult	:	16 September 2022

Thank you for asking me to see Ms ██████ on 16 September 2022 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.

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.

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.

Medicins Legale

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DOCUMENTATION REVIEWED

- (a) MRI of lumbar spine dated 25 November 2016;
- (b) MRI of cervical spine dated 9 December 2016;
- (c) Ultrasound of the left hip dated 21 December 2016;
- (d) Treating report of Dr James Van Gelder dated 20 February 2017;
- (e) MRI of left hip dated 10 July 2017;
- (f) Treating report of Dr Broe dated 6 August 2017;
- (g) MRI of cervical spine dated 19 September 2019;
- (h) Treating report of Dr George Wu dated 30 October 2019;
- (i) Ultrasound of left hip dated 22 January 2020;
- (j) Your prior report dated 23 January 2020;
- (k) Qualified report of Dr Mohammed Assem dated 11 March 2020;
- (l) Your prior report dated 26 March 2020;
- (m) Treating report of Dr R E Pope dated 8 April 2020;
- (n) Bone scan dated 19 April 2020;
- (o) Treating report of Dr R E Pope dated 28 April 2020;
- (p) MRI of left hip dated 15 June 2020;
- (q) Report of Dr George Wu dated 17 June 2020;
- (r) Qualified report of Dr Assem dated 24 March 2021;
- (s) Your prior report dated 12 April 2021;
- (t) WorkCover NSW certificate of capacity dated 19 November 2021;
- (u) Treating report of Mr Adrian Brezniak, physiotherapist, dated 8 December 2021;
- (v) Your prior report dated 21 December 2021;
- (w) Treating report of Dr George Wu dated 18 February 2022;
- (x) Qualified report of Dr Assem dated 16 March 2022;
- (y) Treating report of Dr Wu dated 20 May 2022.

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 [REDACTED], the appropriate clinical examination and the documentation provided.

BACKGROUND

Ms [REDACTED] request to record the interview was declined.

Ms [REDACTED] has a long and complex history of pain symptoms in various areas of the musculoskeletal system.

At the time of onset of symptoms in 2014, Ms [REDACTED] had commenced work earlier in the year in a television newsroom.

This work was principally computer based getting various stories and images, sending emails, and so on, on a computer using a keyboard and mouse.

The job was very busy. Ms Chu worked 9 hours days without a break and the office was short staffed and there was a lot of pressure.

HISTORY

Ms [REDACTED] commenced her job in early 2014.

Symptoms commenced around April 2014.

There was no specific incident.

Ms [REDACTED] started to become aware of pain symptoms in the lower lumbar region, about the upper shoulder blades mainly on the right, and in the dorsoradial aspect of the right forearm.

Shortly after onset of symptoms, she also became aware of pain symptoms about the left lateral gluteal region, radiating into the groin area.

She noticed symptoms when at work.

She needed to change her position constantly, and often needed to sit on a chair to do her work.

Symptoms increased in severity and she saw her doctor later in the year. By around September 2014, she had difficulty walking because of the severity of pain symptoms.

It was found that there were design difficulties with her workstation and seating, as it was not designed for her small size.

Ergonomic assessments were made and it was recommended that she have a sit-stand desk. Difficulties had been identified that her chair was too high, the keyboard and screens were too far away for her to use, and it was determined that this was the source of her symptoms through "*musculoskeletal strain*".

Ms [REDACTED] went off work around September 2014 because of her symptoms, and there was some delay in obtaining the workstation.

In December 2014, a sit-stand desk was obtained.

During the period when she was off work her symptoms did improve.

She utilised analgesics and had been referred for physiotherapy, doing various exercises.

When she returned to work with her sit-stand desk she found shortly afterwards that her symptoms returned.

It was determined that there were design difficulties with the desk, as the keyboard was determined to be too high, causing Ms [REDACTED] to need to dorsiflex her wrists, increasing her forearm pain, which also started to trouble her on the left.

When she was standing, the keyboard area was too low, which caused her to lean forward, causing pain about the shoulder regions (indicating about the trapezius and upper scapular region, which also started to involve the left side).

The screen could not be altered and was too close and was a double screen, and this caused her to need to move her head from side to side repeatedly, as well as to attempt to lean backwards, stretching her arms out, all of which increased her symptoms in the upper limbs, as well as the development of neck pain, along with an increase of lumbar region and left hip area symptoms.

There were difficulties in getting changes made to her desk.

Ms [REDACTED] found symptoms increased in severity and in 2018, she was terminated from her job.

She took the sit-stand desk home with her as apparently it belonged to her, and she had used it at home to do her various submissions, correspondence and so on.

She obtained a new job on a trial basis, taking her sit-stand desk with her. She did this for around 12 weeks, but as it was unsuitable, a request for revision of more suitable equipment did not eventuate she lost that job after 7 months.

Her pain difficulties and losing two jobs moved Ms [REDACTED] into anxiety and depression, and she has required management under the guidance of her general practitioner for this, in addition to her musculoskeletal pain symptoms.

Ms [REDACTED] attended pain management, changing physiotherapists, and had the assistance of a psychiatrist and a psychologist, and has utilised the various techniques learned through this up to the present.

Physiotherapy routines, gym work and exercise were changed frequently as she went through the various programmes.

She found that her symptoms persisted, but fluctuated in intensity.

Further assessment for ergonomic desk design was undertaken, and Ms [REDACTED] was provided with new equipment in December 2021.

She found that once she started using her new equipment, which had been designed for her, that there was improvement in her musculoskeletal symptoms.

She has found that symptoms about the hands and forearms have now resolved, as she does not do much typing, and having voice recognition technology.

Ms [REDACTED] finds that there has been improvement in shoulder/trapezius region symptoms, as the keyboard and computer positioning is better and she does not need to lean up or down so much. She does find discomfort develops around the trapezius region with prolonged standing at her desk.

Neck symptoms have become intermittent, as her need for head/neck rotation and screen positioning has reduced strain.

In the lumbar region, Ms [REDACTED] experiences discomfort as well as in the left buttock and groin region with prolonged standing or walking of about half an hour or so, and she relieves her symptoms by the use of a TENS machine and doing her stretching exercise.

In the past 2 weeks, her gym membership has not been renewed through the insurer. (She went to the gym twice a week doing the exercises recommended by her therapist and being changed every 6 weeks or so with the various programmes that her therapist recommends, which includes Theraband work, light weights, stretching and so on.

This has resulted in an escalation of her previous symptoms particularly in the back and left hip region, as well as about the neck and shoulder areas.

Ms [REDACTED] continues to use analgesics when symptoms determine and also uses anti-inflammatory rubs on her various areas of complaint when they occur.

She remains under the management of her general practitioner and the supervision of her pain team.

No other treatments have been suggested.

PREVIOUS HISTORY

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

She has had no other injury, illness nor operation and takes no medication for any other condition.

WORK HISTORY

Prior to her job at the newsroom, Ms [REDACTED] worked in the film industry doing various freelance jobs, depending upon availability including camera work, director's assistant work, box office work, and so on.

She has obtained employment, having started to look for work once her symptoms improved in late 2021, and obtained a job as an editor in March 2022, which she continues to do to the present.

Currently Ms [REDACTED] does her job from home, with the equipment provided.

She has been into the office once.

This is supposed to be a hybrid job and she has requested duplicate of her current equipment be provided by her insurer at her workplace, so that she can undertake work in the office as well as at home.

This role is full time.

ACTIVITIES

Prior to onset of symptoms Ms [REDACTED] undertook activities such as bushwalking, community walking, rock climbing, and so on. She did this socially with friends and not competitively. She has not returned to these activities, apart from doing some walking in relation to her rehabilitation programmes.

DOMESTIC

Ms [REDACTED] spends half of her time in a small unit with her partner, and half of her time in a house with her mother.

In the unit there is minimal housework to be done, as it is very small, and she can manage the light activities required.

Her mother does the housework at her own house.

EXAMINATION

Ms [REDACTED] appeared to sit comfortably through the interview in an upright sitting posture, and did not appear to have discomfort with movements of her head, neck nor upper limbs in demonstrating her areas of complaint, with equal facility using both hands and upper limbs.

She was examined in a gown.

She was of short stature and her general posture appeared normal.

Her gait was even and she could heel and toe-walk with good power and control and balance. She could do a single leg stand without difficulty, and a full squat and rise, which was synchronous and without irritation, with symmetric motion in both lower limbs.

Cervical Spine

Head/neck posture appeared normal.

There was no tenderness of the neck itself, but rather in the upper thoracic region and in the periscapular muscles, a little more on the left than right.

There was no differential muscle wasting about the cervical musculature, nor muscles of the shoulder girdle, and muscle contour and tone were symmetric and within normal limits.

Cervical movements showed a slight restriction of right rotation compared to left, and lateral flexion was symmetric. Flexion and extension would be considered full range without dyssynchrony nor muscle irritation.

Upper Limbs

Ms [REDACTED] demonstrated full movement in the elbows, forearms, wrists and fingers.

General circulation, soft tissue integrity, temperature and sweating were symmetric and within normal limits, and there were no abnormalities of the soft tissues of the palms nor fingers identified.

Grip strength was symmetric and normal, and intrinsic function was intact. Sensation was intact and reflexes were brisk and symmetric.

Carpal mechanics about the wrists were normal. (On formal examination of the wrists, Ms [REDACTED] showed some restriction of dorsiflexion bilaterally to around 50° with full palmar flexion, but in other components of the assessment she demonstrated dorsiflexion to 80° bilaterally without discomfort.)

Shoulders

There was no particular tenderness about the shoulders. There was slight tenderness to deep palpation of the mid trapezius region bilaterally.

At the right shoulder, active range of motion showed flexion to 160° with extension of 60°. Abduction was to 150° with adduction of 40°. External rotation was to 60° and internal rotation to 80°. There was some crepitus through the mid range without dyssynchrony in movement. The rotator cuff was clinically intact.

At the left shoulder, flexion was to 120° limited by a feeling of tightness posteriorly, with extension of 60°. Abduction was to 90° limited by a feeling of tightness with adduction of 40°. External rotation was to 60° and internal rotation to 80°, the movements being synchronous and without discomfort and negative impingement signs.

Lumbar Spine

There was slight tenderness at the lumbosacral junction. Thoracolumbar contours were normal.

There was slight discomfort with extension, though without guarding, and the range being full. Movement into forward flexion was synchronous and full. Lateral flexion and rotation were symmetric and full without discomfort nor dyssynchrony.

On abdominal examination, there was some tenderness in the left iliac fossa region (this had become apparent over the last 2 weeks since Ms [REDACTED] stopped going to the gym), which extended to the upper lateral gluteal region.

She was able to do an unassisted sit-up.

There was no discomfort on loading the pelvis through anterior nor lateral compression, nor with rotation loading.

Lower Limbs

Leg lengths were equal.

General circulation, temperature and sweating were symmetric.

Muscle contour in the thigh, calf and foot were symmetric and normal with no fasciculation.

Thigh and calf circumference were symmetric.

Sensation was intact. Reflexes were symmetric. Plantar responses were equivocal.

Straight leg raise was to 80° right and left.

Knee movements were full, ranging from 0° to 150° bilaterally, with normal tracking of the patellae, and without discomfort.

Ankle and toe movements were full.

Power to manual testing was symmetric and normal.

At the hips, left hip flexion was to 110°, being to 120° on the opposite side, without fixed flexion deformity. (She complained of some discomfort about the left lateral groin region in flexion.)

Other movements in the hips were symmetric and full with abduction to 40°, adduction to 20°, internal rotation to 20° and external rotation of 40°, without discomfort on abduction in flexion.

INVESTIGATIONS

Ms [REDACTED] had no investigations with her.

From previous report dated July 2021:

MRI Cervical Spine 20 April 2020 (report supplied) showed disc desiccation at C3/4 with slight posterior bulge indenting the thecal sac. There was uncovertebral joint osteophytes more marked to the right. At C4/5, there was disc desiccation with left paracentral protrusion abutting the cord without signal change (unchanged in size from previous study), also abutting the C5 root without impingement. At C5/6, there was disc desiccation with broad based disc bulge indenting the thecal sac without canal stenosis, abutting the C6 roots. At C6/7, there was disc desiccation with a broad based disc bulge indenting the thecal sac without canal nor foraminal stenosis.

Bone Scan dated 19 April 2020 showed slight uptake about the facet joints of the lower cervicothoracic junction at C6/7 and C7/T1. There was slight facet joint uptake at L3/4 and L4/5, in the sacroiliac joint region and the C5/6 disc region.

MRI Cervical Spine dated 19 September 2019 showed normal alignment of the cervical region. There were multilevel changes with left paracentral C4/5 disc protrusion effacing the cervical cord without signal change. No nerve root impingement was noted. There was a broad based disc bulge at C3/4, C5/6 and C6/7 without neural impingement. Facet arthrosis was noted at C6/7 and C7/T1.

MRI Lumbar Spine dated 19 September 2019 (report supplied) showed normal alignment. There was disc desiccation at L5/S1 and a subtle left disc bulge. The previous annular fissure was no longer evident. No neural compression was noted.

MRI Left Hip dated 10 July 2017 (noted in my previous assessment) showed some signal change in the origin of semimembranosus at the ischial tuberosity. Some signal change was noted in the quadratus femoris muscle belly. There were mild dysplastic features of the hip with slight reduction of head/neck offset. There was some signal change at the trochanteric bursa.

Bone Scan dated 4 January 2017 (noted in my previous assessment) showed uptake at both sacroiliac joints, mild uptake in facet joints at C1/2, C3/4 and L2/3 and L3/4.

Ultrasound Left Hip dated 21 December 2016 (report supplied) showed thickening in the trochanteric bursa with some fluid in the bursa. Insertional tendinosis of the gluteal tendons was noted.

X-ray Sacrum dated 21 December 2016 (report supplied) did not show any structural abnormality.

MRI Lumbar Spine dated 25 November 2016 (report supplied) showed normal lumbar alignment. There was a small left paracentral annular fissure at L5/S1 with broad based disc bulge contacting the S1 root.

MRI Lumbar Spine dated 25 November 2015 (noted in my previous assessment) was within normal limits.

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From previous report dated January 2020:

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] developed widespread pain symptoms in the cervical region extending into the right upper limb and hand and in the lower lumbar region extending into the left buttock and groin in 2014, several months after commencing a busy job working in a newsroom office on computer equipment.

It was found that her furniture was not suitable for her body frame.

Ms [REDACTED] was found to have spondylitic change in the cervical and lumbar region and non-specific imaging changes about the left hip region.

Management has been with modification of office equipment with a recent provision of modified workstation and equipment, physiotherapy and exercise programmes, and pain management including the use of medications.

Symptoms improved in 2022 following the provision of her new workstation, but have returned recently on suspension of gym programme support.

In answer to your questions:

(a) History received;

The history of onset of symptoms and progression has been outlined above and in previous reports, commencing around April 2014 several months after commencing her job in a newsroom.

There was no specific incident associated with the commencement of symptoms.

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There has been some improvement in Ms [REDACTED] level of symptoms following provision of a modified workstation late in 2021, with symptoms recurring in September 2022 several weeks after support for a gym programme and exercise routines provided through her therapist were suspended.

(b) Complaints generally;

Current complaints have been outlined above.

Following provision of an altered workstation and equipment, symptoms in the hands and forearms had resolved, symptoms about the shoulder and trapezius region had improved, and neck region symptoms became intermittent.

Symptoms in the lumbar region and left hip region developed with standing or walking for more than half an hour, and were relieved by the use of a TENS machine.

There had been a return of symptoms in these areas when support for her exercise programme through her therapist and undertaken at the gym was suspended.

(c) Your diagnosis;

Imaging undertaken in assessing Ms [REDACTED] various areas of complaint had identified that she has multilevel cervical spondylosis with disc and joint changes throughout the cervical spine.

She also shows some changes of spondylosis in the lower lumbar spine with bone scan imaging showing some uptake about the sacroiliac joints, suggesting inflammation. (No overarching inflammatory disorder has been identified. She was assessed by Dr Portek, Rheumatologist, early in her presentation with no systemic disorder being identified.)

Imaging about the left hip region has shown some mild dysplastic features at the head/neck junction and non-specific changes about some muscular origins and about the trochanteric bursa, although Ms [REDACTED] clinical examination does not show active trochanteric bursitis.

These imaging changes suggest an underlying disorder of degenerate origin that is most likely constitutional in nature with no specific overarching condition.

From an orthopaedic perspective it is difficult to identify a cause for the development of symptoms from 2014. The physical nature of Ms [REDACTED] work was not sufficient to cause aggravation of an underlying degenerate disorder.

Ms [REDACTED] is very symptom focused and particularly associates her symptoms with office furniture design. Her progression over time with fluctuating symptom levels suggests that she has moved into some form of chronic pain disorder. The specific diagnosis of these types of conditions, however, is not in my area of expertise.

Ms [REDACTED] recent escalation of symptoms following change in her gym activity suggests a non-organic cause for her symptoms.

(d) Your prognosis;

From a orthopaedic perspective, Ms [REDACTED] prognosis is good. While she does show some imaging changes consistent with degenerate disease, these are at an early stage of development and her clinical examination does not indicate significant impediment of movement nor of function. Her physical demands are low in the type of work that she does, and in her current general activities, and so this condition, while it will continue to follow its natural history, is likely to progress slowly.

Causation

(e) Do you consider the worker suffered an injury to their left hip arising out of or in the course of her employment on 7 October 2014 (deemed)? If not, what do you consider to be the cause of the worker's complaints?

No.

Pain symptoms about the left hip region (buttock and groin) developed spontaneously along with the development of pain symptoms in other areas of her body in 2014 that were not associated with any mechanical incident that might be sufficient to cause any structural injury about the hip region nor elsewhere.

The level of physical activity associated with Ms [REDACTED] work (which was sedentary) is not sufficient to cause any mechanical strain of components of the hip region.

Ms [REDACTED] current physical examination does not show any physical signs of chronic asymmetric disuse of the region arising from the symptoms. There is no loss of muscle bulk, contour nor tone about the hip region nor proximal thigh which would be expected with altered function over time. The limitation in motion, being only a slight limitation in flexion, does not indicate intra-articular nor peri-articular pathology.

Determining the source of pain symptoms (which cannot be independently identified, qualitated nor quantitated) is often difficult if not impossible to determine.

Determining whether image changes identified on sophisticated imaging techniques such as MR are a cause or associated with a patient's reported symptoms is frequently a matter of interpretation and often debate.

Ms [REDACTED] does show some changes in the proximal head/neck junction at the left hip, which would be considered dysplastic, but these are of a very mild degree and would not cause symptoms in their own right. There is no indication of early degenerate disease within the hip joint arising from these changes as yet. The muscular origin imaging changes are non-specific but most likely represent early degenerate change and are frequently seen in those that are active in doing gym based exercise and other heavy physical activities involving the lower limbs and may in time give rise to localised symptoms, (although Ms [REDACTED] regions of symptoms do not correlate to these changes).

Thickening in the trochanteric bursa is a non-specific sign and represents attritional change from the influence of the underlying trochanteric movement against the overlying iliotibial band (the bursa being interposed between these structures to allow freer movement). These changes occur with age and are more common in females as they have a broader pelvis and thus trochanteric prominence. Ms C [REDACTED] description of symptoms and clinical examination on the various times that she has been assessed do not indicate active localised trochanteric bursitis.

Some times pelvic disorders can be felt as buttock and groin region symptoms. Ms [REDACTED] has noticed, since the cessation of her gym programme, left iliac fossa discomfort and was also tender in this region. However, this is a recent development and she has not had any further specific assessment by her general practitioner to determine if there is any active pelvic pathology. This recent change, however, does not explain symptoms in the region over the past 8 years or so.

Proximal lower limb symptoms can also be referred from lumbosacral disease and Ms [REDACTED] is known to have early degenerate disease of the lumbosacral region which is a possible source for her symptoms but difficult to isolate specifically. (Her current clinical examination does not suggest that her lumbosacral disease is active.)

(f) If so, do you consider the worker's employment to have been a substantial contributing factor to the alleged injury to her left hip? The following factors are not exclusive, but can be taken into account in determining whether the worker's employment was a substantial contributing factor to the injury:

- (i) The time and place of injury;
- (ii) The nature of the work performed and the particular tasks of that work;
- (iii) The duration of the employment;
- (iv) The probability that the injury or similar injury would have happened anyway, at about the same time or at the same stage of the worker's life, if the worker had not been at work or had not worked in that employment;
- (v) The worker's state of health before the injury and the existence of any hereditary risks; and
- (vi) The worker's life style and activities outside the work place.

There is no indication that Ms [REDACTED] employment has caused any pathology at the left hip region. Her work at the time of onset of symptoms (and subsequently when she was working) is not of sufficient mechanical load to cause any injury or pathology at the hip region, nor to influence any underlying degenerate or other condition of tissues in the region.

(g) If you form the view that the employment was not a substantial contributing factor to the alleged injury to the left hip, please detail the factors you have taken into account in forming that determination.

This has largely been outlined above.

No specific injury has been identified about the left hip region. No specific underlying condition has been identified, the imaging changes being of a non-specific nature and principally constitutional in nature. There is no current clinical evidence that they are active about the left hip region and there is no indication of chronic disuse that would be expected with long term dysfunction of the region.

Ms [REDACTED] had not been in her job for very long and the job itself was sedentary with no indication of a specific injury event nor of the activities of her work being of a sufficient mechanical nature to cause injury nor to influence any underlying disease about the left hip region specifically.

Symptoms in the region have persisted despite Ms [REDACTED] being off work more than doing any work over the subsequent 8 years.

- (h) **In the alternative, do you consider that the worker's condition of the left hip is best described as a disease of gradual process?**
If so, do you consider that the worker contracted or suffered an aggravation, acceleration, exacerbation or deterioration of a pre-existing condition of the left hip arising out of or in the course of her employment on 7 October 2014 (deemed)?

As outlined above, there is no specific disease entity at the left hip region. There are some imaging changes noted on scans to various components of the region which are essentially of a degenerate nature which in combination with a known degenerate disease elsewhere in the musculoskeletal system would be considered a constitutional tendency towards musculoskeletal degeneration.

The mild dysplastic change in the proximal femur is most likely developmental in nature but not sufficiently advanced to cause biomechanical dysfunction and early arthrosis (which is currently not evident).

The trochanteric bursa changes are considered incidental in nature and, as outlined above, are most likely reactive in nature to Ms [REDACTED] anatomy in the region, though not currently active.

There is no indication that Ms [REDACTED] has any general inflammatory nor connective tissue disorder.

- (i) **As a result of the 2012 amendments to the legislation an "disease injury" is now defined as follows:**

- "(i) a disease that is contracted by a worker in the course of employment but only if the employment was the main contributing factor to contracting the disease, and**
(ii) the aggravation, acceleration, exacerbation or deterioration in the course of employment of any disease, but only if the employment was the main contributing factor to the aggravation, acceleration, exacerbation or deterioration of the disease"

The Macquarie dictionary defines main as the "chief", "principal" or "leading".

There is no indication that Ms [REDACTED] has developed a disease injury at the left hip region arising from her work.

- (j) **Do you consider the worker's employment was the main contributing factor to the contraction or aggravation, acceleration, exacerbation or deterioration of the pre-existing disease of the left hip?**

Further, when providing your response please advise what factors contributed to the contraction, aggravation, acceleration, exacerbation or deterioration of the disease.

As indicated above, there is no indication that Ms [REDACTED] employment has caused any pathology at the left hip region. Her work at the time of onset of symptoms (and subsequently when she was working) is not of sufficient mechanical load to cause any injury or pathology at the hip region, nor to influence any underlying degenerate or other condition of tissues in the region.

- (k) **In the alternative, do you consider the left hip condition to be consequential or causally related to the cervical and lumbar injuries on 7 October 2014 (deemed). Please provide reasons for your answers.**

The association of the imaging changes about the left hip region with regard to those identified in the cervical and lumbar region are that Ms [REDACTED] has a constitutional tendency to musculoskeletal degenerate disease. (Your contention in the question that the changes in the cervical and lumbar region relate to injury is incorrect.)

Capacity

- (l) **Do you consider that the worker continues to suffer from the effects of the work-related injury?**

No.

There is no indication that Ms [REDACTED] has suffered any form of musculoskeletal injury arising from her work from an orthopaedic perspective.

Ms [REDACTED] appears to have some form of chronic pain disorder.

- (m) **Do you consider the worker's current capacity for work is reasonable and related to the workplace injury?**

- (i) **If not, what alternative recommendations would you make for the worker's work capacity?**
(ii) **In your response, please indicate the nature of the duties the worker is able to carry out and the probable duration of the incapacity for normal duties;**

This question does not make sense.

Ms [REDACTED] current incapacity for work is related to her self-reported pain symptoms, but not to any injury component (neither at the left hip region nor elsewhere in the musculoskeletal system).

Ms [REDACTED] has been found to have cervical spondylosis and in an effort to reduce potential for mechanical exacerbation of this condition she would be wise not to undertake work that requires high range head/neck movement. She is also known to have some early lumbar spondylosis and would be wise to avoid work activities that require moderate to heavy lifting. (The type of work that she tends to do, being office based, however does not expose her to these mechanical factors.)

From an orthopaedic perspective, Ms [REDACTED] would be capable of undertaking office type work with no specific limitation. Hours of work may fluctuate depending upon her self-reported pain symptoms.

- (n) Please indicate whether the complaints made by this worker and resulting incapacity for work is a reasonable and direct result of the worker's injury;**

As outlined above and previously, there is no indication that Ms [REDACTED] has suffered any musculoskeletal injury arising from her previous work.

Ms [REDACTED] limitation in work relates to her self-reported pain symptoms that seem to be associated with the chronic pain disorder that afflicts her.

- (o) Please take a history of the worker's current employment and duties;**

Currently Ms [REDACTED] has obtained a new job that she is performing from home with her new workstation and modifications with computer technology that she utilises.

- (p) Please ask if the worker is currently seeking alternative employment and if so:**

- (i) What type of employment is she seeking?**
(ii) Please comment as to whether you would accept that any such employment being sought by the worker is in your view, a reasonable reflection of the extent of the worker's capacity, having regard for the effects of the alleged injury.

Ms [REDACTED] is not currently seeking other employment, but indicated that she wishes to have a workstation, the type that she has at home, supplied in her workplace so that she can go into work to do the office component of her new job.

Treatment

(q) What treatment is the worker currently undertaking for her injury?

Ms [REDACTED] is not currently having any active treatment.

She has been attending the gym for exercises, supervised by her physiotherapist, but this is not specific treatment but is general maintenance.

(r) Do you consider these are reasonably necessary treatments of any work related injury?

Ms [REDACTED] current management is associated with chronic pain rather than for any musculoskeletal injury.

(s) Do you consider the worker requires any additional treatment in respect of her injury?

From an orthopaedic perspective there is no indication that any additional or other treatment is required.

Impairment

(t) Paragraph 1.15 of the New South Wales Workers Compensation Guidelines for the Evaluation of Permanent Impairment (4th Edition) provides that:

“assessments are only to be conducted when the medical assessor considers that the degree of permanent impairment of the worker is unlikely to improve further or has attained a maximum medical improvement. This is considered to occur when the worker’s condition is more stabilised and unlikely to change substantially in the next year with or without medical treatment”.

Do you consider the worker’s condition has reached maximum medical improvement? Please provide reasons for your opinion;

From an orthopaedic perspective any exacerbation in the musculoskeletal system in the cervical and lumbar regions that might have developed in the course of Ms [REDACTED] work in 2014 has long since passed and she would thus be considered to have reached maximum medical improvement.

- (u) **Please provide your combined assessment of the percentage of the whole person impairment suffered by the worker due to the injury on 7 October 2014 (deemed) in accordance with the AMA 5th Edition Guides and the New South Wales Workers Compensation Guidelines for the Evaluation of Permanent Impairment (4th Edition) for lumbar spine, cervical spine and left lower extremity - hip (if work-related).**

In the cervical region, assessment using AMA 5, Table 15-5 would place Ms [REDACTED] in DRE Cervical Category II with 5% whole person impairment on the basis of asymmetric rotation motion noted at today's assessment.

This impairment is entirely related to cervical spondylosis, the underlying condition in Ms [REDACTED] cervical region, which is unrelated to her work. Any symptomatic exacerbation that might have occurred at the time of initial presentation in 2014 has long since passed and has not had any influence on the natural history of her disorder which has, and will, remain and is responsible for her current cervical impairment.

The work related component is 0%.

Limitation in motion at the shoulders noted at today's assessment, more limited on the left than right, cannot be rated as permanent impairment. It is noted that at assessment in 2020, there was full symmetric motion at both shoulders. At assessment in 2021, there was limitation in shoulder motion more marked on the right than left, and a different range of motion noted at today's assessment.

The cause of limitation in motion has not been determined, and seems to have arisen since 2020, and therefore not associated with Ms [REDACTED] initial development of symptoms in relation to any work injury in 2014. There has been no assessment of Ms [REDACTED] shoulders through her general practitioner nor through any referrals made, nor has any imaging been undertaken to ascertain the nature of any pathology. There is no indication in her history of any specific injury to her shoulders, nor is any aspect of her work likely to be a source of shoulder pathology.

SIRA Guidelines 2016, paragraph 2.3 require there to be an explanation for the physical findings in order for an assessment of impairment to be made, which currently there is not.

In the lumbar region, according to AMA 5, Table 15-3, Ms [REDACTED] is in DRE Lumbar Category I, with 0% whole person impairment due to lumbar pain symptoms but without limitation in motion.

This impairment relates to Ms [REDACTED] underlying condition of lumbar spondylosis which is unrelated to her work. Any symptomatic exacerbation that may have developed at the time of initial presentation has long since passed.

There is no rateable impairment at the left hip, the limitation in motion not being sufficient to attract an impairment rating under AMA 5, Table 16-9, and the trochanteric bursitis not being assessable under Table 16-33 as it does not alter gait pattern.

- (v) **Please note any compensation is only payable in respect to the degree of loss or impairment caused by the injury. In making an assessment it will be necessary for you to distinguish any apportionment of the loss of impairment that is due to any previous injury or that is due to any pre-existing condition or abnormality.**

Do you consider the worker to have suffered any previous abnormalities, injuries or conditions and, if so, do you consider a deduction for such to be warranted? Please provide reasons for your opinion.

The influence of pre-existing and continuing disease on Ms [REDACTED] presentation, from an orthopaedic perspective, has been outlined above.

- (w) **Do you agree with the 13% whole person impairment percentage provide by Dr Mohammed Assem? Please provide detailed reason for why you either agree or disagree.**

I have outlined the reasons for my assessment of impairment and contributing factors above, and therefore do not agree with the findings of Dr Assem with regard to the influence of Ms [REDACTED] work on her level of impairment.

Yours faithfully



Dr James Powell
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Orthopaedic Surgeon
WorkCover Approved Impairment Assessor