# MEDICAL REPORT

On

Mr G

Mr Lindsay Muir  M.B., M.Ch.Orth., F.R.C.S. Orth (Glasg)
Consultant hand surgeon

Salford Royal Hospital,
Stott Lane,
Salford,
M6 8HD.

| | |
|---|---|
| Patient: | Mr G |
| Address: | |
| Date of birth: | |
| Occupation: | (Right handed) |
| Report requested by: | Messrs Solicitors LLP,<br>Solicitors. |
| Solicitor's reference: | |
| My reference: | |
| Date of Zoom teleconsultation:<br>Date of clinical examination: | |
| Place of examination: | Oaklands Hospital,<br>19 Lancaster Road,<br>Salford M6 8AQ. |

## 1. INTRODUCTION

1.1. This report has been prepared at the request of Messrs Solicitors. In their letter of instruction they note that they represent Mr G in connection with a proposed claim for clinical negligence arising out of a scaphoid fracture sustained on.

1.2. In preparing this report I understand my duty is to the Court and I have done my best to discharge this duty conscientiously.

1.3. The contents of the history section of the report are based on the information conveyed to me by Mr G in the course of our Zoom teleconsultation on.

1.4. This consultation was supplemented by a face to face clinical examination on 1 November 2021, followed by completion of the report.

## 2. DOCUMENTS EXAMINED

2.1. Letter of instruction

2.1.1. The letter of instruction notes simply as above.

2.2. Hospital records

2.2.1. Hospitals. Case Sheet No.

2.3. GP records

2.3.1. Surgery.

## 3. HISTORY OF ACCIDENT

3.1. The accident to which this report pertains occurred on 27 March 2018. Mr G was playing rugby. He took a pass. He was tackled. He landed with his palms down. Someone then landed on top of him and he sustained a hyperextension injury of his right wrist. His wrist was painful. The physiotherapist came on and taped up his wrist .

3.2. There were just ten minutes of the game left and Mr G was able to play on. In the bar that evening after the game he had pain in his wrist when he tried to lift up his drink and he therefore asked the physiotherapist to have another look. The physiotherapist recommended that he attend hospital.

3.3. Later that night Mr G therefore went to the A&E department. It is of note that Mr G had previously sustained a fracture of his opposite scaphoid and this had not been initially recognised and he had required internal fixation and grafting. He states therefore that he explained to the A&E surgeon that he had had this experience and that on this side his injury felt very similar. The A&E surgeon arranged an x-ray including a set of scaphoid views and no fracture was demonstrated. Mr G was advised to return in two weeks if he was still sore but in the meantime he was to rest.

3.4. Mr G took two weeks off sport and took some paracetamol. He was still sore two weeks later and went back to the A&E department and asked if he could have another x-ray. Mr G states that his request was declined. He was advised that he could be seen in four to six weeks and that it was ok to return to sports.

3.5. Mr G returned to playing sport for the last two games of the season. He then went to Spain on holiday. When on holiday in Spain he was doing an obstacle course and his wrist gave way. When he returned to the UK therefore he went back to A&E. He saw a consultant who advised that he should not worry. The consultant stated that he himself had had a similar injury and that it had taken some time to settle down. He prescribed Voltarol gel and recommended light exercise.

3.6. Mr G saw some improvement with this but when he returned to pre-season training at his rugby club on the occasion of the first tackle of the game he had increased pain. On 17 August 2018 he therefore went back to A&E. At this time x-rays were taken and they demonstrated a fracture. Mr G was referred to the fracture clinic. He underwent a CT scan and on 27 September 2018 he underwent internal fixation of his scaphoid fracture. The surgery was performed with distal radial graft and a screw was inserted. Post op he was in a plaster cast for six weeks. He did not require any physiotherapy. The surgery was performed as a day case under general anaesthesia.

3.7. Some 12 months later Mr G attended for his final consultation. A CT scan showed that the fracture had healed but that the screw was somewhat exposed. He did not think that this was likely to cause any problems and Mr G was therefore discharged.

3.8. When he returned to sport Mr G once again had a fall on his wrist and he went to the Hospital in. This was in approximately October or November

2019. X-rays were taken. He was reassured that there was no acute fracture and he has not had any further treatment or investigations.

## 4. PRESENT CONDITION

4.1. Mr G states that he still has occasional pain. He has aches and pains if he writes a lot. He has restricted extension and if he pushes this he develops pain from the centre of the palm up as far as the wrist. He has lost strength in lifting but he has managed to return to the gym.

4.2. <u>DASH score</u>

4.3. Mr G has kindly completed a DASH (disabilities of the arm, shoulder and hand) score. This is a standardised questionnaire returning a score ranging between 0 (minimal) and 100 (maximal) disability.

4.4. The calculated scores are as follows:

| | |
|---|---|
| general module | 8 |
| work module | 19 |
| sports/performing arts module | 38 |

2.1. <u>Activities of daily living</u>

2.2. Mr G is able to wash and dress. He is able to do up zips, buttons and laces. He is able to cut up food. He is able to cook. He is able to clean. He is able to iron. He is able to make the bed. He is able to carry shopping. He is able to drive. He is able to write but as indicated above his wrist aches

when he does so. He is able to type but again if he does too much of this he has ache.

## 3. OTHER INJURIES

3.1. Nil.

## 4. GENERAL HEALTH

4.1. Fit and well.

## 5. PAST HISTORY

5.1. Fracture left scaphoid in 2011 as indicated above.

5.2. Nil since.

## 6. DRUG HISTORY

6.1. Paracetamol and ibuprofen.

6.2. Mr G does not smoke cigarettes.

## 7. EMPLOYMENT

7.1. At the time of the accident Mr G was in his first year in . He was studying for a B.Ed in primary education (ages three to seven years). He missed the first two weeks at one term at the time of his surgery. He then managed to return to his studies with the above mentioned assistance. He required an extension for one of his assignments.

7.2. This was a three year course and he qualified in 2020.

7.3. Mr G now works at the School in. He started on 5 October 2020. He works full time.

7.4. He is managing well. He teaches a class of to year olds.

## 8. DOMESTIC CIRCUMSTANCES

8.1. Mr G now lives with his girlfriend and her parents. The couple have moved in together to his "in-laws" to try to save some money for a deposit on a house.

8.2. Housework

8.3. Mr G and his girlfriend share the housework and he manages his share without difficulty.

8.4. Gardening

8.5. Mr G does some gardening without difficulty.

8.6. Hobbies

8.7. Mr G enjoys squash, rugby and gym. He has returned to rugby this season. He plays for Club. This is a high level amateur club. He plays outside centre or on the wing. He also enjoys going to the gym.

8.8. Care and assistance

8.9. At the time of the accident Mr G had assistance from his girlfriend. He had difficulty in showering. He had difficulty with his shoelaces. His girlfriend had to help him type up his notes at university. He did manage some sort of cleaning however.

## 9. CLINICAL EXAMINATION

9.1. Mr G is cm tall and weighs kilos.

9.2. Neck

9.3. He has full extension/flexion.

9.4. Shoulders

9.5. He has full pain free elevation.

9.6. Elbows

9.7. He has full extension/flexion.

9.8. Wrists

9.9. Ranges of movement are as noted below:

| | Right | Left |
|---|---|---|
| Pronation | 80 | 80 |
| Supination | 70 | 70 |
| Extension | 70 | 80 |
| Flexion | 95 | 90 |
| Ulnar deviation | 45 | 60 |
| Radial deviation | 20 | 20 |

9.10. There is no gross malalignment of either wrist. There is no pain on stressing the distal radioulnar joint on radial or abutment testing, on Kirk Watson testing, on scapho or triquetrolunate shear testing. There is mild

discomfort on ulnar abutment testing on the right only. Of note is the fact that both pseudostability tests are positive.

9.11. Hands

9.12. He has full extension and full wind up. In the fingers the Kapandji score is 10 on either thumb.

9.13. Scars

9.14. On the dorsum of the right wrist he has an angled scar. The distal limb points towards the thumb and is some 3 cm. The proximal limb points up the midline and measures 3.5 cm. The maximum width of the scar is 2 mm. The scar is not tender.

9.15. In the left hand side he has a volar, almost straight, scar with only slight hockey stick at the distal end. This measures some 5.5 cm.

9.16. Neurology

9.17. Fine touch sensibility is intact throughout. Grip strength in consecutive readings in kilos on the Jamar dynamometer is right 47, 32, 42; left 54, 42, 40.

9.18. The circumference of the forearms as measured 11 cm distal to the lateral epicondyle with the elbow flexed to 90 degrees and the forearm in mid prono supination is right: 32 cm and left: 29 cm.

## 10. RADIOLOGICAL EXAMINATION

10.1. I recommend an up to date CT scan unless one has already been performed.

## 11. OPINION AND PROGNOSIS

4.1. Timeline

| | |
|---|---|
| 27 March 2018 | Mr G, a 24-year-old right-handed man, injures his right wrist playing rugby. |
| 27 March 2018 | Attends. Diagnosed as having a sprain. Given advice and to return in 1 week if not improving. |
| 3 April 2018 | Reattends, complaining of pain. Given splint for 10 days. Advised to return if no improvement in 2 weeks. |
| 29 May 2018 | Reattends A&E. Diagnosed as sprain. To be seen again in 4 weeks if no improvement. |
| 17 August 2018 | Reattends. X-ray shows fractured scaphoid. Given a Futuro splint and referred to fracture clinic. |
| 20 August 2018 | Seen in fracture clinic by Mr H. Referred for a CT scan. |
| 21 August 2018 | CT scan. |
| 22 August 2018 | Seen by Mr M and listed for surgery. |
| 27 September 2018 | Operation. Grafting and screw fixation of scaphoid. (I do not have the operation note for this.) |
| 19 December 2018 | CT scan reported as showing union of the fracture. My opinion is that union is not complete. |

4.2. Preamble

4.2.1. I would ask the Court to view my opinion where appropriate as being based on the balance of probabilities test throughout, to avoid cumbersome repetition of the phrase.

11.1. Present position

11.1.1. Mr G seems largely to have made a satisfactory recovery from his scaphoid injury.

11.1.2. Clinical examination shows some stiffness. Even when compared with the previously operated left hand side he has some degree of stiffness. Unfortunately there is no longer a normal side to compare with. There is no real tenderness.

11.1.3. There is loss of grip strength. One would normally except the dominant side to be at least as strong as, or 10% stronger, than the non-dominant side and he has thus lost some 10 – 15% of grip strength. His residual grip strength is however perfectly satisfactory for day to day life.

11.1.4. A CT scan has not yet shown solid union in my opinion and I think that a further CT would be indicated to be absolutely certain assuming that there has not been one in between 19 December 2018 and today.

11.1.5. The evidence suggests that with a fracture of the scaphoid one would see a 5% increased risk over the background rate of 5%

approximately of radiocarpal arthritis. This does not from the literature seem to be increased if the fracture has healed in a satisfactory position, which is Mr G's case (assuming that is that the CT shows that the fracture has united). Therefore he has this standard 5% risk.

11.1.6. The evidence shows that following a scaphoid fracture there is a 7 – 10% chance of persistent pain. Mr G is subject to this.

11.2. Further treatment.

11.2.1. I do not believe that further treatment is indicated for Mr G. I believe that he can return to all normal sporting activities.

11.3. Care and assistance

11.3.1. Mr G had some assistance after his surgery. This is reasonable. He will not have any further or future accident related requirements for assistance.

11.4. Employment

11.4.1. Mr G missed two weeks off university which is reasonable. He is not at a disadvantage in the open labour market for teaching.

11.5. Difference between the position with an earlier diagnosis and now

11.5.1. With early diagnosis Mr G would have undergone early fixation, based on his sportiness and his relatively proximal fracture.

11.5.2. He would not have required bone graft.

11.5.3. The fracture would have united albeit that there was a chance that it would not have united. He would have seen resolution of his pain and treatment at an earlier stage.

11.5.4. The scar would have been rather smaller.

11.5.5. His pain and discomfort would have settled sooner.

11.5.6. He would have been slightly less stiff.

11.5.7. He would have recovered full grip strength.

11.5.8. The aspects that have not changed are the increased risk of degenerative change and the chance of ongoing pain.

11.5.9. All of the above relies on the fact that Mr G's fracture has united.

11.5.10. If it has not united on an updated CT scan other considerations will apply. I shall be happy to review a CT and issue an addendum to this report.

11.6. <u>Further comments</u>

11.6.1. I understand my duty is to outline for the Court any potential variation in medical opinion.

11.6.2. I hope that there would not be any significant controversy over the above.

I understand my duty is to the Court and have complied and will continue to comply with that duty. I am aware of the requirements of Part 35, this practice direction and the Protocol for the Instruction of Experts to give Evidence in Civil Claims.

I confirm that 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 own 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.

I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Mr Lindsay Muir,
Consultant hand surgeon,
Honorary senior lecturer in orthopaedic surgery at the University of Manchester
23 November 2021

## 12. APPENDIX 1 REVIEW OF HOSPITAL RECORDS

12.1. Left scaphoid (2009)

18.08.09 X-ray report on left scaphoid. There is a fairly convincing fracture line through the waist of the scaphoid on the AP view. [Page 12.1]

25.08.09 Note of a left scaphoid fracture. [6.24]

02.11.09 CT, left wrist. There are small areas of bony bridging across the scaphoid suggestive of partial union. Overall this is approximately 20% of the overall surface area. [12.3]

24.11.09 Listed for screw fixation of left scaphoid.

21.04.10 Operation note for left scaphoid fixation and grafting. [6.30]

20.07.10 X-rays of left scaphoid show encouraging progress. [6.41]

12.2. Right scaphoid (2018)

27.03.18 A&E card.

The nurse writes: Patient playing rugby this p.m. Hyperextended arm. Complains of radiating pain to right wrist. [6.84]

The doctor writes: Patient bent back right wrist at rugby. On examination, tender ulnar side of wrist. Elbow: Full range of movement, non-tender. Anatomical snuffbox/scaphoid non-tender. X-ray, right wrist, normal. Diagnosis: Sprain. Discharged with advice. [6.87]

27.03.18 X-ray report on X-ray, right wrist. No acute bony injury seen. Bony alignment through the carpus appears satisfactory. [12.7]

03.04.18 A&E card.

Triage details: Right hand injury, playing rugby 1 week ago. Hyperextended hand. Seen in A&E 1 week ago. No obvious fracture seen but advised to return if pain continues. Pain still present. [6.88]

The A&E surgeon notes: 24-year-old student. Hyperextension injury 1 week ago, playing rugby. Not improving. On examination: Bruising over palmar distal radioulnar joint. Pain on pronation, supination, flexion. No bony tenderness. No scaphoid

tenderness. X-ray (previous): No fracture seen. Diagnosis: TFCC sprain. Plan: Splint for 10 days. Advice: Rest, etc. Return if no improvement in 2 weeks. [6.91]

29.05.18 A&E card.

The triage nurse writes: Injured wrist 6 weeks ago. Has been seen here intermittently as pain is not going away. Pain continues in scaphoid. [6.92]

The doctor writes: Right wrist pain for 8 weeks. Hyperextension injury to right wrist in late March 2018 whilst playing rugby. Attended emergency department, had X-ray which was normal, discharged with wrist splint, advised to rest and return if no improvement. Returns today, complaining of pain in right wrist, worse when gripping and heavy lifting. On examination, mild swelling over palmar distal radioulnar ligament. Pain on flexion. No bony tenderness. No scaphoid tenderness. No scaphoid tenderness or pain on application of longitudinal thumb compression. Plan: Home with advice to rest wrist, to return if no improvement in 4 weeks. [6.95]

17.08.18 A&E card.

Presenting complaint: Pain right wrist. [6.98]

The doctor writes: Injury to right hand. 24-year-old man, right-

handed. Patient injured his wrist in March 2018 playing rugby. He was X-rayed, and reported that there was no fracture. However, patient still experiencing pain. He was advised that it was a ligament injury and to return if no improvement in 4 weeks. Indeed he returned and was told it was tendon damage, told to rest for 3 months and return if pain no better. Patient experiencing pain and occasional loss of power (dropping things) … and complains of aching of wrist radiating into carpal bones and reduced range of movement. Lives with partner. No children. Works at a children's nursery. Studying primary education at university. Occasional alcohol. Non-smoker. On examination, no obvious swelling. Wrist was painful and tender and had marked restriction of range of movement. X-ray shows fractured scaphoid. Plan: Scaphoid cast or splint and fracture clinic follow-up. [6.101-6.102]

20.08.18 Seen by Mr H. Diagnosis: Non-union, proximal pole fracture, scaphoid, right wrist. Treatment: CT and review. The history is outlined. Urgent CT requested. [3.83]

22.08.18 Seen by Mr M, Consultant Orthopaedic Surgeon. He outlines the history. He notes the past history of fracture of the left scaphoid. Examination revealed tenderness over the scaphoid tuberosity, full wrist flexion, wrist extension slightly limited by pain. X-rays and CT show a fracture of the proximal pole and cystic change. Recommends surgery arthroscopically. [1.45]

Of note, I do not have the operation note for the operation of 27 September 2018.

19.12.18 CT scan report shows the scaphoid fracture looks solidly united. [12.11]

## 13. REVIEW OF RADIOGRAPHS

13.1. A number of radiographs have been sent on CD. I shall comment only on those relating to the right scaphoid. Of note is, however, that I agree that the plain films of 18 August 2009 do show a fracture of the waist of the left scaphoid which, by the time of the films of 20 July 2010, does seem at the very least to be attempting to heal.

27.03.18 Right wrist PA and lateral views.

Even with the benefit of hindsight, no scaphoid fracture is visible here.

17.08.18 Right wrist PA and lateral views.

There is a fracture of the waist of the scaphoid, more towards the proximal than the distal pole.

21.08.18 CT, right wrist.

The fracture is demonstrated with a clear non-union and some cystic change.

27.09.18 Intraoperative films showing the position at the time of screw fixation.

The placement of the screw appears excellent on all views. Probably on the PA view, it is outside the bone but inside the cartilage.

07.11.18 Right scaphoid.

The fracture appears to be healing. There is a defect at the site of the bone graft harvest.

19.12.18 CT of wrist.

The fracture of the scaphoid has been fixed as indicated by a screw. There is probable partial union, albeit that the fracture line is still visible.

## 14. APPENDIX 2 REVIEW OF GP RECORDS

14.1. Handwritten notes

14.1.1. There are no handwritten notes.

14.2. Computerised records

14.2.1. These were printed on 5 October 2018. There are notes noting receipt of correspondence but there are no other relevant entries.

14.3. Correspondence and reports

14.3.1. There are copies of the hospital records. There are no other relevant entries.