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Date: 05 July 2023

Stephen Brown Lawyers
Ms Leanne Downsborough
PO Box Z5471
St Georges Terrace
PERTH WA 6831

Re: **Patient:** **Mr Raymond MORRISON - DOB 19/08/85**
Address: 40 Toledo CCT PORT KENNEDY WA 6172
Home Phone: Mobile: 0459 570 046

I am writing this report with regards to your letter from 04 May 2023 requesting one.

Background

Raymond Morrison was reviewed at Claremont Pain Clinic at 10 am on 24 May 2023. The patient had a workplace injury in the course of employment on 24 February 2022. He was subsequently reviewed again on 4th of July 2023 at 11am at Claremont Pain Clinic. He was moving a coiled-up wire fence and slipped while twisting to the right side. His right foot remained planted on the floor and he felt two pops and then had extreme pain. The patient was unable to ambulate following this.

Following a delay of about an hour, an ambulance arrived and the patient was taken to Rockingham Hospital. No fracture was identified at that point and the patient was placed into a CAM boot.

Following on from this, the patient has had ongoing severe pain with regards to his right ankle and has had treatment through the Painless Clinic in the form of right lumbar sympathectomies for a presumed diagnosis of CRPS. The patient has had severe, unremitting ankle pain which failed to settle despite the application of a CAM boot and appropriate conservative treatment.

The patient did not have any ankle pain prior to this accident. It has become apparent that the patient has ongoing neuropathic symptoms related to his ankle.

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The fact that this has happened after the accident and the pain is directly linked to the timing of the accident leads me to believe that his condition and the ongoing pain in his ankle is a result of the accident completely.

Work Capacity

At this stage, the patient is not able to perform his original duties. The patient previously worked as a truck driver which required the use of his right foot. As a part of his job description, he was involved with the loading and unloading of items. He is not able to do this and in addition to this, he is not even able to drive a normal vehicle.

The patient is completely unable to return to his pre-accident occupation. The patient has not been able to return to his previous capacity and while he did briefly have a trial of light duties, unfortunately, according to the patient, his employer did not believe that it was worthwhile him continuing this. The patient has not regained capacity and indeed, over time, the condition has worsened. Initially, the condition involved primarily pain in his right ankle but the pain has now progressed up to involve his entire lower limb. It is also starting to involve his right upper limb. Generalisation of neuropathic symptoms with conditions such as CRPS is a well-described phenomenon. The patient has significant symptoms which are present at all times and which have episodic exacerbations.

I do not believe that it is likely that the patient will return to his previous occupation on the basis of this and the progression that has happened since. He has considered other potential occupations but he has difficulty with prolonged sitting and he has to move around in order to improve his symptoms. He has also found that prolonged concentration tends to exacerbate his neuropathic symptoms.

At this stage, I do not believe the patient would be able to be directed to another occupation given his ongoing symptoms.

Current Treatment

The patient is currently taking duloxetine 90 mg and he is taking vitamin C which has been recognised as a potential treatment for CRPS. He is also on PEA 600 mg twice a day which has a role in desensitisation of neuropathic conditions. In addition to this, he uses a lidocaine patch which he finds gives a small degree of improvement. I believe that he will need ongoing medication and it will also probably be necessary to try other medication at some point in the future. I believe that the patient will incur costs of anywhere up to \$200/month for ongoing medication for the foreseeable future.

Examination

The patient has a CAM boot on along with a number of lignocaine patches over his foot. There is a difference in colour between the right and left foot, with the right foot appearing more flushed and the toes having a slight purple appearance. In addition to this, there is a difference in sweating between sides and the patient also has significant allodynia and quite significant pain even to extremely light touch. This extends up through most of the leg. In addition to this, the patient has a sweatier hand on the right than the left and while there are no colour differences between the hands, there is definitely some degree of increased sensitivity to touch.

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There is very little movement of his ankle and for functional purposes, his movement is essentially equivalent to it being arthrodesed in the neutral position. Due to the amount of sensitivity, his foot was not examined at the first appointment. On the 4th of July the patient was examined after taking analgesia, there was no movement possible involving the mid foot or toes essentially equivalent to Arthrodesis. With this in mind, I believe that the patient has adequate criteria to satisfy the Budapest Criteria for the diagnosis of CRPS.

Medical Treatment

The patient needs to have ongoing medical treatment. He has painful neuropathic symptoms and there will be an ongoing need for pain specialist review. I would also recommend that the patient see a pain psychologist for consideration of counselling with regards to how to deal with pain. Somebody such as Bryan Suter in South Perth may fulfil this role. The patient is also seeing an occupational therapist through the Painless Clinic which seems to be of value in terms of maintaining his function.

I recommend that the patient be encouraged to do ongoing exercise with the relevant body parts to try and minimise sensitisation. The use of water-based exercise may in some way benefit this and he should also have some input from a pain physiotherapist.

The patient has had treatment to the sympathetic nerves which was done quite recently and this is yet to cause any improvement. The patient had right lumbar sympathectomies at L2, L3 and L4.

I believe the pain specialist has talked about possibly trying a stellate ganglion block. Stellate ganglion blocks have had some role in sympathetically mediated pain but in my experience, they are probably more useful for upper limb pain.

The patient may also be a perfectly reasonable candidate to consider a neurostimulator. Neurostimulators can be useful in terms of the management of pain. He may also benefit from a ketamine infusion in hospital and repeated infusions may desensitise his pain somewhat. I have also had some experience with using lignocaine for this purpose.

As such, I believe that the patient will need ongoing pain therapy for the foreseeable future and the cost of this pain therapy over the next 10 years, depending on whether or not a stimulator is required, could be anywhere up to \$100,000.

Treatment

As I mentioned, the patient will need ongoing treatment. At this stage, the need for stimulator surgery has not been fully assessed and as part of this, I would typically recommend that the patient have a pain psychologist opinion and this matter should also be considered by his pain specialist. I believe the prognosis for any treatment to return him to full work capacity is poor but the major aim of any treatment would be to improve his quality of life and help him deal with his ongoing disabling pain.

Development of Degenerative Changes

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Typically, CRPS is not associated with degenerative joint changes although this may be the case. What is evident in this case is that the patient is having a progression of symptoms related to the ongoing neuroplastic processes in the nervous system. The spread of these symptoms as it becomes more generalised may cause additional effects. Obviously, this will cause ongoing issues with regards to his capacity.

Stabilisation of Condition

I believe that the patient's condition has not been fully treated and that the patient requires additional treatment. I do believe, however, that the patient's condition has stabilised with regards to the persistence of ongoing symptoms which are unlikely to improve fully with time. Based on the patient's current conditions, I believe that his whole-person impairment (WPI) is likely to persist as it is. There is a small chance that he may have more generalisation of symptoms but the development of these is not inevitable.

Impairment

As the patient has quite widespread symptoms related to his CRPS covering multiple distributions of nerves, the patient has developed hyperpathic and allodynic symptoms in the distribution approximating the entire leg and also the hand on the right. This would correspond to the distributions of the following nerves, Femoral Nerves (3%WPI) and sciatic nerve (5%WPI) in the lower limbs. The upper limbs would correspond to the median nerves, radial nerves and Ulnar nerves, with 5% for radial, 7% for Ulnar and 39% for Median nerve(upper limb impairment).

The patients upper limb impairment on the basis of the sensory changes involving the entire hand would correlate to a WPI of 26%. The total WPI of his lower limb would be 15%, based on sensory pain changes. In addition to this, the patient has had a restriction in movement of his ankle which, in effect, places his ankle in an arthrodesed neutral position, which would correlate to a WPI of 4%. His mid foot impairment would be 4% WPI and his impairment related to loss of toe mobility would be 6% WPI. The total WPI for his lower limb would thus be 20%.

His upper limb impairment on the basis of his sensory changes involving his entire hand would translate to a WPI of 26% combining these two would translate to a WPI of 41%

Yours sincerely



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